

The Rise of a Healthcare State? Recent Healthcare Reforms in Norway

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Preface

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

The aim of the ATM-project is to study processes of reform and change within the Norwegian healthcare 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 healthcare by the means of comparative research
- General competence development in organization and management of healthcare
- assist the health institutions in their efforts to improve service delivery and create more innovative structures for organization and management.

The funding for the ATM-project 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 the ATM project at:
<http://www.polis.no>

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Summary¹

The major elements of the Norwegian hospital reform in 2002 were a state takeover of ownership of hospitals and the establishment of local and regional healthcare enterprises. The reform followed in the aftermath of a series of smaller and larger reforms in the sector. In combination these reforms represent a challenge to the established system for healthcare governance, and a potential for the state to increase its capacity for governance.

There has been a long-term development trend from welfare localism to direct state involvement in governance of healthcare institutions. The welfare state is increasingly becoming a healthcare state, a change linked to the increased emphasis on the perfectibility of individual health, and an increased emphasis on the politics of efficiency as a substitute for a one-sided «politics of redistribution». More actors now take a role in the politics of healthcare governance than in the traditional regime, where the relationship between the medical profession and the state was central. In particular, «the patient» is now seen to take a more active role, and one may thus speak of the rise of a more patient-centered regime for healthcare governance. An extensive information system for control of quality and efficiency is being developed and various actors develop strategies that in combination seem to lead to a stronger role for the government and the patient-centered paradigm in healthcare governance.

One possible consequence of this development is an erosion of the established alliance between the state and the medical profession. However, the new regime also depends on medical knowledge and professional standards as a way to legitimate itself, and this leaves the way open for the medical profession to regain some of its lost power. The term New Public Management (NPM) has often been used to characterize the recent reforms. Clearly, many of the recent reforms belong to the NPM-family of reforms, but a public-purchaser model has not been introduced. It is thus too simplistic to use the term New Public Management as a way to characterize the new regime for healthcare governance.

¹ Based on a key note speech at the FLOS concluding conference «Reform-, Ledelses- og Organiseringsprosesser i Sundhedsvæsenet», Copenhagen 2. december 2004; and a presentation at the National conference in Political Science in Bergen January 5th 2006.

Sammendrag

I 2002 ble det gjennomført en større sykehusreform i Norge, der hovedelementene var statlig overtakelse av eierskapet av sykehusene og etablering av helseforetak på lokalt og regionalt nivå. I tillegg er det de siste årene gjennomført en rekke større og mindre reformer i helsesektoren som samlet sett kan ha frambrakt en ny form for styring; med større vekt på effektivisering enn fordelingspolitikk og større vekt på helsestatlig enn velferdsstatlig styring. Historisk sett har det skjedd en utvikling fra velferdslokalisme til sentralstatlig styring av sykehusene, med fylket som et mellomspill. Fremdeles har imidlertid sykehusets lokale tilknytning stor betydning, det ser man ved at det også etter sykehusreformen har skjedd en sterk lokal mobilisering. På de fleste områder dreier det seg om en New Public Management reform, men bestiller-utførermodellen brukes i liten grad og dermed er et av de viktigste kriteriene for markedsfremmende reformer i offentlig sektor fraværende.

Elementer som må vektlegges i et forsøk på å forklare dagens styringsordning; helsestaten, er de moderne mytene om «den selvskapte helse» og «pasienten har makten». Disse mytene bidrar til at stadig flere individer og aktører trekkes direkte inn i styringen av helsevesenet, ved at de tillegges ansvaret for egen helse eller ved å bidra som kunnskapsleverandører. Omfanget av styringsinformasjon øker og dermed også antall aktører som har interesse av å påvirke slik informasjon. Via media aktiviseres politiske organer og profesjonelle stadig i helsepolitiske føljetonger omkring enkeltindividers skjebne i helsesystemet. Helseministeren kan dermed innta en mer direkte og aktiv rolle, ved påkalle seg pasientens beste og om nødvendig hoppe bukk over den medisinske profesjonenes tradisjonelle rolle som portvokter og ivaretaker av pasientinteresser. I dag virker det som staten er på vei til å styrke sin rolle i det norske helsevesenet. Det er ikke gitt at dette må skje på bekostning av helseprofesjonene, og det kan heller ikke utelukkes at statens rolle vil bli endret som følge av nye regulativer fra EU eller andre internasjonale organer der fri bevegelse i helsemarkedet blir aktuell politikk.

Introduction

For a long time Norway has been considered to be a slow reformer, not only in public administration, but also more specifically in healthcare. This changed rather abruptly on June 6th 2000, when the newly appointed Social Democratic prime minister introduced a reform plan. This plan, which was passed as a law in Parliament exactly one year later, took effect from 2002 and has been presented as a «big-bang-reform»: the biggest reform ever in the Norwegian public sector. The new law transferred responsibility for public hospitals from the counties to the central government. Five regional health enterprises were established, and these, in turn, have organized hospitals under local health enterprises. These local enterprises are separate legal entities of varying sizes and geographical spans. Both the regional and the local enterprises have their own executive boards and managing directors. The Minister of Health appoints the boards of the regional health enterprises, and the directors of the regional health enterprises and the boards of the local enterprises are appointed by the regional boards.

Simultaneous reform efforts are now taking place in the other Nordic countries, with a large structural reform on its way in Denmark, and a similar solution being considered in Sweden (Byrkjeflot and Neby 2004, 2005). This is an indication that there may now be a movement towards a convergence among healthcare systems, in particular between the former centralized model in the UK, the more decentralized Scandinavian systems and the continental insurance-based models (Moran 1999, Freeman 2000).² Quite contrary to what has been argued by some, however, it is not a movement towards a weaker state and a weaker health ministry. Rather, what we are seeing is a movement towards an expanding healthcare state in combination with a more patient-centered mode of governance.

Questions about recent reforms

This paper presents an analysis of recent reform dynamics in the Norwegian healthcare sector; an attempt to make sense of recent events in healthcare reform. Elsewhere it has been argued that the period of county ownership in Norway from 1970 to 2002 was an interlude, a transition from a period of welfare localism towards a stronger state initiative (Byrkjeflot and Neby 2004, 2005). The current reform wave has been presented as a movement both towards decentralization and centralization,

² Norway has so far belonged to a Nordic «family» of countries classified as single-payer decentralized systems. In addition to the Nordic model there are also the original centralized Beveridge model (UK) and the continental social insurance models. The argument is that the Nordic decentralized and integrated systems are moving towards centralization, the integrated centralized model in the UK being decentralized and that the continental countries are now also moving towards establishing a stronger position for the state (Moran 2000, Byrkjeflot og Neby 2004).

due to the transfer of power to local enterprises and the shift of ownership from counties to the central state (Læg Reid, Opedal and Stigen 2006).

The stated aims of the reform were improved cost control and a more equal distribution of health resources across counties. Neither of these goals has been achieved so far. Doctor's wages increased by 17 per cent over a two-year period after the reform and activity has increased most in those regions that already had reached the highest quality levels. The rate of growth in the annual budget for Norwegian healthcare services has not been slowed. As noted in the recent OECD economic survey on Norway; spending has accelerated after the reforms, and per capita spending on health is now one of the highest in the world (*Dagens Medicin*, May 8th, 2004 and May 14th, 2004, OECD 2005, Hagen and Kaarbøe 2006).

Partly due to this acceleration in spending, it did not take more than two years for some of the most ardent reformers to change their minds, from supporting the idea that the regional health enterprises were core instruments for equality, cost control and decentralization to arguing that these enterprises are just a superfluous level in the hierarchy.³ What some of these reform agents suggested instead was not a return to the old decentralized model of county ownership. Instead they wanted the state to create a new central directorate in order to deal with the local hospital enterprises directly (*Aftenposten* 2004 a,b).

Is it possible, then, that the post-reform period (2002–2006) has also just been an interlude in a movement towards a more centralized medical regime where doctors and medical experts play an even greater role in decision-making? Or is it just an interlude on the way to a further strengthening of state governance based on patient rights? I will now present three perspectives or frameworks for how to understand the recent reforms, and discuss whether each perspective makes sense in light of the recent reform experiences, and, furthermore, whether each perspective is of help in explaining the long-term development trends in healthcare governance. Such frameworks make it possible to see different aspects of what has happened and to outline a more diverse set of possibilities for the future.

I will first use the New Public Management perspective as a background to present the recent reforms and discuss to what extent it makes sense to understand the recent changes in governance in such a perspective.

³ A survey in *Aftenposten* (2004a,b) showed that 59 per cent of hospital directors in local health enterprises thought that the regional level was unnecessary. Similarly, 57 per cent thought that bureaucracy has increased as a consequence of the reform.

Recent healthcare reforms in Norway

The New Public Management perspective is currently the predominant interpretation of any reform undertaken in the public sector.⁴ From this perspective purchaser-provider arrangements and independent regulatory agencies are necessary in order to establish separate roles in the public sector. Similarly, the smart thing for the state to do is to withdraw from its direct role as producer of services, either by allowing for competition between private and public providers or by the transfer of responsibilities for services to independent agencies and enterprises. The successes so far have been in those areas where the state has withdrawn and transferred more and more responsibilities to enterprises and markets, such as in the areas of energy and telecommunications (OECD 2003).

This perspective suggests three ways to deal with the present and the future (Figure 1). I would make it a requirement that all these three criteria are fulfilled in order for a reform program to qualify as a full-scale New Public Management reform or for a sector to have been transformed into a New Public Management mode of operation.

1. The state has to make use of *quasi markets*, i.e. develop market instruments and information systems that makes it possible for owners and customers to monitor and control the production processes. The purpose is to achieve efficiency, accountability and transparency and allow for customers' free choice and competition among service providers.
2. Independent *enterprises* are to take care of the production and provision of services, whereas it is the role of governmental or quasi-governmental agencies to make orders on behalf of government and regulate such roles and contractual relationships. Purchaser-provider-arrangements are necessary in order to establish separation between roles and competition among service providers.
3. It is necessary to strengthen the role of *management*. The argument is that the state ought to establish general management identities and create space for managers to act as entrepreneurs.

To what extent have these requirements for a full-scale New Public Management «revolution» been fulfilled as a consequence of recent healthcare reforms in Norway?

⁴ The recipe for New Public Management (NPM) presented here is based on close readings of major documents from the OECD and other transnational reform agencies, e.g. the OECD's Public Management Committee (PUMA) (Sahlin-Andersson (2001). Other sources for the construction of such an ideal type are policy documents, such as the Norwegian governmental program for modernization of the public sector (Normann 2002), the white paper on state ownership (White Paper 2001–2002), and the OECD regulatory report on Norway (OECD 2003). The NPM-movement presents a narrative for how the problems of the public sector ought to be fixed that is strictly oriented towards the future. The ongoing changes are part of a global «public management revolution» (Kettl 2000), the past is something that one ought to get away from.

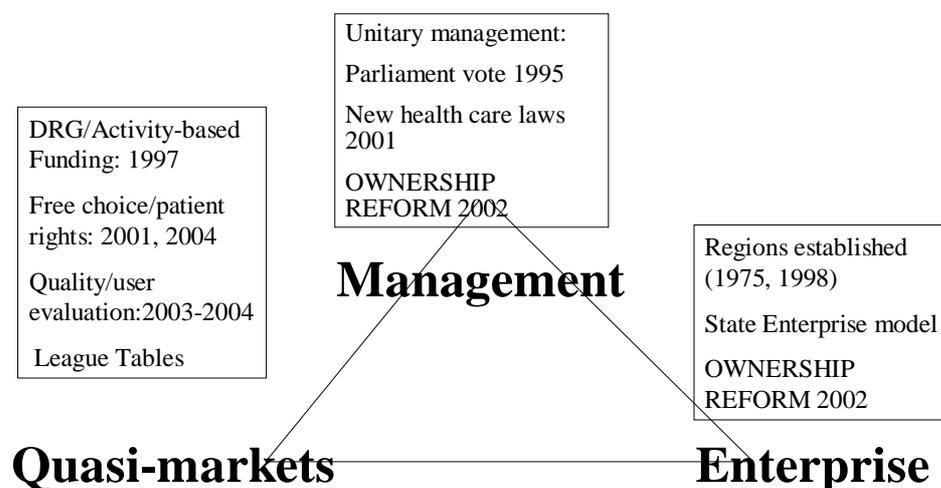


Figure 1. Overview of reforms in Norwegian healthcare

Quasi-markets and performance measurements

The first requirement was the introduction of quasi-markets. One step in this direction was when the system for state funding of somatic hospitals was changed on 1 July 1997, when 30 per cent of the block grants from the central government to the counties became related to hospital activity. Later, this share was raised gradually to 60 per cent in 2003, and then reduced to 40 per cent in 2004, again to 60 per cent in 2005, and 40 per cent in 2006. Patient rights legislation and the right to «free hospital choice» have also been important in creating a demand for more instruments for quality control and a more transparent healthcare system. The patient rights act was further enhanced in 2004. One part of the act concerns patients' right to choose a provider, which grants patients the right to choose where he or she wants to be treated, thus creating competition among hospitals (Bleiklie, Byrkjeflot and Østergren 2003).

A range of national quality criteria has been introduced and user evaluation surveys are produced regularly. A national homepage and telephone line providing information in order to help patients make their own hospital choices was introduced in August 2003. Each hospital is evaluated according to several quality standards. The standards have been met with criticism, but the health minister announced in 2004 that the system will be further developed and improved and that the aim is also to establish a system for league tables with ranking of hospitals according to quality and

performance. Such «unofficial» league tables have been presented several times in the media, and are usually followed with political demands for more extensive league tables and more reliable information. Accordingly, the present government wants to establish a new patient register in order to improve the information content of such league tables (Verdens Gang 2005).

Management

Another requirement for a shift towards New Public Management was that *Management* was introduced on a broader scale. This seems to be the case. There has been a reform in management structures in hospitals in accordance with New Public Management recommendations for stronger and more independent management functions in all organizational units. In Norway management structures in hospitals have become a hot political topic, and as a consequence, it has become mandatory for all hospitals to be organized according to the same principle of management; unitary management. This was first affirmed through a vote in the Norwegian parliament in 1995, and it has later become part of a set of laws regulating the Norwegian healthcare sector (2001). The need to develop a new, and unitary, management role was also regarded as one of the pillars of the hospital reform in 2002 (Vareide 2002). The idea that management must be conceived of as a profession in its own right; independent of the respective medical and healthcare professions has also been circulated and institutionalized in a new national management development program (Vrangbæk and Torjesen 2004). Before these events a model of shared management had become predominant at the ward level. In 1999 still only 20 per cent of the hospitals had introduced unitary management at all levels, while 80 per cent had implemented such a model in 2003 (Kjekshus 2004).

Enterprise model and separation of state roles

The third requirement was the establishment of enterprises and separation of state roles. A precondition for the health enterprises that were created in 2002 was the establishment of health regions and the invention of the state enterprise model. The five regions that were first set up in 1975 and made mandatory, as instruments for planning in 1999, became the basis for the regional health enterprises. The search for new organizational forms in the public sector has been an ongoing concern, long before the term «New Public Management» was invented. There is, in Norway, a distinct tradition for the development of state enterprises allowing for the responsible minister to intervene in matters of public interest. The first company with such a statute was *Statoil*, the national oil company, and the same statute was introduced in the telecommunications firm *Telenor* when the telecommunication administration of Norway was transformed into a state enterprise in 1994. Since then there has been a great deal of creativity in Norwegian state administration towards inventing new kinds of intermediate forms between state public administration and

private enterprises. The health enterprise follows in this tradition, but in this case a new kind of hybrid is created, moving even further along towards a combination of enterprise and public administration to the extent that some have used the term «public administration dressed up as enterprise» or even «perverted public administration» to describe the current situation. Basically the minister may intervene in any case that he or she prefers, given that it is in the public interest. It is frequently hard to distinguish between matters of detail and principle, and this problem has been made visible by actions taken by the health minister as well as words spoken by central politicians in the parliament and in the government since the Norwegian hospital reform (Byrkjeflot and Grønlie 2005, Danielsen, Hagen and Sørensen 2004).

A New Public Management reform?

It came as a surprise to many that the OECD was so satisfied with the Norwegian government in its review on regulatory reform in 2003; *Norway; preparing for the future Now! (OECD 2003)*. In one area, however, Norway was criticized for not going far enough in the direction of promoting market mechanisms; healthcare. Noticeably, the report criticizes the hospital reform for leaving too much leverage for political involvement from the top:

«The Minister of Health can in theory instruct the regional health authorities and overturn Board decisions in all cases. The reform appears to represent a break with the stated goals of greater subsidiarity (decentralisation and delegation) under the modernisation programme for the public sector.» (ibid.)

Furthermore, the OECD reviewers also criticized the reform for not making a clear split between purchasers and providers as had been done in the UK and in many Swedish counties:

«The reform does not sufficiently separate the state's roles as purchaser and provider. The regional health authorities are specifically tasked to maintain both roles. This can lead to the pursuit of one to the detriment of the other. For example tensions may arise in relation to whether the regional health authority should focus its main efforts on providing the service or on purchasing it.» (ibid.)

Some regional enterprises, like the Western Norway Regional Health Authority,⁵ did initially, in 2002, follow a strategy of separation of roles between purchaser and provider. They had to change their strategy, however, as the Ministry of Health made it clear that they preferred an «integrated model», both at a national and regional level (Hallingstad 2004). This was explicitly stated in a document presented to the National Leadership Program, a mandatory management training program for top management in the health enterprises. It was admitted in this document that there might be good reasons for choosing a «split model»; the Ministry of Health was particularly worried that the regional authorities would prefer their own providers

⁵ This is not the literal, but official translation of the term. The Norwegian term is more «enterprise-like»: Health West, regional health enterprise (RHF). I prefer to translate the term in the latter way.

and discriminate against the private providers.⁶ In conclusion, then, it seems like the OECD is right in pointing out that the reform does not follow the recommended NPM-recipe of creating a split between purchasers and providers in healthcare.

A shift towards neo-liberalism?

In order to make sense of the hospital reform from a New Public Management perspective, one would perhaps suggest that the reform came as a consequence of a shift in Norwegian politics towards a neo-liberal agenda for the government. This does not seem to be the case, at least if what is meant by a shift is that there was a change in policies as a consequence of democratic processes, such as elections bringing a new party with a new political program into position. It was actually a social democratic government, and not a conservative government, that introduced the hospital reform. This government introduced the change in ownership from the counties to the state, an idea that had originally been pushed by the conservatives and the right wing Progress Party, but resisted by the social democratic party. As we have seen the outcome of the reform process was not a full-scale NPM-reform, and it was probably not intended in this way either. What is clearly the case was that the reform proposal came as a consequence of a change of mind among central politicians in the social democratic party. Both the party leader (Jagland) and the prime minister (Stoltenberg) had earlier supported the existing system for county ownership of hospitals. The new health minister, Tore Tønne, was an experienced industrialist and state bureaucrat. He argued strongly for the introduction of the state enterprise model and state ownership in the health sector. His strong determination to effect a serious change in the sector and his ability to dramatize the situation with accounts of how the counties had lost their ability to control costs etc. were instrumental in convincing the majority of the party to support the new reform agenda (Herfindal 2004). The reform may thus not necessarily be seen as a consequence of a change of politics in a neo-liberal direction, but rather as an attempt to defend the public health sector against the neo-liberal agenda of privatization and marketization. This has been the preferred argument among social democrats in defense of the reform.

Cost control as argument for hospital reform

One may then ask what problem caused the social democratic party to change their mind, and what kinds of arguments were used? In accordance with the prevailing reform climate associated with the New Public Management movement, the major

⁶ Three major reasons were listed for choosing an integrated model: 1) Competition is not an appropriate method when close physical proximity isn't possible. Due to the geography of Norway this is the case in large parts of the country, and this means that the integrated model must be preferred in most circumstances. 2) The danger that a «contract bureaucracy» will develop. 3) The expertise needed to handle such contracts is not yet available, and it may take some time to develop it. (Ministry of Health and Social Affairs 2003).

argument was the economic circumstances; there was a growing perception among policy makers that Norway was facing a financial problem in the health sector. Health budgets had grown very rapidly, particularly in the period 1995–1999 and they had grown twice as fast as in the rest of the public sector. Some of the increases may have been a consequence of a political will to allocate more resources to healthcare, but there was at the same time an increasing suspicion in the public and the media of weak cost management in the hospitals. The reform was framed as a solution to this problem, the implication being that there was a problem with the whole organizational structure in the sector, leading the various actors to play a «blame game» (Slåttebrekk and Aarseth 2003). The fact that Norway ranked as one of the biggest spenders on healthcare among OECD countries, measured in US \$ per capita, was also used as an argument in support of the reform, implying that the counties were not able to control costs in the sector (Hellandsvik 2001).⁷

The agenda of modernization of the public sector has been a long-term trend, and governments of various political origins have pushed it. The Social Democratic party has also moved far in this direction, but neither this party nor any of the other parties, perhaps with an exception of the conservative party, has ever adopted the complete New Public Management agenda. Nonetheless, it is the New Public Management spirit that has provided the impetus for most of the recent public sector reforms (Normann 2002). This was clearly the fact in the 2002 White Paper «Reduced and Improved State Ownership», in which it was noted that the state has several roles (owner, policy maker and regulatory authority), and that it is important to separate these. The central administration in the Norwegian healthcare system was also reorganized in accordance with such principles, and this reorganization had implications for the relationship between professional power and administrative accountability.

Against professions?

The professions, and particularly the medical profession, have traditionally been assigned a central role in the governance of Norwegian healthcare, and the term «iron triangle» has been used to indicate that the medical profession dominated education and research, the central administration (particularly the Directorate of Health) and service provision (Ramsdal 2004). The most ardent protagonists for New Public Management tend to see professional dominance as a problem, arguing that it is necessary to marginalize the influence of the professions both in politics and in the hospital (Hagen 2004). It is to the story of the rise of the professions and the possible NPM attack on their power that we turn now, when we move on to the profession-state perspective on healthcare service provision in Norway.

⁷ As noted in a recent paper from Magnussen, Hagen and Kaarbøe (2006), however, the real growth in resources granted to the hospitals has been even higher in the period after the reform. The share of total costs coming from extra funding has also increased. Furthermore, the regional enterprises may even have been less responsive to the stated policy goals for activity growth than the counties.

The profession-state perspective

It is very difficult to avoid the issue of professions when discussing healthcare, or even when accounting for the rise of welfare states. Accordingly, a common narrative is «the rise and fall of the medical profession», sometimes even in parallel with a story about the rise and the fall of the welfare state (Starr 1982, Stevens 2001). The profession-state perspective, which may be seen as a combination of a welfare state-centered and a profession-centered account of what happened, originally emerged as a criticism against what was presented as the established theory of professions (Parsons 1964, Freidson 1970). According to this established theory, the state and the professions were understood as antithetical phenomena, with states being a threat to professional autonomy. This theory was first criticized by Terry Johnson (1972), followed by a group of European scholars who argued that the professions are part of any state formation, and that it is the relationship between the state and the profession that ought to be the key issue in the study of professions (Burrage and Torstendahl 1990). Firstly, it was argued that it is necessary to understand how state-professional relationships were established in the first place in order to estimate the level of autonomy and discretion granted to any profession in any specific country, and, secondly, that the empirical basis for the theory of professions had to be broadened, since the original theory of professions was based on an analysis of mainly doctors and lawyers in Great Britain and the USA (Hafferty and McKinlay 1993, Johnson, Larkin and Saks 1995, Erichsen 1995, 1996, Evetts 2002).

It was pointed out that the medical and legal professions were somewhat unique in their achievement of a regulative bargain with the state. It is as a consequence of such a bargain that the medical profession has become a «self-regulating profession», but also in the case of many European societies, an integrated part of the state. Professions are part of a nation-specific process of governing: «The form governmentality takes and the ways in which the institutionalised expertise of the professions operates will vary according to the particular history of the particular country» (Dent 2003). In the history of the rise of the Scandinavian hospital-centered systems for instance, the emphasis is put on the simultaneous rise of the health bureaucracy and the medical profession as the twin partners at the center of the national health system (Erichsen 1995). The rise of the Norwegian health administration, personified by Karl Evang in the powerful position as Health Director between 1938 and 1972, was just an «extension of the medical clinic into the state» (Berg 1997, Nordby 1989). It was thus the medical profession who controlled the health system in the first place and increased its power by penetrating state administration, rather than the opposite.

Until about 1970, Ole Berg says, the doctors were on the offensive, not only in the state apparatus, through their position in corporatist networks, but also at a more local level, as leaders and managers in hospitals and as Local Medical Officers in municipalities. They succeeded in building a healthcare system on the basis of a principle of clinical and professional autonomy and the derived principle of medical self-governance. It was a precursor of a decline in medical power when the Health

Directorate was moved out of the Ministry in 1983. A new division for health policy was established inside the Ministry, and the Health Director, who had been a powerful figure in Norwegian health administration, lost most of his powers. As a consequence of this dual loss of power, in local institutions and in state administration, the doctors had lost terrain (Berg 1997, Fugelli, Stang and Eilmar (eds) 2003).

It has been argued that there has been a shift in strategy among governments from a system heavily based on empowering and trusting doctors, towards one based on empowerment of patients and putting more trust in market mechanisms and contracts. In the first model associated with the profession-state the medical competence was personal and delegated to doctors in intimate encounter with patients. The second strategy, associated with a breakdown of the idea of the professional as empowered caretaker, was towards developing wider strategies of health surveillance based on the idea of the patient as a customer and a citizen (Petersen and Lupton 1996, Armstrong 1998, Vidler and Clarke 2005). The expansion of consumerism, quasi-markets and the associated introduction of external control instruments (clinical governance) may also threaten the established power base of the medical profession (Charlton and Miles 1998, Fitzpatrick 2001, Gray and Harrison 2004). The movement that has emerged with the aim to establish effectiveness and quality in medical services has expanded also on an international level (Lundbäck 2002). This movement «offers medicine the hope that its work can be placed more squarely on the altar of scientific rationality, but at the risk of incursions by outside experts into its domain» (Hafferty and Light 1995). Other indications of a development trend away from the established way of organizing hospitals is the expansion of organizational practices associated with «managed care», a development that started in the USA, but is making its influence felt also in Europe (Rodwin 1997).

The exact turn of events may not be essential here; a typical characteristic of a state-profession narrative is that it will construct a rather unique story in the case of each nation-state. Its focus is on how the professions cope with the new regulatory challenges and organizational models and how it affects the relationship between the government and the medical profession. However, while it may be expected that such a story ends with a narrative about how the professions lost their power, it is often the case that it tells a story about the reconfiguration or reappearance of professional power instead. Several studies show that after the rise of neo-liberalism and the associated attack on professional monopolies, it has been possible for professional bodies to defend their work jurisdictions and their autonomy and discretion due to their established power position, e.g. their monopoly in knowledge production and their access to established networks (Stevens 2001, Fitzgerald and Ferlie 2000, Salter 2004).

The hospital reform; how does it challenge the profession-state?

To what extent does these two variations within the profession-state theme (rise and fall, rise and decline and reappearance) make sense in light of the recent reform events? Firstly, the major professional associations, the doctors and the nurses supported the Norwegian hospital reform, so it is not likely that the change of ownership in itself marked a major shift in power relations in the sector. The introduction of unitary management structures created some dramatic episodes, as the doctors protested against the idea that any profession other than the doctors could be appointed as clinical managers in the hospitals. There was a round of negotiations between the Norwegian Medical Association and the Health Minister on this issue, however, and the president of the medical association claimed that the outcome was a victory for its point of view (Den Norske Legeforening 2003). He said that the health minister had gone as far as he could in supporting their position, without explicitly making a statement in favor of the right of the medical profession to manage the hospital. Perhaps it was the medical experts at the center of the health system that again strengthened their position in relation to the periphery, i.e. general practitioners, patient organizations, nurses and other healthcare professions? The current fear among nurses certainly is that they may lose some of their influence along with the implementation of the new system of unitary management. The Norwegian nurses are doing better than their Danish colleagues in entering top management positions, but the new system of unitary management also means that they have lost some of their established positions, as the positions of head nurses in hospitals are eliminated (Sveri 2004, Nerheim 2006, Naustdal 2006).

The Danish experience with a similar trend towards centralization based on quality criteria in service provision, i.e. the establishment of the function-bearing units, is that the medical societies may have strengthened their position as a consequence of the introduction of new quality standards (Borum 2004).⁸ According to historical comparisons of the Nordic medical professions, the Danish medical profession has had a more local orientation and has been less integrated into the state than its Norwegian counterpart (Riska 1993). This orientation towards the nation-state may have proved advantageous for the Norwegian medical profession in the process of transfer of hospital ownership from the counties to the state. Temporarily it has also given them a strong position in their relationship with the new and relatively inexperienced administrations and boards in the regional and local health enterprises, which during the first years after the reform rewarded them with a solid pay increase.

Another question is what kind of skills the health professions actually have developed in organizational politics and management. It has not been necessary for the professions, so far, to develop any positive program for reorganization of the

⁸ See also Salter (2004) for a similar argument about how organizational reforms in the National Health Service in the UK has «strengthened the medical profession and weakened the state» (p.206).

health system, due to their long-term success in acting as veto-groups and taking control «from below». It has been argued that none of the many reform plans since the 1970s have had any effect on the daily affairs of hospitals, and that the reason for this is that doctors run hospitals, not administrators and general managers (Marstein 2003, Hoffmann 2002). Until now? The professions themselves may be affected by the reform movements associated with evidence-based medicine and clinical governance; movements that may also be seen as an attempt to reestablish professional control. The major challenge to the established medical power may be in the redefinition of the professional-patient relationship. The traditional idea of this relationship was that the needs of the patients were identified and modified as part of the interaction between individual doctors and patients. Clinical governance means that governments and medical experts seek to redefine this relationship, by arguing that doctors now should act in a more rational way, by using evidence-based procedures and sorting patients into predefined categories (Harrison 2004). The restricted focus on the relationship between governments and doctors is clearly both the strength and limitations of this perspective. A strength since it represents a clear focus, a weakness because it underestimates the role of patients and several other actors and knowledge systems that may be increasingly relevant in an analysis of any modern system for healthcare governance. I now turn to a perspective that also includes other actors than the healthcare professions and the state in its narrative; the healthcare state perspective (Moran 1999, Byrkjeflot og Grønlie 2005).

The healthcare state perspective

Michael Moran launched the concept of healthcare state as part of an argument for the need to understand the role of healthcare in society in a different way than that which has been presented in the predominant tradition of welfare state research, where the major distinction is between Bismarckian, Beverian and liberal welfare states (Moran 2000, Esping-Andersen 1990). Moran suggests an alternative based on an account of how states relate to what he considers the three major spheres of healthcare: consumption, provision and production. He then ends up with four families of healthcare states according to how important the state is in these three spheres; entrenched «command-and-control» states, such as the UK and Scandinavian model, «supply states», (mainly the US) and corporatist states (E.g. Germany and France). He also has a rest category of «insecure command and control states». This classification is a useful alternative to the welfare state literature, but it shares some of its weaknesses; the categorization is mainly based on statistical observations of structural differences at a given point of time, without taking into account the ideas and discourses that sustain the systems and give them inertia, as well as the long-term processes by which these various healthcare systems came into being.

An alternative notion of how «the interpenetration of the institutions of the healthcare system and the institutions of the state» happened would emphasize the multiple origins of the various healthcare states, e.g. by taking into account the role

of voluntary organizations and local politics. The criticism raised by Abrahamson (1999) and Grønlie (2005) against the «welfare modelling business» is thus also valid here. Abrahamson points explicitly to the one-sided focus on state and markets and the neglect of civil societal institutions such as family and networks. Grønlie points out that the established categorizations basically takes their departure from the situation during the three four decades following WWII. He notes about the healthcare systems in the UK and Norway before WWII that «they were, in general, not coordinated in any way, and consisted in a set of autonomous, in Britain also frequently competing, institutions, generated and run by local initiatives and for a long time local funding as well» (Grønlie 2005:151). In 1945 the two countries made different choices, when the British authorities undertook a reorganization under central government direction leading to the birth of the NHS in 1946, while the Norwegian authorities kept a decentralized pattern of ownership and control until 2002 when the state took over ownership in the hospital sector. At that point of time, however, the UK was moving towards a more decentralized system, e.g. by the introduction of Primary Care Trusts. It may thus be necessary to take a more dynamic and open-ended view of healthcare systems than that offered by the framework presented either by Moran's conceptualization or the one received from established classifications of welfare states.

Richard Freeman, who follows in the footsteps of Moran in using the concept of the healthcare state, admits to the limitation of the established line of thought when he extends the concept of healthcare state to include the social; e.g. the ways a community conceives and organizes its response to health and illness (2002:9). It is hard to tell a meaningful story about the role of the healthcare state in Norway, e.g. its relatively late development in comparison with the UK; without taking into account how the social and spatial aspects of the healthcare system have been intertwined. The politics of the social has in Norway to a large extent overlapped with the center-periphery cleavage (Rokkan 1966). Local hospitals have been part of projects for place-making as well as state formation and nation building (Rokkan 1999). Such phenomena are often better captured in «moving pictures» that situate a given outcome within a broader temporal framework than in «snapshots» based on cross-sectional data (Pierson 2004).

Phases in the rise of the healthcare state

Freeman has identified two phases in the rise of the healthcare state: The first phase (1880–1980) consisted in establishing and universalizing a public presence in healthcare. The second phase, beginning around 1975, was concerned with establishing new mechanisms of governmental control (Freeman 2000: 31). These phases overlap with Ole Berg's recent periodization of health politics, arguing that welfare redistribution was the central issue until 1975, and that the politics of efficiency has taken over since then (Berg 2006). In comparison with the New Public Management story, this plot works almost in the opposite way; it is a story of state

advancement rather than state withdrawal. NPM predicts that the state will have to privatize a great deal of its current activities, whereas the «healthcare state» perspective presents a narrative of a movement from «private government» towards an advancing state:

«For cost containment, management, competition, quality controls are all predicated on public (state) intervention in what once was thought of as a realm of private government. If formerly the role of the healthcare state was simply to finance and administer health services provided by medical professions, these changes imply that, far from being in retreat, the state has made significant advance.» (Freeman 2000: 75).

A similar view of change dynamics have been presented on the official web-page of the Norwegian Ministry of Health:

«an increasing degree of standardisation of medical processes and the electronic registration and reporting of all medical activities have 'changed the clinic from a private chamber to an open stage'. It gives the term 'medical monitoring' a completely new meaning. From close political control through political presence in the county municipal model, this development has given central government genuine opportunities to gain insight into most aspects of the production of medical services. Thus, it is possible for an essentially peripheral central government owner to exercise shrewd overall control» (Hellandsvik 2001).

When comparing this way of sketching out the turn of events with the profession-state perspective it may thus be argued that the professions take different roles in these two phases, that «the rise of professional self-control» may make most sense in the phase of the rise of a public presence in healthcare. In the current phase of political-professional reconfiguration, on the other hand, it may be necessary to admit several other actors onto the stage in the display of change dynamics.

Firstly, we must consider the classical roles of the politician, the journalist, the manager, the consultant and the patient, but, secondly, also all sorts of experts serving as facilitators for change; "Hence the final arbiters of EBM practice are 'systematic reviewers' drawn from biostatistics, epidemiology, health economics and other 'Infostat' disciplines" (Charlton and Miles 1998: 372).

Other examples of such experts are; the communication expert, the medical manager and the quality controller. These experts speak on behalf of the generalized patient or the health consumer, not the unique patient defined by his relationship to the individual doctor. Their expert status is frequently based on their access to surveillance technologies or knowledge related to technological and classificatory systems aiming at achieving a better control of costs and quality in the name of the patient, e.g. the Cochrane library, the DRG-system, the patient surveys and so on. The idea that patients have the right to be informed about what choices are available to them and also about the risks associated with the various alternatives is of a great interest to modern mass media and also governments who depends on the media to legitimate their position in the public mind. Clearly «rational myths» play a role in modern healthcare politics as previously, it is only the content of these myths that have changed.

Accordingly, the transition from phase 1 (welfare expansion/redistribution) to phase 2 (healthcare governance/efficiency) may be associated with a shift in predominant themes and myths that influence thinking about health politics.⁹ One theme is the rising costs of the health system, which makes it legitimate for the state to intervene more directly into the hospitals. According to this myth the state has to intervene in order to narrow the «health gap», i.e. the gap between ever-increasing demand for health services and the state's ability to develop sufficient capacity and cost control in the public health sector. The second myth presented as a reason for state intervention is the «knowledge explosion». By this it is meant that there is an information overload that makes it difficult for policy-makers, healthcare workers and patients to distinguish good information from bad information. It is thus necessary for the state to support and develop agencies that make use of methods like those associated with evidence-based-medicine in order to evaluate and improve the quality of information and establish common standards. The Norwegian knowledge center for the health services have been established to do this. This center is granted a status as an «independent public administration agency without governmental responsibilities» (Haug 2005) an interesting example of how the modern healthcare state centralizes knowledge production and standard-setting, while at the same seeking to legitimize its actions by appealing to traditional norms of independent science (Aakre 2006).

The patient as partner and customer-citizen

Another myth that has gained in strength is the idea that the patient is a customer-citizen and a partner in the healthcare system. This idea is sustained by the emergence of patient rights and the expansion of a new and more patient-centered mode of governance. Patient rights first surfaced as a critical concept during the 1960s and 1970s, partly as a challenge to the authority of the medical profession. In 1978 patients' rights were recognized as a legitimate concern in healthcare provision by the Alma Ata declaration, and in 1994 thirty-six European nations unanimously endorsed a common framework of principles for promoting patients' rights (WHO 1978, 1994, Sheldon 1994). This movement towards acting on behalf of the abstract patient in decision-making and planning had been long under way also in Norway, but it was not until the 1990s that the patient-centered paradigm began to take seriously hold. The expansion of actors and the increasing diversity in viewpoints among those getting involved in healthcare politics, most of them speaking on behalf of patients or users, partly explains why healthcare became an increasingly politically

⁹ Myths are stories that make it possible for practitioners in organizations and social fields to make sense of their experiences and devise interpretations of history as common themes (March 1998). The classical myths associated with medicine according to Hogg (1999) were the myths of scientific certainty, medical progress and heroic medicine. The modern myths are the myths of infinite demand and rationing, the patient as customer, the patient as partner and the perfectibility of health. I have added the myth of information explosion (see below).

contested issue between 1987 and 2001, as seen in election campaigns and in the parliament (Jørgensen 2005, Opedal og Rommetvedt 2005). Such issues simply mean a lot for voters; it is difficult for politicians with serious ambitions not to address them, and it is increasingly difficult to talk about healthcare without speaking on behalf of the user or the patient. The rise of a new patient-centered and consumerist mode of governance takes place in parallel with a general expansion and centralization in the knowledge system associated with healthcare management; this means that the discourse on healthcare management increasingly moves on to the center stage both in the media and in politics.

Hogg (1999) presents another reason for the increased focus on healthcare management in modern societies; the myth of perfectibility of health; «Illness is no longer something that just happens to us; we can determine our own health, if we are prepared to work for it». This trend towards an increased demand for information on how to achieve better health is encouraged by a decrease in the trust in doctors, but also the expansion of media reports on individual healthcare needs and the general increase in strategic communication from other sources trying to influence the media to present a favorable view of health related products and services. A report on the daily press coverage of welfare issues in Norway concludes that healthcare is increasingly the predominant topic; «the welfare state is increasingly positioned as a healthcare state» (Bay and Saglie 2003). News stories about healthcare frequently present individualized drama with potential consequences for all of us, rather than dry facts that relates to collective issues (Seale (ed.) 2004, Eide and Hernes 1987).

To summarize, I claim that the state is taking a more predominant role in healthcare governance as a consequence of recent reforms, and that part of the reason for this is found in the expansion of patient rights and increasing demands for perfectibility of health. The patient may now be presented as a «consumer- citizen» (Vidler and Clarke 2005) with a right to get more detailed knowledge about the quality and costs of the various healthcare services. Accordingly there is an expansion in the number of actors who seek to influence the production of knowledge and information about healthcare and earn their living from it. These movements along with the expanding institutional sphere relating to healthcare governance provide the state with a motive and an opportunity to expand its role in the healthcare system. I will now move on to discuss the more specific way the Norwegian state has increased its involvement in governance of healthcare.

The rise of state governance in healthcare

The NPM version of the history of healthcare governance is that there has been a movement away from a system of strict state control towards decentralization and autonomy in healthcare systems. The limitation of this concept, and the associated idea that the healthcare systems in Northern Europe have been «command and control-bureaucracies» is that most research show that neither the hospitals or the professions in the UK or in the Scandinavian countries were in any strict sense

controlled from above, at least not to the extent that is indicated by the term «command and control». There are also many researchers in the UK that have criticized this view, arguing that this way of contrasting the past with the present is part of New Labor's reform rhetoric (Harrison 2004, Paton 2005, Mohan 2002). The truth is that, from 1948 to 1991, the NHS (the National Health Services) was the antithesis of «command and control», Calum Paton argues. A more realistic view, perhaps, is to emphasize the constant strive to develop a balance between decentralization and central control in healthcare governance, and that it is the specific content of this balancing act that is changing over time rather than the essential characteristics of the system for healthcare governance.

One may also distinguish between the use of hierarchy, markets, standards and clan/communities as instruments for governance. Markets are clearly the predominant theme for the New Public Management movement, whereas professional networks and hierarchical regulation is the predominant theme for the profession-state. It is harder to point out the major theme for the modern healthcare state, but standard setting, «organization-making» and monitoring of performance in organizations are clearly important (Brunsson et al. 2000).

Karl Evang, the powerful health director of Norway from 1938 to 1972, may have wanted to establish a «command and control-state» in Norwegian healthcare, but he did not see it as a realistic option for the state to run the hospitals in such a way. He stated as late as in 1970 that «the health authorities had come to increasingly emphasize the decentralized approach in the administration of hospitals»... «this was a consequence of the bitter experience that the state is not suited to actually run hospitals» (Nordby 1989: 254). This was said this in the context of the rise of a strong movement for decentralization of democratic decision-making from the central state to the municipalities and counties, in combination with the introduction of a hospital law in 1970, which led to the first general debate in the parliament about the Norwegian hospital system.

Most decisions in healthcare had traditionally been taken on the local level, i.e. in each hospital or municipality and the transfer of power was more from the municipalities and hospitals themselves to the counties rather than from the state to the counties. A major instrument for creating equity, at this point of time, was the demand put to the counties that they submitted plans for hospital development that had to be approved by the state. Certainly the counties depended on state approval to have such plans implemented, but the county council was also democratically elected (from 1975) and there were limits to how far the state could intervene into county planning. The consequences of state or county intervention was often counterproductive, such as in the case of Sogn and Fjordane, a county with a disperse population and no central hospital at the time. The government wanted to build a new central hospital and close down several others, whereas the local politicians wanted to keep the traditional structure. The conflict, which was very tense, ended with sort of a compromise in 1975. A new hospital was built, but the county also kept the established ones. The same pattern of successful local mobilization against decisions taken centrally, either in the central state or the county council, has been seen elsewhere. Since the defeat in the case of Sogn and Fjordane

in 1975, it has been difficult for the state to insist on a strong centralization of hospital functions in the Norwegian healthcare system.

The predominant pattern in the governance of the Norwegian healthcare system, then, seems to be welfare *localism*. This is a system of governance that has been based on the recognition that the local hospital is a central part of place-making and local identity. For the communities that have built them and hosted them, the hospitals are regarded as important employers as well as «safety-bases» (trygghetsbaser), meaning that everyday life becomes more risky for everyone in a given geographical area if the hospital functions are centralized. Furthermore, every town or city that has a hospital also has traditionally been competing with another hospital town or a central hospital in order to maintain its place in the healthcare system and in the status system associated with the distinction between center and periphery (Vikingstad 2006). It is necessary to have a hospital in order to be a «real» town or city. Any efforts by the central state to centralize local hospital functions will therefore reactivate strong local mobilization along well-known conflict-lines. The hospital in *Røros* has been saved 18 times, and there are several other examples of such long histories of local resistance.

Giddens (1994) have pointed out that the foremost threat against such place-bound organizations that base their existence on community norms and tradition are «disembedding mechanisms», such as expert systems (e.g. medicine) and standardized systems of exchange (e.g. money, league tables). Clearly, there is an affinity between this argument and Brunsson's argument that standards and «organization-making» create a certain level of uniformity in the public sector that leaves it more open to reform. Such mechanisms are now at work in the Norwegian hospital system. For instance, the argument that it is necessary to develop quality standards based on evidence, is used to challenge the idea that local hospitals are «safety bases». It is argued that it is more risky to be treated in local hospitals than in central hospitals, and that one should for this reason develop a more «disembedded» hospital system based on functional specialization and common standards for medical treatment. The efforts to develop blueprints for a new division of labor among hospitals have been combined with an ambition to establish an authoritative system for implementation of rational standards. Such reform ambitions have always been met with strong local resistance in Norway, as well as in the United Kingdom (Mohan 2002). It has thus not been realistic for the state to develop plans from above and implement them in the way indicated by the term «command and control». For this reason, the state uses a combined strategy, by issuing directives and at the same time encouraging processes for voluntary adoption of rational standards.

The experience since the 2002 reform has been that governmental, regional and local plans for restructuring healthcare often contradict each other. According to the design of the hospital reform in 2002 it was the Regional Health Enterprises that were to take the major role as reform agents. The regional enterprises have introduced ambitious plans for restructuring, but so far it has been difficult for them to have such plans implemented. One reason for this has been the health minister, who has ended up making decisions in favor of local movements who protest against the plans. This political activism from above and below, along with an image problem relating to regional managers who have been rewarded with major wage

increases, has created a legitimacy problem for the regional health enterprises. They have not yet been able to build the kind of reputation and authority that they may need in order to implement bold plans for regional reform or even to survive in the long run.

A stronger role for the minister of health?

In an interview in *Eurohealth*, the second post-reform Norwegian health minister, now retired from his post to take up leadership in the Christian Party, tried to explain the idea behind the reform to an international audience. He said that the health reform in question was «very much a Norwegian product ... we have been traveling in a different direction. Perhaps though others can learn from us. This new structure has reduced somewhat irrational political interference.» (Høybraathen 2003). This way of framing the reform, as being uniquely Norwegian and in defense of rationality are an interesting example of an attempt to link up with central themes in Norwegian culture; equality, national values, but also a history of decentralized governance. The same kind of active framing of the reform had been demonstrated by Tore Tønne, the first post-reform minister and the «founding father» of the reform, when he underlined that it was up to the health minister to decide on all issues in the end, while also reiterating the idea that the reform was an act of decentralization:

«If the health enterprises start doing politics by getting involved in localization struggles or other matters that are against instructions from above, then I will interfere in my capacity as minister ... the state can still decide everything» (quoted in Neby 2003).

By defining the reform as unique, as well as a way to balance contradictory aims, the minister sought to establish a reform legacy different from the neo-liberal agenda associated with similar reforms in New Zealand and United Kingdom. It seems like it has become increasingly more important for the post-reform health ministers to avoid referrals to the purchaser-provider models, or the integrated enterprise («konsern») idea that was initially presented as ways to talk about the new organizational invention. Instead, they created their own concepts and dualisms like «split-model», versus «integrated model» and «provider-responsibility» and «caretaker-responsibilities». Instead of integrated enterprise it was suggested to call the collection of local enterprises located in a given region an «enterprise group» (foretaksgruppe). Creating such a new inventory of concepts and saying that others shall learn from «our reform» may have prevented some of the criticism from the left. The cost-control-as-rationality story idea has proven to be a difficult way to create support for a reform. Norway is still a small oil-rich country, where any government can afford to be «irrational» in the amount of money spent on healthcare, or perhaps it has to be in order to improve its chances of getting reelected. Clearly, there has been a movement away from putting emphasis on cost control and rationality in use of resources towards an increased emphasis on quality and a broader definition of accountability to the public. One illustration of this is the

increased use of the term «reputation» and «reputation management» among healthcare managers and in politics (Byrkjeflot and Angell 2006).

Both the health minister and the Parliament have taken a rather active role in commenting on and discussing the day-to-day-affairs of hospitals. Indeed, the number of questions in the Norwegian parliament related to health politics and hospitals has increased since the reform was implemented (Opedal and Rommetvedt 2005). Health policy issues, including the question of whether hospitals should be merged and centralized, are quite hotly debated, and the MPs and the government may issue directives to the enterprises if there is a majority in parliament for it or if the health minister wants to do so. In Norway as elsewhere, individual politicians rely on events covered by the media and the local electorate in order to get the kind of attention they need in order to be renominated and reelected.

In contrast to in Denmark where organizational researchers find that the hospital has lost its mobilizing power as a local project, there is still a strong mobilization in support of local hospitals in Norway (Borum 2005). The health ministers have been eager to play a role in these local mobilizations, frequently making statements in support of the movements and even questioning the legitimacy of local health directors when they face criticism for alleged wrongdoings and plans made by the regional health enterprises to centralize healthcare services. Members of parliament have taken over the role that the local representatives in the county councils had before the reform in support of such local mobilizations, now however they act through the national media and in the parliament. It may thus be difficult to judge whether there is now more or less «irrational» political interference in the running of the daily affairs of the hospitals.

By emphasizing the needs of patients, the health ministry opens up for a new discourse centered on the patient as the central node in the governance system. A state of constant reform in the name of the patient, based on a dual rhetoric of decentralization and centralization, while evoking decision-making and strategy-making on many levels of the healthcare system may be a way for a modern state to increase its capacity to govern. In contrast to what has been the case in the United Kingdom during the latter years, where clinical governance has become a central concept, there has until now been a lot of emphasis on general management in the Norwegian reform. There seems to be a premise that it is possible for managers and state administrators to take control over the medical system, in contrast to the situation in the UK where it is argued that it is the medical system that controls the managers, not the opposite (Knudsen 2004, Torjesen og Gammelsæter 2004, Salter 2004).

Conclusion

The argument in this paper has been that there has been a long-term development trend away from welfare localism towards central state control, and from an emphasis on professional self-regulation towards a more patient-centered mode of governance. Both the design and the rhetoric used in defense of the Norwegian

hospital reform in 2002 have to be understood in such a perspective. The rise of a stronger central state in healthcare has made some of the basic dilemmas more apparent, e.g. the dilemma relating to the question about how one may best balance control and autonomy and direct and indirect means of governance. Another dilemma relates to who should deliver the knowledge and information required for the new systems of quality control and free choice of hospitals. A recent evaluation report recommend that the regional health enterprises themselves take care of some of the tasks relating to knowledge production and quality control that are now located in the Directorate for Health and Social Affairs (Evalueringssrapport 2005).

The stated purpose of the Norwegian reform was to transfer power to govern the daily affairs of hospitals from local politicians to local managers and professional boards, while at the same time strengthening the capacities of the central government to establish principles for hospital governance in its capacities as owner of hospitals. The idea was that the hospitals should be subject to considerably less intervention from local and central politicians, and in this sense act more like private enterprises. Certainly the local politicians in the counties have lost influence, but at least in some cases, they have been more active than ever in the local media and in local political mobilizations (Johnson 2005). The introduction of state ownership has, however, made it possible for national politicians to take a new role in health politics. The Norwegian state now rules the hospitals both by indirect means (quality and performance control, activity-based funding) and through directives (annual letters of command, general assembly meetings). The Norwegian state has become a more patient-centered state, speaking in the name of the patients as consumer-citizens (Hellandsvik 2001). It is accordingly downplaying the role of the professions in healthcare, at the same time as it also relies on the same professions to produce the knowledge it relies on in its efforts to improve quality of services and empower the patients.

The system is still quite unpredictable, due to the complex and multi-level nature of governance, and the constant challenge from local movements in defense of the established hospital structure. Several actors still point out the problematic and blurred division of labor between the various units of the health ministry and the Directorate for Health and Social Affairs, and that the authorities have developed a whole range of methods for intervention into decision processes at lower levels in the system. It may thus still be a wise strategy for healthcare workers and managers to wait for «signals» from above before they make up their minds about what to do, rather than act as institutional entrepreneurs. The new hospital enterprises cannot go bankrupt and they are fully owned by the state. It is increasingly acknowledged that the idea that it is possible to run health enterprises as if they were private enterprises is unrealistic. The idea that the new boards are not political, but strictly «professional», has also been exposed as a fiction (Hegrenes 2005), and recently there has been a modification of the reform leading to the reintroduction of politically active board members.

In this paper I have tried to make sense of recent reform events by using different theoretical frames. The purpose has not been to demonstrate the inadequacy of any of the frameworks, the NPM-perspective, the profession-state-perspective or the

healthcare perspective, but rather to make use of the various perspectives in order to categorize and make sense of recent reforms.

The NPM framework was useful in the sense that it allowed me to categorize the various reform initiatives, evaluate to what extent the reforms experiences overlapped with the narratives told by NPM enthusiasts and whether the expectations from an ideal-typical NPM-model was fulfilled.

I concluded that the instruments for quasi-markets were present, as well as programs and laws for the development of general management. The enterprise model was also present, although in a way that allowed for stronger state intervention than expected. What was also lacking was the purchaser-provider-model and I thus concluded that the recent Norwegian hospital reforms was not completely in accordance with a prototypical NPM-model for governance of healthcare.

The second framework was the profession-state perspective. This framework for understanding recent health reforms in Norway was meaningful, since it brought forth the dilemmas and limitations associated with the mutual dependency relationship that existed between the medical profession and the state in Norway, and how this relationship was affected by recent reforms, the hospital reform in particular, but also the trend towards performance management, quality control and clinical governance. The conclusion was that the reforms may be seen as a challenge to medical power, but that the medical profession had supported many of the actual reforms, and that it remains to be seen whether the medical profession will strengthen its position as a consequence of the reform or not. The advantage with this perspective is that it has a clear idea about what kind of actors that matters most in the healthcare system and that it thus may be possible to use it to explain change; e.g. as a consequence of a shift in the power balance between professions and states.

The third framework was the healthcare state interpretation of the recent developments in Norwegian healthcare. Clearly this perspective needs to be further specified. I prefer to use the concept in a different way than Michael Moran (1999), since I do not think that it makes sense in a study that focuses mainly on the Norwegian healthcare system to depart from the assumption that this is a «command and control»-system. Rather, it is a system where the state has become increasingly involved in healthcare governance as a consequence of a movement away from welfare localism towards an emphasis on central state governance. The local hospital emerged as a central part of place-making and local identity-building within a setting of state formation and nation-building. The central state has strengthened its position vis-à-vis other actors in the healthcare system over a long-term-perspective, and there has also been a trend towards centralization of policy-making and knowledge production, particularly in the aftermath of the 2002 reform. The traditional center-periphery conflicts persist, however, and this means that it is difficult for the state as well as the new regional enterprises to implement their reform plans. In order to understand in what way healthcare governance is changing it is also necessary to take into account the changing role of the patient as well as the impact of knowledge development and standardization, and how this affects the relationship among the major actors in the healthcare system (central and local actors, medical profession and government). There has been a movement towards a more reflexive mode of

governance, and an associated change in the framework the various actors use for conceptualizing and representing the interests of the patients and the citizen in relation to healthcare governance.

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