

Two variants of decentralised health care: Norway and Sweden in comparison

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Two variants of decentralised health care: A comparison of Norway and Sweden

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Abstract

This paper discusses the development of the Norwegian and Swedish hospital systems from a historical-comparative perspective. The development of the Swedish system has been characterised by institutional stability, while the Norwegian system has been characterised by instability and change. The paper contributes to research on the historical development of health care systems. In a more general sense, it also informs historical research about welfare states.

Keywords: Hospital system, historical comparison, Norway, Sweden, historical institutionalism

Introduction

Historically, the governance of somatic hospitals in Norway has followed a clear developmental path, beginning with a very high degree of decentralisation, followed by centralisation at the regional level, and later by a very high degree of centralisation. From the mid-19th century until 1970, most Norwegian somatic hospitals were owned and administered by institutions based in local communities.¹ Between 1970 and 2002, hospitals were owned and managed by counties, and hospital committees were appointed according to the political composition of the county assemblies.² From 2002 onwards, the ownership and management of Norwegian somatic hospitals became the responsibility of the central state. The hospitals were organised as regional and local health enterprises and committee members were appointed by central authorities.

Hospital governance in Norway could, in certain respects, be said to be characterised by continuity and institutional stability, but a long-term historical comparison with Sweden's hospital system suggests that Norway's system is characterised instead by developmental discontinuity. The structure of Sweden's system has remained largely unchanged since the 1860s: somatic hospitals are still owned by the nation's counties, and Swedish hospital committees still reflect political representation in the county assemblies.³ Major reforms within the hospital sector in Sweden have been conducted mostly within the framework of its existing institutional arrangements while reforms in Norway's hospital sector have, by contrast, caused substantial institutional transformations.⁴

This article aims to describe and discuss the differences between the institutional development of the somatic hospital systems in Norway and Sweden using a historical-comparative perspective.⁵ We will argue that such an analysis offers an important contribution to health care research. During the last decade, research on the historical development of European health care systems has been substantial and several authors have noted that the development of health care systems has been characterised by far more variation and nuance than had been previously assumed. In a comprehensive study of the development of the health care systems in Italy, Sweden, the United Kingdom (UK), France and Germany, for example, Richard Freeman argues that what appear to be characteristic national financial, organisational and institutional designs for national health care systems are, in reality, a complex mixture of systems. Freeman notes that health care systems are also «dynamic, continually adapting and readapting to the wider political, economic systems of which they are a part».⁶

Historical analyses of health care systems, such as those used by Freeman, are often concerned with the relationship between health care systems and the wider contexts of which they are a part.⁷ Such historical research is characterised by comparative analyses of different systems. Tore Grønlie, for instance, compared the development of the Norwegian and British hospital systems, arguing that the UK and Scandinavian countries are often regarded as having very different systems of health care governance. The British National Health Service (NHS), for example, is often seen as the prototype of a centralised and state-run system. While the British and Scandinavian health care

systems are similar in the sense that they are based on public ownership and funding⁸, Scandinavian countries are perceived as having typically decentralised systems. Grønlie argues that by exploring the development of the health care systems in both Norway and the UK over a longer time span, a number of similarities and differences can be detected. Prior to the Second World War, both countries used a highly decentralised model of health care provision (in Britain's case, strongly influenced by voluntarism), but this later diverged after 1945. As Grønlie reasons, observations of change demonstrate a necessity for «a *temporal delimitation* of any 'model' of health care and hospital organization». Models tell us little «if anything, if they are not situated in rich historical contexts».⁹

Such comparative historical health care research aims to identify nuances within the development of what might otherwise be considered particular «types» of systems in regions such as Scandinavia.¹⁰ The historian Per Haave, for instance, focused on three aspects of the development of the hospital systems of Norway, Sweden, Denmark and Finland during the period from the 1930s to the 1970s. These were: the role of the state in the development of hospital systems, the extent to which the development could be viewed as social democratic in character and whether a common «Nordic approach» Haave argued that if there is indeed such a phenomenon as the «typical» Nordic hospital system, the decentralised structure was its most prominent hallmark.¹¹ Similarly, the social scientists Haldor Byrkjeflot and Simon Neby analysed reform efforts and institutional arrangements in the Norwegian, Swedish and Danish hospital sectors using an historical-institutional perspective, and questioned the validity of the term «model of health care governance». In the context of Scandinavia, they argued, this term is restricted to describe the period between 1970 and 2000.¹²

The rise of research on the historical development of health care systems has corresponded with renewed interest in the historical development of European welfare 'states'.¹³ Studies such as those noted above have demonstrated that an exploration of variations and nuances in health care system development between countries, and within «clusters» of apparently similar health care systems and welfare states, can be particularly fruitful. Such comparative analyses provide an opportunity to identify and explain developmental similarities and differences in relation to context.¹⁴ However, it is more methodologically beneficial to limit the number of countries compared within studies as this allows a more thorough understanding of the comparative development of health care in each country.¹⁵

Our analysis is rooted in what Charles Tilly terms «the variation-seeking type of comparisons» – a comparative approach concerned with how similar processes are revealed in different ways within different historical settings.¹⁶ When studying variations within the development of the health care systems in the Nordic countries, there are good reasons for focusing only on Norway and Sweden. As Byrkjeflot and Neby have noted, of all the Scandinavian countries, Sweden is characterised by the highest degree of continuity in hospital governance, and Norway the least.¹⁷ Haave, in his comparison of four of the health care systems also observed that the central state had been most active in the historical development of the hospital system in Sweden, but least active in Norway.¹⁸ Norway and Sweden may therefore be seen as representing the most contrasting institutional arrangements within the hospital sector in Scandinavia and

most suited to elaborating the nuances and variations in the organisation of health care governance.

The following questions are addressed in this paper: How could the institutional differences in the historical development of Norway and Sweden's hospital systems best be described? How could these differences be explained in relation to the institutional context in which they developed? Why has health care development been characterised by discontinuity in Norway, but by continuity in Sweden?

The analysis in this paper is based on official reports about the hospital systems in Norway and Sweden, parliamentary records, sources from the Norwegian National Archives, as well as secondary sources. To begin the discussion, we will now review the analytical approach we have chosen in more detail.

A historical–institutional approach to understanding the development of the Norwegian and Swedish hospital systems

A parliamentary report in Norway issued in the mid-1970s stated that any kind of development or transformation within the hospital system would necessarily confront prevailing structures and organisational patterns:

That sudden radical changes could be carried out in such huge and complicated, long-establish sector of society is an unrealistic assumption.¹⁹

The historical heritage of the hospital system, as this quote suggests, was clearly regarded by politicians and health bureaucrats at the time as a framework that shaped the conditions of governance and the [potential?] space for action inside the hospital realm. In this paper, we will argue that an approach focused on historical institutionalism offers valuable opportunities for analysing the continuities and discontinuities of hospital system development. Historical institutionalism aims to explore how historically inherited institutional conditions constitute the framework for political action and it helps to facilitate an understanding and explanation as to why certain developmental trajectories have been followed in particular settings but not in others. More specifically, historical institutionalism is oriented towards exploring how the organisation of policy making affects the power which historical actors are able to have.²⁰ According to Kathleen Thelen, recent studies within the tradition of historical-institutional analysis have focused more on how institutions react and adapt to new conditions rather than elaborating on how historical actors have adapted to institutions themselves.²¹ Such an emphasis is implicitly similar to what is termed a «path-dependency approach» – a term describing a focus on the role of historical causation and how historical dynamics are being reproduced in new contexts.²² According to Thelen, while previous «path-dependency» approaches have been dominated by deterministic perspectives, many current theorists have focused their attention on «positive feedback effects that help [to] explain important institutional continuities over time». More specifically, this approach focuses on how institutions created by one set of

political actors and created for one purpose can – due to positive feedback – be embraced and carried forward [in new ways and] by new coalitions. Changes in political coalitions are therefore seen to «hold the key to understand[ing] shifts over time»²³ within institutions. An historical-institutionalist approach is founded on the assumption that the origins and development of institutions and the process of institutional reaction and adaption should be understood in terms of the institutional framework that has characterised their historical formation.²⁴ A central assumption of this approach is that institutions exert a «powerful influence on the strategies and calculations of...the actors that inhabit them». On the other hand, institutions are also seen as objects of ongoing political contest. In order to elaborate further on institutional reproduction and change, it is therefore also necessary to focus on the political dynamics and processes that drive «institutional genesis, reproduction and change».²⁵

Much of the analysis of the historical development of the hospital systems in Norway and Sweden to date has been informed by historical-institutional approaches, although not necessarily in explicit ways. This influence is evident, for example, in an overview of the historical development of hospital governance in Norway, in which it is suggested that the institutional reforms introduced in the hospital sector in 1970 were unable to cope with the inherited problems of governance. The role of local communities in the development of the hospital system – known otherwise as «localism» – was seen as a key influence in the shaping of hospital policy and the creation of the embedded political struggles. This framework for hospital governance lasted from the mid-19th century through to the mid-20th century²⁶ and was interpreted in the article as one of the key reasons for the institutional instability of the Norwegian system and the introduction of new reforms in 2002.²⁷ In contrast, the analysis of the development of the Swedish hospital system suggested that, in contrast, the role of county assemblies that had operated since the 1860s had contributed to institutional stability.²⁸

To describe and explain these developmental variations from a historical-institutional perspective, and to understand the characteristic hospital structures in Norway and Sweden in the 20th century, it is therefore necessary to begin our analysis in the middle of the 19th century and to understand the historical circumstances of this time.

While it was local government that was to influence the development of the hospital system in Norway, it was the counties that were to shape the hospital system in Sweden. In 1860 there were approximately 27 general hospitals in Norway. By 1900 this number had risen to approximately 36, with all the new hospitals run by the town councils.²⁹ In Sweden, approximately 46 general hospitals had been built by 1861, and by 1900 this number had risen to approximately 76. All of these hospitals were owned and managed by the county assemblies.³⁰

The characteristics of the institutions that formed the institutional framework of the development of the hospital systems at this time can be summarised as follows:

Institutional framework of the hospital systems in Sweden and Norway, mid-19th century

	Central state	County assemblies	Local government
Sweden	<p>Strong executive powers.</p> <p>Two-chamber Parliament, upper chamber recruited from socially elite groups.</p> <p>Dynamic relationship between counties and local councils.</p>	<p>Clearly defined role within political-administrative system.</p> <p>Executer of central state policy.</p> <p>Able to place tax on income.</p> <p>Dynamic relationship between assemblies and the central state.</p>	<p>Dynamic relationship between county assemblies and central state. Members recruited from socially elite groups.</p> <p>Restricted autonomy.</p>
Norway	<p>Strong one-chamber Parliament, especially after 1884. Municipal councils have strong impact on the central state.</p> <p>Members elected from farmers and middle-class, influential groups.</p>	<p>Restricted role.</p> <p>All towns and cities excluded.</p> <p>Unable to place tax on income.</p> <p>Recruited from among municipal mayors.</p>	<p>High degree of autonomy.</p> <p>Legally permitted to fix level of taxation.</p> <p>Farmers and middle class influential groups.</p>

Norway and Sweden had three levels of governance in the 19th century, namely the central state, the counties, and local government. Distinct national differences were evident in the tasks ascribed to these different institutions as well as in the relationship between the different institutional levels – variations that were to have direct consequences for the development of the different hospital systems. In Norway, for example, local governments were characterised by a high degree of autonomy³¹ and municipalities had the legislative right to set taxation levels between the years 1838 and 1911.³² The role of local government in Sweden was more restricted.³³ County and municipal legislation ratified by the Swedish Parliament in 1862 gave county assemblies the right to tax county residents. Assemblies were delegated a number of tasks and responsibilities in industry and trade, agriculture, communication, education and health care³⁴ and a government decree of 1864 added hospitals to this list of responsibilities.³⁵

The Swedish county system could be seen as having provided a better structure for hospital governance than the equivalent system in Norway. While both countries had a local government consisting of both rural and city municipalities³⁶, the number of city municipalities outside the county assemblies varied significantly. In Norway, the county assemblies included only rural municipalities and *all* towns or cities were excluded.³⁷ In contrast, in Sweden only the two major cities of Stockholm and Goteborg were not included as part of the county assembly system at this time.³⁸ This variation implied that the population in the Norwegian counties was more scattered than in Sweden. Furthermore, the Norwegian county assemblies were unable to raise tax from the most prosperous citizens and enterprises of the time, typically located in cities.³⁹ Furthermore, this arrangement suggests that Norwegian hospital establishments during this period were essentially a city- and town- rather than a rural-phenomenon (cf. above).

Differences in the relationship between the central state and other levels of government also had implications for the development of the different hospital systems in the two countries. Reforms in the Swedish governmental system during the 1860s saw a transition from a four-estate structure to a bicameral Parliament. The upper chamber was given powers to veto decisions made by the lower chamber⁴⁰ and representatives in the first chamber were elected by members of the county assemblies and city assemblies who were not included in one of the counties.⁴¹ The electoral system in Swedish towns and municipalities reflected the importance of income and property: those with large properties or high incomes – landowners, industrialists, civil servants and professions – came to exert greater influence in local assemblies, county assemblies, as well as in the first chamber.⁴²

These reforms in the governmental system in Sweden during the 1860s were part of a process in which public institutions were assigned a more active role in development of society.⁴³ Using county assemblies as instruments to implement central governmental politics formed part of this change. In her influential study of the historical development of health insurance systems in Western Europe, Ellen Immergut argues that the governmental system established in Sweden at this time gave the executive body a strong influence on the shaping of health policies, and that the Swedish government had comparatively better opportunities to carry out comprehensive reforms within health care.⁴⁴ This was because the system encouraged a dynamic relationship between governmental bodies at different levels of the politico-administrative system, especially as county council politicians appointed the representatives in the first chamber in Parliament and were themselves the main executors of health policy.⁴⁵ This dynamic relationship between Parliament, the executive body and other interest groups, as Immergut contends, informed health policies in a more positive and conciliatory way.⁴⁶

The construction of the Norwegian politico-administrative system, in contrast, mirrored and reinforced the autonomy of *local* government. Unlike the Swedish system, the Norwegian Parliament had only one chamber, and the electoral system was not adjusted according to income or property ownership.⁴⁷ Local election districts were used for general elections, and regional assemblies did not act as intermediaries between local and central government as in Sweden. Norwegian parliamentary delegates were chiefly recruited from among local politicians. In the parliamentary elections during the 1870s and 1880s, 90% of the Parliamentary representatives came from rural areas and 80% of the town and city dwellers had served as politicians in local councils.⁴⁸ Farmers and middle-class groups dominated the Parliament⁴⁹ and the county assemblies consisted of mayors from each municipality in the local area. Several of the assemblies at the time wished to avoid taking on tasks which could result in further expenses being imposed on the municipalities⁵⁰ and similar attitudes were also evident in Parliament.⁵¹

Political developments in Norway from approximately 1860 were characterised by rivalry between the liberal coalition in Parliament and the civil servant-dominated government. A new health law introduced by the Norwegian Parliament in 1860 afforded a high degree of autonomy to the municipalities and gave the central state modest opportunity to influence the institutional development of health care.⁵² The development of the hospital system was therefore affected strongly by this higher degree of autonomy afforded to local government. Unlike in Sweden, the executive

body did not have an equally strong role and therefore did not have the same degree of impact on shaping the framework of health policy. This autonomy allowed local government to assume responsibility for new societal tasks and was reflected in the establishment of hospitals in both towns and cities and also seen in the development in the countryside after 1900 (cf. below).

Further analysis in this paper will now focus on the development of the Norwegian and Swedish hospital systems from the 1860s until the 1970s. The discussion will focus on the extent to which the initial institutional framework in the respective countries was adapted and perpetuated by new actors and the impact and effects of these processes on hospital policies. This discussion focuses on how the development of the hospital system in these countries can be understood in light of the roles afforded to the local government and the county assemblies responsible for executing hospital policy in each of the countries. The study also focuses on how the development of the hospital systems can be understood in terms of the relationship between these bodies and the central state. These relationships will be explored on a local community level, a regional governmental level, and a central state level.

The analysis that follows is divided into three sections. In the first, we provide a brief sketch of the development of the hospital system during the period after the establishment of the institutional arrangements within the hospital realm, i.e. the period from approximately 1860 until 1910. In the second section, we explore the period between approximately 1910 until 1930, while the final section examines the period from the late-1930s until the early 1970s. These delineations correspond to key periods in the development of hospital systems in the two countries and serve to frame major turning points in their historical-political development. The first period, as we will show, was characterised by significant differences between the two countries (parliamentarianism, for example, grew significantly in Norway in 1884 and this was followed by several extensions of the franchise). The period from 1910 to 1930 was characterised by further significant developments in the establishment of democracy in both countries under both liberal and conservative governments and coalition governments.⁵³ The analysis of the final period is the most comprehensive and provides a review of the social democratic governments of Norway and Sweden and the strong belief in both nations that development could be controlled by central governmental measures.⁵⁴

Hospital expansion in the early phase

County assemblies in Sweden in the mid-19th century were the main providers of health care, and a significant proportion of their income was spent on general hospitals during the two decades after the governmental reforms of the 1860s.⁵⁵ The relationship between the central state and county assemblies was a dynamic one and the electoral system resulted in civil servants and particular professions (such as physicians) being among the dominant groups in Parliament and county assemblies. One effect of this structure was that actual medical considerations shaped the development of hospitals in the counties. In the county of Kopparbergs län (Dalarna) in Western Sweden, three new

hospitals were built in the period after 1862 and an older hospital restructured. These changes were organised by committees led by physicians who were/ [had been elected as?] representatives in the assembly.⁵⁶ In the ensuing political struggle over their establishment, the purpose of the county assembly, it was reasoned, was to establish and coordinate health measures within these regions.⁵⁷

In Norway, the county assemblies were also used to expand the provision of general hospitals but were seen in different ways. Like Parliament, the composition of the Norwegian county assemblies reflected and supported the high degree of autonomy offered to municipalities in the political-administrative system. One of the consequences of this autonomy was that it enabled initiative at a local community level. This enabled the incorporation of medical considerations: when a new hospital was established in Trondheim (the third biggest city in Norway) in 1902, for example, it was the result of the efforts of the chief physician at the old city-hospital combined with the efforts of the head of the local health administration (the *Stadsfysikus*).⁵⁸

But the establishment of the hospital in Trondheim was also the result of the wider democratic changes taking place. The significant development of the Parliamentary democratic system in 1884 was followed by further extensions of the franchise, and in 1896 all adult working class men gained the right to vote in local elections. For the Liberal Party, the inclusion of these new voters encouraged and enabled its radical social policies, and it was these changes lay behind its motivation to establishment the new Trondheim hospital.⁵⁹ In turn, the Liberal Party's health concerns had a politicising function within local communities, and saw a strong local commitment to the hospitals (cf. below).

In Norway, no new general hospitals were established in the countryside during the second half of the 19th century. Instead, towns and cities became the providers of health care services for their neighbouring counties. Like the counties themselves, the Norwegian medical districts lacked the resources and mechanisms necessary to establish hospitals in the way that the Swedish counties were doing at the same time. Under «The Public Health Act» passed by the Norwegian Parliament in 1860, municipal health committees were established as mandatory institutions in rural areas.⁶⁰ Typically, district physician became leaders of the committees, thus helping to give medical expertise a prominent role in local health issues.⁶¹ The system, however, was too decentralised to properly encourage hospital expansion, and the medical districts too extensive.⁶² In the county of Søndre Bergenhus (Hordaland) in western Norway, citizens from the region who took ill were admitted to a municipal or private hospital in the city of Bergen which was not officially part of the county⁶³ and similar systems of reliance were developed in other regions as well. But as a result of the systemic weaknesses, while the system provided valuable resource to those within the counties, it also contributed to the creation of imbalances in hospital service provision.

In Sweden, by contrast, the establishment of hospitals in cities and counties was a parallel process.⁶⁴ The Swedish central government also instructed how the hospitals should be administered and influenced the way the way they were governed. Governmental regulations resulted in the county governor – the central state's representative at the county level – being appointed as the chairman of hospital committees. The district physician – a civil servant appointed by the state – was also

appointed as a member of the committee.⁶⁵ No similar system of governance was established in Norway during this period.

Consolidation and expansion

After the start of the 20th century, the dynamics triggered by the democratisation of Norwegian local communities became evident on a national level. The period between 1900 until approximately 1920, saw intense rivalry between the Liberal Party (the dominant political party at the time) and the Labour Party over working-class voters.⁶⁶ Acts such as the Sickness Insurance Bill passed by Parliament in 1909 (enabling people to access insurance to cover a large proportion of the fees imposed on hospital patients⁶⁷) were a direct result of this battle between the two parties.⁶⁸ Norway also saw the largest increase in the number of general hospitals during this period.⁶⁹ Legal changes during this time increasingly stimulated municipal autonomy and reflected its growing importance. During the parliamentary debate related to the Sickness Insurance Bill, the liberal majority coalition sought to ensure that while the insurance would be administrated by the municipalities, the local councils would be able to avoid the expenses associated with the proposed insurance. The bulk of these expenses (60%), it proposed, would be charged to individual employees, and only 10% would be charged to the local council. The Labour Party also spoke in favour of a having an even larger proportion of the expenses covered by local councils and the state.⁷⁰

The political negotiations related to the sickness insurance scheme demonstrated the impact of the wider institutional framework that was shaping the development of the Norwegian hospital system. Importantly, although the establishment of hospitals during this period was undertaken by municipalities it was also deeply rooted in local community politics and influence. A large proportion of the Norwegian population, as it transpired, did *not* join the sickness insurance foundation: membership was mandatory only for employees in private enterprises or those in the public sector.⁷¹ Moreover, the insurance covered expenses specifically related to physicians' salaries. Other expenses, such as those related to hospital equipment still needed to be financed from the budgets of local councils or raised from other sources such as cure-fees.⁷² Another particularly important financial resource in many communities was fundraising through voluntary organisations. These played an important role in the establishment and running of hospitals – particularly after 1910 – and local branches of women's organisations such as the *Norwegian Women's Public Health Organisation* (the *Norske Kvinners Sanitetsforening*) were particularly important. Between 1909 and 1941, twelve local general hospitals were established due to the efforts of public health organisations.⁷³

Although voluntary organisations influenced the development of hospitals, it can be argued that they were not a dominant force. Local savings banks, too, also helped to fundraise and granted part of their surplus to local charities; the money was used to found several local hospitals.⁷⁴ Together with local branches of public health organisations and related associations, these institutions formed a network of supportive political institutions, and civil society and local community organisations that collectively contributed to the development of the Norwegian hospital system and its rapid public

expansion after 1900.⁷⁵ This amalgamation of effort, we would argue, indicates that local hospitals had a wide range of stakeholders within local communities, and that this influence was an important factor in shaping the overall framework of hospital policies in Norway during the 20th century.⁷⁶ Somatic hospitals helped to satisfy the health needs of local citizens⁷⁷ and such «localism» – and the commitment to hospitals within local communities – must also be viewed within the wider context of changing development patterns.⁷⁸

The development of the Swedish hospital system during the first decades after 1900 was, unlike in Norway, strongly influenced by central governmental measures, including the consolidation of the county-based system. Although the counties' role as hospital administrators was determined by governmental decrees, this responsibility was not regulated by law until 1928 and the passing of the The Hospital Act by the Swedish Parliament. This Act obliged county councils to provide for hospitals or, when there was no other provider, to be responsible for the provision of hospitals within the county area.⁷⁹

From our perspective, the preparatory processes which occurred prior to the approval of the legislation are of particular interest as these reflected the dynamics operating between the governmental bodies at the time and the interest groups inside the hospital system. Formed in 1920, a royal committee was appointed to prepare new legislation, and consisted of representatives from the central state's Medical Committee, county governors, the county assemblies, and the physicians at county-owned general hospitals as well as some of members of the Upper Chamber in Parliament.⁸⁰ This inclusiveness reflected the cooperation between all the governmental levels involved in the execution of the Swedish hospital policy and the dynamic relationship which existed between them.

These preparatory processes also demonstrated that the conciliatory mechanisms apparent during the original development of the Swedish hospital system continued after the broadening of democracy within the country.⁸¹ Prior to the passing of the legislation in 1928, the committee received statements from professionals as well as from different groups in Parliament.⁸² This maintenance of stability and continuity inside the hospital realm was made possible during the preparatory legislative process by the so-called «*remiss*-system» – a consultation-system institutionalised at a comparatively early stage in the development of the Swedish politico-administrative system⁸³ which gave those involved the opportunity to express their opinions and interests. This mechanism ensured that conflicts between the different interest groups were considerably reduced by the time the decision-making process reached Parliament.

This Swedish institutional framework allowed for a greater degree of central control over hospital development than in Norway – both on a state and county level. The 1928 Hospital Act, for example, contained several provisions that shaped hospital organisation and administration. Detailed legislative obligations were provided and county assemblies were made responsible for the needs of the hospitals within their area and for hospital development plans within each county. The state, according to the legislation, could be consulted when needed and plans for new hospitals, or for heating and sanitary systems needed to be approved by the state in advance. Physicians were

also required to be appointed by the state and the law indicated that hospitals were to be inspected by the state's Medical Committee at regular intervals.⁸⁴

The institutional framework in Norway was markedly different. The Public Medical Service Act passed by Parliament in 1912 replaced the Public Health Act of 1860 and provided a new legislative framework to strengthen central government control over health care services. This law introduced a more hierarchical system headed by the state's Medical Director; and municipal health committees headed by district medical officers, formed the basic structural and administrative unit. The law helped to improve access to medical services nationwide, especially in rural areas, by increasing the number of medical districts.⁸⁵ The law however did not improve opportunities for the central state or the regional health authorities to exercise control within the hospital sector. According to The Public Medical Services Act, county physicians were required to inspect health institutions in their counties and report to the state's Medical Director.⁸⁶ But the law did not provide for opportunities to regulate hospital development on a national scale, and several county physicians complained that new institutions were being established without approval by the central authorities. In Troms, one of the northernmost counties in Norway, the county physician reported that a small hospital had been established and financed by a local branch of the local public health organisation. Once the hospital had been established, the county council took over operational responsibilities. But the district physician noted that the construction plans had not been submitted to him or the county authorities prior to its establishment, and that the county would try to prevent such events from recurring.⁸⁷

A similar example illustrating the very modest opportunities that the Norwegian authorities had to plan or administer local hospitals occurred during the 1920s in Sogn og Fjordane, a county in the west of the country. A committee appointed by the county assembly proposed the restructuring of the county's old and only hospital and the additional construction of a new one. While the state's Medical Director supported this proposal, it became impossible to unify the county politicians in support of this plan. Lacking the means to implement the committee's proposals, a power vacuum offered a space for local alternatives and, consequently, *four* hospitals were built, initiated by private efforts and local fundraising in the county. The hospital system in the county therefore failed to develop according to a general plan. From a central state perspective, the developments would have seemed uncontrolled and uncoordinated.⁸⁸ In contrast, the Swedish hospital laws passed in 1928 stated that the development of the hospital system *should* follow general plans. The ambitions of the central government to influence the development as well as the organisation of hospitals, were further reflected in a report issued by the Swedish state's hospital commission in 1934 urging the establishment of one central hospital in each county.⁸⁹

Between centralisation and decentralisation

The implementation of the Law on Hospitals in Norway in 1969 had the county ownership of general hospitals as its main principle. The reform reflected a shift towards an intended centralisation of the hospital system. Hospital policy in both

Sweden and Norway during the post-war period was characterised by efforts to improve centralised planning and coordination and a growing desire to increase the central state's administrative power as a central feature of social democratic policy.

In both countries, these changes were rooted in events that had occurred before the Second World War.⁹⁰ In Norway, increased efforts to better coordinate the central health administration emerged during the early 1930s: these included initiatives to develop a coordinated plan for hospitals, and a system aimed at controlling the establishment of new hospitals nationwide implemented in 1936 by the Ministry of Social Affairs.⁹¹ As part of their efforts to develop a general national plan, the central authorities created an overview of hospital institutions, which was based on survey data, and assessed the need for hospital services in different parts of the country determined by existing infrastructural requirements, population size, etc.⁹² This survey was completed and published in 1941.⁹³

In the late-1930s, initiatives to improve coordinated planning efforts within the hospital sector were also undertaken. The young and radical physician, Karl Evang, became the driving force behind this effort as head of the Medical Directorate in 1938. Striving to increase coordination and the influence of medicine on the development of the hospital system, Evang sought to strengthen the central state health authorities using the Swedish model as a guide. In his correspondence with the Norwegian Medical Association in 1939, Evang referred to the Swedish Medical Committee as being more efficient and centralised because it included specialised hospital branches:

This system represents huge advantages compared to the system in our country and it is my intention ... to propose that a similar system is introduced in Norway.⁹⁴

A new health directorate with extensive powers was established under Evang's leadership in 1948, merging both the old directorate and the medical branch of the Department for Social Affairs.⁹⁵

Efforts to improve the centralised planning of the Norwegian hospital sector after the Second World War were manifested in several ways. In 1946, a proposal for a national plan for hospital development was introduced, based on regional plans for hospital development conducted by the counties. A central advisory hospital council – the *Statens Sykehusråd* – was appointed simultaneously.⁹⁶ In 1957, the Ministry of Social Affairs appointed a committee for hospital planning, and its report was delivered in 1963. The report contained the main elements which were to be introduced in the Hospital Act of 1969: county ownership of hospitals and the coordination of specialist medical services between counties when necessary.⁹⁷

Attempts to improve the coordination of the Norwegian hospital sector in the immediate post-war period were, as noted above, a continuation of efforts initiated during the 1930s. This process effectively had to be re-started because no development in the hospital sector took place under the German occupation and a number of hospitals had also been destroyed or damaged during the war.⁹⁸ In spite of the expansion of the hospital sector during the 1950s, huge differences in the availability of hospital services across were evident across different areas of the country. In 1964, for example, 9.9 hospital beds were available per 1,000 inhabitants in Oslo, the capital city

of Norway; the county of Sogn og Fjordane had an average of just 2.9 per 1,000 people⁹⁹ despite the fact that three new hospitals had been built there during the interwar period (cf. above). This maldistribution of hospital beds showed that while the Norwegian hospital structure was widely distributed, the decentralised hospital planning structure and the small size of the actual institutions meant that the *availability* of hospital services was not guaranteed.

Differences in the physical structure of the hospital systems of Norway and Sweden are also well illustrated when the bed/population ratios of the two countries are compared. Norway by 1970 had approximately 50,000 inhabitants for each general hospital, while in Sweden there was one bed for every 73,000 people.¹⁰⁰ However, there were far more hospital beds relative to the total population in Sweden than there were in Norway. By 1957, the availability of hospital beds in Sweden had risen to 15 per 1,000 inhabitants, while in Norway it was only 10.¹⁰¹

During the post-war period, the lack of coordination and planning in the hospital sector in Norway were raised as problematic issues in public reports as well as by the counties and local authorities and the lack of a central institution responsible for these tasks was seen as frustrating. The Norwegian Association of Municipalities and Towns established a hospital department in 1960 with the intention of encouraging better coordination, planning and rationalisation. In a preparatory report to the establishment of the hospital department in 1960, two problems were noted as being particularly significant: that there was no common institution representing hospital owners in Norway, and that recourse to the central authority (the Health Directorate) was insufficient to ensure sufficiently rationalised planning within the hospital sector.¹⁰² One of the members of the [health?] department, director Tormod Brækken, voiced his frustration in a comment that followed an article published in 1962:

... the problematic factor is to coordinate the development internally within and between the counties. Many assume that the Health Directorate takes care of this coordination, but unfortunately this is not the case. According to the law the Directorate is supposed to approve hospital planning technically, but it does not consider whether development is required ... In truth, a general plan for hospitals was established, but no one is committed to it. Hospital owners deal with planning individually and independently of the general plan.¹⁰³

The implementation of the Hospital Act in 1969 sought to address this lack of synchronisation/coordination, stating that county assemblies were now legally bound to provide for the general hospitals within each county area. This suggested that Norway had effectively introduced a similar system of governance to Sweden. However, towns had already been included within the counties in 1964, as part of an effort to make the counties a more clearly defined entity within the politico-administrative system. As several hospitals nationwide were already owned by towns – this effectively meant that the counties thus became the main owners of Norwegian hospitals.¹⁰⁴

The county ownership of hospitals, associated with transformations within the institutional frameworks presented different institutional challenges in Norway and Sweden. Understanding this difference helps us to identify better some of the long-term factors affecting the Norwegian hospital reforms of 2002 and what came to be seen as

the «inherited problems» underlying the institutional instability within the hospital realm at the time. One such difference was the variation of the political-spatial/physical structures of ownership already described. Another was the degree to which their legitimacy varied. Several analyses of the development of the Norwegian hospital system post-1970 claimed that these inherited problems materialised in the form of crises of legitimacy for the counties. Some local communities protested against changes in the hospital services which had previously been under their control. The counties also came under pressure from above due to the expectations of the central state that the counties should be committed to the nationally-formulated objectives for hospital policies.¹⁰⁵

The Swedish hospital system during this same period did not appear to have been characterised by such tensions, even though the development of the Swedish hospital system in the 1950s and 1960s was similar in some ways to the system in Norway and had, in fact, inspired the changes implemented by Norway. From the 1950s, enforced centralised planning measures came to characterise health care in Sweden and the problems that occurred were, to some degree, similar in both nations.¹⁰⁶ In 1951, a committee on hospital legislation was appointed to evaluate the degree to which hospital establishments in the counties should be subject to centralised plans.¹⁰⁷ Although the legislation implemented in 1959 did not provide for centralised planning, it did afford the county assemblies a higher degree of autonomy, particularly with regard to economic matters.¹⁰⁸

During the 1960s, Swedish county councils were given responsibilities previously undertaken by other governmental bodies. Decentralisation was seen as a way of strengthening the county councils and as the most appropriate way to organise health care in Sweden. In addition, these changes were motivated by a need to improve conditions for coordinated resources planning and usage in the hospital sector and in primary health care.¹⁰⁹ Further changes in line with this policy included county councils assuming responsibility for district physicians in 1963 and responsibility for mental hospitals in 1967; medical officers in towns were incorporated within the county council organisation in 1968. In 1974, responsibility for dental care was also transferred to the county councils.¹¹⁰

These developments represented a consolidation of county council power and underpinned the role of the counties as key players in the Swedish political-administrative system, particularly related to health issues. They also represented the continuity of a development in Sweden's health system since the 1860s. In Norway, locally based and strongly politically articulated interests undermined the authority of the county councils with regard to hospital development, resulting in difficulties for central planning and coordination efforts. These challenges must be seen in light of the historical factors which had characterised the hospital system. The impact of the historical role of local government was evident in the fact that municipalities were still the main providers of primary health care after 1970. In the political debate during the post-war period, the primary health care sector was considered particularly problematic with regard to the coordination and overall planning of the hospital sector.¹¹¹

The relationship between the counties and central government was also significantly different in each country. When the county ownership of hospitals was implemented in Norway, the State's advisory council for hospitals (the *Statens sykehusråd*) was

restructured: council representatives were recruited from central authorities, hospital trade unions and hospital owners, and represented by The Norwegian union of municipalities and county councils.¹¹² This union was established in 1972, as a merger of The Norwegian Association of Municipalities and The Norwegian Association of Towns. The county councils also became members of the union, which meant that also the counties became members of a joint national organisation for the first time.¹¹³

The organisational system in Sweden was similar to that of Norway during the late 1960s and early 1970s. The county assemblies' own organisation – the CCA (or *Landstingsförbundet*) – was represented on a government standing committee (the *Centrala sjukvårdsberedningen*) which drew up plans for the health services. A key difference between Norway and Sweden, however, was that Sweden had already seen the relationship between central government and the county assemblies develop over several decades. The CCA had been founded in the 1920s and county assemblies had been members of the union since 1928. The CCA had also been represented on the government's standing committee since the 1930s.¹¹⁴ In the 1960s and 1970s, the CCA developed into an association which spoke on behalf of the county councils. Its own health policy document issued in 1969 therefore impacted strongly on health policies in general¹¹⁵ and its role reflected the characteristic high degree of institutional coordination at the central state-level in Sweden. Importantly, the role of the CCA in the development of Swedish hospital policy in the late 1960s and 1970s also reflected a continuity of development within the system and the continuance of conciliatory decision making mechanisms within the Swedish model that had been evident since the mid-19th century. The CCA became an instrument for carrying out central state hospital policies, yet at the same time the organisation was also central to the *formulation* of this policy function. There is therefore reason to assert that this organisational mechanism provided greater legitimacy to hospital-related policies in Sweden than those in Norway. In contrast, the Norwegian union of municipalities and county councils never assumed a similar role or set similar conditions for hospital policy as its Swedish counterpart had done. Discussions between the organisation and the Norwegian authorities were chiefly restricted to financial and technical matters rather than the strategic and general elements of hospital policies.¹¹⁶ This reflected the fact that planning and coordination routines within the Norwegian hospital system had not been effectively established by the introduction of the new hospital legislation issued in 1970.¹¹⁷

Conclusion

This paper has highlighted the nuances within the historical development of the hospital systems of Norway and Sweden. While these systems may appear to be superficially similar, our comparative perspective has identified subtle differences related to the development of the politico-administrative systems of these two countries. This perspective enabled us to identify the reasons for the discontinuity within the Norwegian system and the contrasting continuity of development in the Swedish system.

We have drawn on historical institutionalist perspective in order to examine the issues discussed in this paper. Central to our evaluation has been a discussion of the institutional frameworks within the hospital realms of Sweden and Norway and how these were constructed in the 19th century, and then reproduced or transformed later under new political coalitions. We have also shown how the continuities and transformations within the two systems can be understood against this background. Characteristic differences between the institutional frameworks in the development of the hospital systems were identified. Municipal councils were shown to be the dynamic elements within the development of the Norwegian system, and these were evaluated in relation to the higher degree of autonomy afforded to local levels of government. In Sweden, counties were the key driving forces within the hospital system. The reforms in the Swedish politico-administrative system during the 1860s resulted in counties becoming instruments for the execution of central governmental policies. Another difference which was shown to have had a significant impact was the fact that Sweden was characterised by more dynamic relationships between the different levels of the politico-administrative system – to a far greater extent than in Norway. The hospital system in Sweden therefore developed more in accordance with central governmental measures than it did in Norway.

During the first phase of our analysis, ranging from approximately 1860 to 1910, we noted that hospital expansion in Norwegian local communities was rooted in an ongoing process of democratisation. This encouraged a strong political commitment to local hospitals. This was further enforced after 1910 as the role of the municipalities and city councils was strengthened through the introduction of the national health insurance. The law, however, was not intended to provide the central state with additional opportunities to coordinate the development of the hospital system and neither did the later Public Medical Act of 1912.¹¹⁸

The institutional framework within the Swedish hospital system was initially shaped by central governmental measures. This Swedish framework, as we noted, developed against a background of more dynamic relationships between different levels of government within the politico-administrative system. The more cooperative mechanisms within the system were maintained and institutionalised during the period between 1910 and 1930. The same applied to the county councils' role with the hospital-law from 1928. From a historical institutionalist perspective, this continuity could be said to be an example of institutional reproduction and path-dependency caused by positive feedback. The development of the Norwegian system during the same period could be described in similar terms. In Norway the development within the hospital realm during this period was characterised by centralisation as well as efforts to improve centralised planning, coordination, and specialisation within the hospital system. These developments represented an institutional transformation which culminated in new hospital laws being passed in 1970. The problems faced by the authorities after this time were the product, we would argue, of Norway's historical heritage, with the uncoordinated hospital structure and strong political commitment to local hospitals reflecting the wider framework for hospital policies. The system established in Norway under the implementation of the Hospital Act in 1969 represented a form of centralisation which was problematic and was an institutional break incompatible with

the wider inherited values within the sector. In effect, it threatened the historical legitimacy that hospitals in Norway had been built upon. The tensions resulting from this, we would suggest, resulted in further changes in 2002 when the county-based system was finally abolished.¹¹⁹

The development of the hospital system in Sweden during this same period was characterised by a consolidation of the role of the county councils, in another example of institutional reproduction and adaption via positive feedback effects. This too represented a form of decentralisation and was, in reality, a continuation of an already well-implemented system.

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End notes

¹ Cf. e.g. Bu, *Sykehusene i Norge*, 56.

² Byrkjeflot and Grønlie, «Det regionale helseforetaket – mellom velferdslokalisme og sentralstatlig styring», 198.

³ Byrkjeflot and Neby, «The end of the Decentralised Model? Comparing Developments in the Scandinavian Hospital Sectors», 333.

⁴ See Haave, «The Hospital Sector: A four-country comparison of organizational and political development», 226.

⁵ In this article we will focus on general somatic hospitals. Specialized hospitals like tuberculosis institutions are left out. We also distinguish between general hospitals and minor hospitals offering primary care, like the Norwegian *sykestue* and the Swedish *sjukstugor*. The definition of general somatic hospital has changed over time and the statistical material must be analyzed due to such restrictions. The statistics still gives an impression of the historical development in number of general hospitals in the two countries. Anell and Claesson, «Översikt över det svenska sjukhusväsendets utveckling till 1900-talets mitt», 109.

⁶ Freeman, *The politics of health in Europe*, 7. Ch. Freeman, «A National Health Service, By Comparison», pp. 503–520.

⁷ Grønlie, «Modern Scandinavian hospital history in recent Norwegian research», 41.

⁸ Grønlie, «Hospital Sector Structure and Organization in Britain and Norway – Contributions Towards a Comparative Study», 147, cf. Larsen, «Folkesykehuset», 385.

⁹ Grønlie, *ibid.*, 150.

¹⁰ Such perspectives are for instance frequently met in within British historical research in recent years.

See e.g. Stewart, «The Political Economy of the British National Health Service, 1945–1975: Opportunities and Constraints?», 453–470, Stewart, «Hospitals, Regions, and Central Authority: Issues in Scottish Hospital Planning, 1947–1974», 263–78.

¹¹ *Ibid.*, 228–229, p. 237.

¹² Byrkjeflot and Neby, «The end of the Decentralised Model? Comparing Developments in the Scandinavian Hospital Sectors», 331, 334.

¹³ Ch. Grønlie, «Modern Scandinavian hospital history in recent Norwegian research». A dominant assumption within social scientific research on the welfare state – and the tradition represented by the works of Gøsta Esping-Andersen in particular – is that there are three dominant models, or clusters, of welfare states: A Nordic, characterized by universalism, tax-financing and social democracy, a «liberal» cluster (UK, USA, Canada, Australia) and a «corporative» cluster (France, Germany, Italy, Austria). Esping-Andersen, *The Three Worlds of Welfare Capitalism*, 26–29. In recent years this research has been supplemented and to some degree questioned by several historians. The new approaches are more oriented at comparing the development of welfare states between a limited number of countries rather than between clusters of welfare state regimes. Due to such a program – as stated by the historians Klas Åmark and Nils Finn Christiansen – «a complicated pattern of both similarities and differences show up». Christiansen and Åmark, «Conclusions», 335. See also Edelbalk and Olsson, «Poor relief, taxes and the first universal pension reform. The origins of the Swedish welfare state reconsidered». As pointed out by Michael Moran «writings on the welfare state often seem to marginalise health care.» In fact, when testing the welfare state classifications against conventional classifications of health care systems, we are confronted with several problems. For instance, on the scale «decommodification–commodification», which measures the re-distributive role of public institutions, the Scandinavian countries and the UK is placed at opposite ends in welfare state classifications. When comparing the re-distributive role of public institutions as health care services are concerned, however, Scandinavia and the UK belong to the same «cluster». Cf. Moran, «Understanding the welfare state: the case of health care» 135. Cf. Byrkjeflot, «Comparing worlds of health care and systems of health care – Lessons from recent research on hospital reforms and healthcare systems», 13–32.

¹⁴ Cf. Kaelble, *ibid.*, 12. This perspective corresponds to Tore Grønlie's argument in his Norwegian–British comparison that cross-national historical comparisons reveal important secrets that «are blurred

in a purely national context». Grønlie «Hospital Sector Structure and Organization in Britain and Norway – Contributions Towards a Comparative Study», 158.

¹⁵ Cf. Kaebler, *Der historische Vergleich – Eine Einführung zum 19. und 20. Jahrhundert*, 142–147, Haupt and Kocka, «Historischer Vergleich: Methoden, Aufgaben, Probleme. Eine Einleitung», 20–26.

¹⁶ Tilly, *Big Structures, Large Processes and huge Comparisons*, 116–119.

¹⁷ Byrkjeflot and Neby, «The end of the Decentralised Model? Comparing Developments in the Scandinavian Hospital Sectors».

¹⁸ Haave, «The Hospital Sector: A four-country comparison of organizational and political development», 216–229.

¹⁹ «Det vil være urealistisk å tro at man kan gjennomføre plutselige og radikale forandringer i en så stor, komplisert og tradisjonsrik samfunnssektor.» Stortingsmelding nr. 9, 1974–75, «Sykehusutbygging m.v. i et regionalisert helsevesen», *Stortingsforhandlinger*, 3B, 1974–75, p. 40.

²⁰ Cf. Thelen and Steinmo, «Historical institutions in comparative politics», 2–3.

²¹ Thelen, *How Institutions Evolve. The Political Economy of Skills in Germany, Britain, The United States, and Japan*, 23.

²² Pierson and Skocpol, «Historical Institutionalism in Contemporary Political Science», 700.

²³ Thelen, *How Institutions Evolve. The Political Economy of Skills in Germany, Britain, The United States, and Japan*, 289, 291.

²⁴ Kathleen Thelen formulates a program for this research as «we need a better sense of where...institutions came from, what has sustained them, and what are the ways in which they have changed over time». *Ibid.*, 4.

²⁵ *Ibid.*, 30–31.

²⁶ *Ibid.*

²⁷ Byrkjeflot and Grønlie, «Det regionale helseforetaket – mellom velferdslokalisme og sentralstatlig styring», 205.

²⁸ See e.g. Haave, «The Hospital Sector: A four-country comparison of organizational and political development» 219.

²⁹ Schjønby, «The Establishment of a Public Health System», 78.

³⁰ Anell and Claesson, «Översikt över det svenska sjukhusväsendets utveckling till 1900-talets mitt», 17.

³¹ See Hovland, «Grotid og glanstid», 35.

³² Haugen, *På ære og samvittighet – Skatteetatens historie etter 1892*, 79.

³³ For a comparative discussion, see Angell, *Den svenske modellen og det norske systemet – Tilhøvet mellom modernisering og identitetsdanning i Sverige og Noreg ved overgangen til det 20. hundreåret*, 152–182.

³⁴ See e.g. Esping and Gustafsson, *Landstinget och länsdemokratien – Uppsatser om länsdemokratifrågans utveckling*, 71.

³⁵ Gustafsson, *Traditionernas ok – Den svenska hälso- och sjukvårdens organisering i historie–sociologisk perspektiv*, 268, 265.

³⁶ Cf. Gustafsson, *Kommunal självstyrelse – Kommuner och landsting i det politiska systemet*, 14–21, Hovland, «Grotid og glanstid», 43–47.

³⁷ In 1865 there were 65 town- and city-municipalities in Norway. *Ibid.*: 75.

³⁸ A few of the others left the county assemblies as well in the last decades of 19th century. Ejevård, *Landstingsförbundet – organisation, beslutsfattande, förhållande till staten*, 43.

³⁹ Ch. Flo, «Staten og sjølvstyret: Ideologier og strategier knytt til det lokale og regionale styringsverket etter 1900», 182, Gustafsson, *Kommunal självstyrelse – Kommuner och landsting i det politiska systemet*, 17.

⁴⁰ Torbjörn Nilsson, *Elitens svängrum – Första kammaren, staten och moderniseringen 1867–1886*, 22.

⁴¹ *Ibid.*

⁴² *Ibid.*, cf. Rune Bokholm, *Städernas handlingsfrihet. En studie av expansionskedet 1900–1930*, 62.

⁴³ Nilsson, *Elitens svängrum – Första kammaren, staten och moderniseringen 1867–1886*, 259–60.

⁴⁴ Immergut, *Health Politics: Interests and Institutions in Western Europe*, 30.

⁴⁵ Immergut claims that the county councils politicians had great opportunities «to shape health care reforms, not only in their capacity as hospital administrators but especially in their capacity as informal interest groups within the political parties». *Ibid.*: 182.

⁴⁶ Immergut particularly points at the development of the routines to prepare decisions made by Parliament. To decrease consequences of conflicts between the two chambers as well as between the Parliament and the executive, the political system relied on the institution of Royal Committees (*Kungliga Kommitéväsenet*) to prepare parliamentary decisions. Such committees were appointed by the executive

and consisted of politicians in addition to other interest groups. The committees were thus arenas where opposing interests could be cleared up prior to negotiations in Parliament and even more so since parliamentary representatives had the opportunity to comment on committee proposals by written statements. *Ibid.*, 180.

⁴⁷ The franchise was restricted though. Up till 1885 – when a minor reform in the voting-system was introduced – only freeholding farmers, persons with property and a certain income and civil servants were franchised. Women were not franchised at all. For a comparative discussion, see Angell, *Den svenske modellen og det norske systemet – Tilhøvet mellom modernisering og identitetsdanning i Sverige og Noreg ved overgangen til det 20. hundreåret*, 119–150.

⁴⁸ Hovland, «Grotid og glanstid», 106.

⁴⁹ Mjeldheim, *Folkerørla som vart parti. Venstre frå 1880-åra til 1905*, 58.

⁵⁰ Cf. Johansen, *På sjølvstyr i 150 år. Hordaland Fylkeskommune 1837–1987*, 34.

⁵¹ Mjeldheim, *Folkerørla som vart parti. Venstre frå 1880-åra til 1905*, 58.

⁵² Schiøtz, *Doktoren – Distriktslegenes historie i Norge 1900–1984*, 22–23, cf. Andresen and Ryymin, «Towards Equality? Rural Health and Health Acts in Norway 1860–1912», 110–113.

⁵³ For a comparative discussion, see Angell, *Den svenske modellen og det norske systemet – Tilhøvet mellom modernisering og identitetsdanning i Sverige og Noreg ved overgangen til det 20. hundreåret*, 119–152.

⁵⁴ For a comparative discussion, see Sejersted, *Sosialdemokratiets tidsalder. Norge og Sverige i det 20. århundre*, 201–361.

⁵⁵ Gustaffson, *Tradisjonernas ok – Den svenska hälso- och sjukvårdens organisering i historie–sociologisk perspektiv*, 268, 265.

⁵⁶ Koppbergens läns landsting, Koppbergens läns landsting. En berättelse om dess verksamhet i hundra år 1863–1962, 203. Götlind, «De första hundra åren», 19.

⁵⁷ Koppbergens läns landsting, Koppbergens läns landsting. En berättelse om dess verksamhet i hundra år 1863–1962, 203.

⁵⁸ Carstensen and Grankvist, *St. Olavs Hospital – Sykehuset på Øya gjennom hundre år*, 65–70.

⁵⁹ Danielsen, «En exempelløs fremgang'er. 1880–1920», 32.

⁶⁰ Schiøtz, *Folkets helse – landets styrke 1850–2003, Det offentlige helsevesen i Norge 1603–2003*, Bind II, 44–46, Andresen and Ryymin, «Towards Equality? Rural Health and Health Acts in Norway 1860–1912», 110.

⁶¹ Schiøtz, *Doktoren – Distriktslegenes historie i Norge 1900–1984*, 22–23.

⁶² Andresen and Ryymin, «Towards Equality? Rural Health and Health Acts in Norway 1860–1912», 121.

⁶³ Johansen, *På sjølvstyr i 150 år. Hordaland Fylkeskommune 1837–1987*, 165.

⁶⁴ Cf. Berge, *Sjukvårdens underklass. Sjukvården i den kommunala fattigvården 1910–1950*, 23.

⁶⁵ Statens Offentliga Utredningar (SOU), *Betänkande med förslag till Allmän sjukhusstadga m.m.* (Stockholm 1922) pp. 60–61.

⁶⁶ Angell, *Den svenske modellen og det norske systemet – Tilhøvet mellom modernisering og identitetsdanning i Sverige og Noreg ved overgangen til det 20. hundreåret*, 159–163.

⁶⁷ Ot. Prp. 19, 1909, Om utfærdigelse av en lov om sykeforsikring, *Stortingsforhandlinger 3D* (1909) p. 7.

⁶⁸ Bjørnson and Haavet, *Langsomt ble landet et velferdssamfunn – Trygdenes historie*, 63.

⁶⁹ Cf. Seip, *Sosialhjelpstaten blir til. Norsk sosialpolitikk 1740–1920*, 241. This was also related to the fact that membership in the insurance increased tremendously over the next decades. Bjørnson & Haavet (1994) p. 73. Cf. Larsen (2009) p. 383. Cf. Ryymin, «Growth of local medical institutions in Hordaland, 1890s–1920», 43 ff., «Anarki og kaos – eller funksjonell regionalisme? Sykehussystemet i mellomkrigstidens Hordaland».

⁷⁰ 10 % of the expenses were put on the employer, 20 % on the state. Bjørnson and Haavet, *Langsomt ble landet et velferdssamfunn – Trygdenes historie*, 69.

⁷¹ *Ibid.*

⁷² Schiøtz, «Folkets helse – landets styrke 1850–2003», 184–185.

⁷³ Norske Kvinners Sanitetsforening, *Norske Kvinners Sanitetsforening – Tiden og menneskene som skapte den*, 324–325.

⁷⁴ See «Norske Sykehus», *Den Norske Lægeforenings Smaaskrifter* (Kristiania 1919), 19.

⁷⁵ Ch. Grønlie «Hospital Sector Structure and Organization in Britain and Norway – Contributions Towards a Comparative Study», 149.

⁷⁶ Ch. *ibid.*

⁷⁷ See Teemu Ryymin's analysis of the hospital system in the Hordaland county in Western Norway in the mid-war period. Ryymin (2009, 2011).

- ⁷⁸ Cf. Grønlie, «Norwegian General hospitals, 1970–2002: County Ownership – An Interlude between Welfare Localism and State Direction», 192.
- ⁷⁹ Samling av Författningar och Cirkulär m.m. angående Medicinalväsendet, nr 74–77, Serie A, 1928. Copy in the Norwegian National Archive, Medisinaldirektøren, Db Kontoret for lege- og sunnhetsvesen, MD 1: 74. Cf. Serner, «Swedish Health legislation: Milestones in Reorganisation since 1945», 100.
- ⁸⁰ Statens Offentliga Utredningar (SOU), *Betänkande med förslag till Allmän sjukhusstadga m.m.* (Stockholm 1922), 4.
- ⁸¹ Lewin, Ideologi och strategi. Svensk politikk under 100 år, 159–203.
- ⁸² Staten Offentliga Utredningar (SOU), *Betänkande med förslag till Allmän sjukhusstadga m.m.*, 34, (Stockholm 1922), pp. 5–6.
- ⁸³ Cf. Elvander, «Interest Groups in Sweden», 27, cf. Immergut, «Health Politics: Interests and Institutions in Western Europe», 190–192.
- ⁸⁴ Samling av Författningar och Cirkulär m.m. angående Medicinalväsendet, nr 74–77, Serie A, 1928. Copy in the Norwegian National Archive, Medisinaldirektøren, Db Kontoret for lege- og sunnhetsvesen, MD 1.
- ⁸⁵ Andresen and Ryymin, «Towards Equality? Rural Health and Health Acts in Norway 1860–1912», 122–123.
- ⁸⁶ Norwegian National Archive, Medisinaldirektøren, Db, 0038, Kontoret for Lege- og sunnhetsvesen, Legedistrikter, allment instruksjer.
- ⁸⁷ Norwegian National Archive, Medisinaldirektøren, Db Kontoret for lege- og sunnhetsvesen, Amtslegers/fylkeslegers innberetninger etter fullført inspeksjon, 1928.
- ⁸⁸ Engesæther and Thue, Sogn og Fjordane fylkeskommune gjennom 150 år, 217–225, ch. Sosialdepartementet, *Innstilling om sykehusordningen, Innstilling II*, Oslo (1963), 6.
- ⁸⁹ Statens Offentliga Utredningar (SOU), *Betänkande angående den slutna kroppsjukvården i riket jämte vissa därmed sammanhängande spörsmål*, 22, Stockholm, 1934, pp. 542–56. cf. Anell and Claesson, Svenska sjukhus förr och nu. Ekonomiska aspekter på struktur, politikk och ekonomi, 19.
- ⁹⁰ Sejersted, Sosialdemokratiets tidsalder. Norge og Sverige i det 20. århundre, 208.
- ⁹¹ Maren Skaset, «I gode og onde dager... – De norske legene og staten 1945–2000», 55.
- ⁹² The Norwegian National Archive, Medisinaldirektøren, Db, kontoret for lege- og sunnhetsvesen, MD I, 1939, Sosialdepartementet (1963) p. 7.
- ⁹³ Bu, Sykehusene i Norge.
- ⁹⁴ «Det byr i mange henseender på store fordeler framfor den tilfeldige ordning som rår i vårt land, og det er min hensikt... å søke å fremme forslag om en tilsvarende ordning for vårt land.» Norwegian National Archive, Medisinaldirektøren, Db Kontoret for lege- og sunnhetsvesen, Amtslegers/fylkeslegers innberetninger etter fullført inspeksjon.
- ⁹⁵ Schiøtz, «Folkets helse – landets styrke 1850–2003», 317–318.
- ⁹⁶ Sosialdepartementet, *Innstilling om sykehusordningen, Innstilling II*, Oslo (1963), 7.
- ⁹⁷ *Ibid.*, 4–5, Ot. Prp. Nr. 36, 1967–1968: Om lov om sykehus m.v., *Stortingsforhandlinger* 4A (1967–68), 116–119.
- ⁹⁸ Sosialdepartementet, *Innstilling om sykehusordningen, Innstilling II*, Oslo (1963), 7.
- ⁹⁹ Ot. Prp. Nr. 36, 1967–1968: Om lov om sykehus m.v., *Stortingsforhandlinger* 4A (1967–68), 16.
- ¹⁰⁰ Cf. <<http://www.ssb.no/>>, 2/8–2010, <<http://www.scb.se/>>, downloaded 2/8–2010.
- ¹⁰¹ Statens Offentliga Utredningar (SOU), *Sjukhus och öppen vård, Betänkande av ÖHS-komiteen* (Stockholm 1963), 134.
- ¹⁰² The Norwegian National Archive, Sosialdepartementet/Helsedirektoratet, H9, nummer 4, F1, Dokument Norges byforbund/herredsförbund.
- ¹⁰³ «Problemet er å få koordinert utbyggingen innen fylkene og fylkene imellom. Mange tror nok at Helsedirektoratet gjør dette, men det er dessverre ikke slik. Etter loven skal Helsedirektoratet godkjenne sykehusplaner rent sykehusteknisk, men de tar ikke standpunkt til behovet for en utbygging ... Det ble nok i sin tid utarbeidet en landsplan for sykehusutbyggingen, men den kan bare betraktes som en uforpliktende anbefaling. Sykehuseierne behandler i dag planene enkeltvis og uavhengig av en landsplan.» Tormod Brækken, «Sentralorgan for sykehusene – sykehusavdeling», *Kommunalt Tidskrift*, 1 (1962).
- ¹⁰⁴ Cf. Flo, «Staten og sjølvstyret: Ideologiar og strategiar knytt til det lokale og regionale styringsverket etter 1900», 301, Hansen, «Sykehusstruktur i historisk perspektiv», 49.
- ¹⁰⁵ Grønlie, «Norwegian General Hospitals, 1970–2002: County Ownership – An Interlude between Welfare Localism and State Direction», 200.
- ¹⁰⁶ Haave, «The Hospital Sector: A four-country comparison of organizational and political development», 225.

¹⁰⁷ Einar Fredriksson, «Sjukhusplanering», 9.

¹⁰⁸ Statens Offentliga Utredningar (SOU), *Betänkande med förslag till sjukhuslag m.m.* Stockholm (1956), 51–52.

¹⁰⁹ Statens Offentliga Utredningar (SOU), *Sjukhus och öppen vård. Betänkande av ÖHS-komiteen*, Stockholm (1963), 18.

¹¹⁰ Garpenby, *The State and the Medical Profession – A Cross-National Comparison of the Health Policy Arena in the United Kingdom and Sweden 1945–1985*, 87, see Isacson, «Landstinget under fyra decennier av expansion och omprövning», 38–39.

¹¹¹ Schiøtz, «Folkets helse – landets styrke 1850–2003», 337–40.

¹¹² St. meld. Nr. 9, 1974–75, Sykehusutbygging m.v. i et regionalisert helsevesen, *Stortingsforhandlinger 3b* (1974–75), 35.

¹¹³ Cf. <<http://www.ks.no/templates/Page.aspx?id=26272>>, downloaded 2/8–2010.

¹¹⁴ Ejvegård, *Landstingsförbundet – organisation, beslutsfattande, förhållande till staten*, 38, 56.

¹¹⁵ Garpenby, *The State and the Medical Profession – A Cross-National Comparison of the Health Policy Arena in the United Kingdom and Sweden 1945–1985*, 73–74.

¹¹⁶ Yngve Flo, «Sjukehuset som kommunalpolitisk problembar. Viktige trekk ved det trettiårige mellomspillet med fylkeskommunal eigarskap av sjukehusa».

¹¹⁷ Cf. St. meld. Nr. 9, 1974–75, p. 35. Another difference, which also illustrates the differences between the two countries, is that the Swedish CCA contained significant resources in comparison to its Norwegian counterpart. The CCA had its own planning unit, and from the 1960s the organisation's staff increased considerably, reaching a number of 200 members in 1980. The development of the Norwegian union of municipalities and county councils had far from similar dimensions. Ch. Garpenby, *The State and the Medical Profession – A Cross-National Comparison of the Health Policy Arena in the United Kingdom and Sweden 1945–1985*, 73–74.

¹¹⁸ Cf. Thelen, *How Institutions Evolve. The Political Economy of Skills in Germany, Britain, The United States, and Japan*, 289, 291, cf. above.

¹¹⁹ Cf. Grønlie, «Norwegian General Hospitals, 1970–2002: County Ownership – An Interlude between Welfare Localism and State Direction».