

# Changing accountability relations in a welfare state – an assessment based on a study of welfare reforms

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## Preface

This paper was presented at the ECPR General Conference Reykjavik 25. – 27. August 2011, in the section on Comparative Perspectives on the Management and Organisation of the Public Sector, It is part of the research project Reforming Welfare States; Accountability, Democracy and Management, funded by the VAM program in the Norwegian Research council.

## Summary

In this paper we investigate how two major reforms in the Norwegian welfare sector changed accountability relationships. The reforms in question were the NAV reform of the welfare administration that Norway passed in 2005 and implemented through 2009 and the hospital reform of 2002. The NAV reform merged the national pension administration and the employment agency and established local partnerships with the municipality-based social services. The hospital reform transferred ownership from counties to the state and merged hospitals into health enterprises. We map formal accountability relations to see whether they were changed by the reform and how they work in practice. More specifically we address the following accountability relations: Political, managerial, legal, professional and social accountability. We show that the actual accountability relations are not always tight coupled to the formal relations. It is a complex accountability pattern in which different accountability relations supplements each other.

## Sammendrag

I dette notatet undersøker vi hvordan to store reformer i den norske velferdsstaten har endret ansvarsrelasjoner. Reformene som studeres er NAV reformen som ble vedtatt i 2005 og gjennomført fram til 2009 og sykehusreformen som ble innført i 2002. NAV reformen slo sammen trygdeetaten og arbeidsmarkedsetaten og etablerte et lokalt partnerskap med kommunene når det gjaldt sosialhjelp. Sykehussreformen overførte eierskapene av sykehusene fra fylkeskommunen til staten og omdannet sykehusene til helseforetak. I dette paperet kartlegges i hvilken grad formelle ansvarsrelasjoner ble endret i forbindelse med reformen og hvordan de fungerer i praksis. Men spesifikt rettes søkelyset mot følgende ansvarsrelasjoner: politisk ansvar, administrativt ansvar, legalt ansvar, profesjonelt ansvar og sosialt ansvar. Vi viser at de faktiske ansvarsrelasjonene ikke alltid er tett koplet til de formelle. Det avdekkes et komplekst og sammensatt ansvarsmønster hvor ulike ansvarsrelasjoner supplerer hverandre.

## Introduction

Comparative studies of public reforms are often concerned either with features of reform processes or their effects. They usually focus on patterns of influence among actors, on efficiency and on the quality of public services (Christensen and Læg Reid 2001 and 2007, Pollitt and Bouckaert 2004). Rather seldom, however, do such studies address fundamental accountability questions. Reform may change accountability arrangements, either deliberately via formal changes in design or else unintentionally, resulting in a new accountability practice (Christensen and Læg Reid 2002). Normally accountability is an ambiguous issue in reform initiatives, and it has been claimed that reforms produce both accountability overload and accountability deficits (Bovens, Schillemans and t'Hart 2008). In most cases reforms involve some kind of trade-off between different accountability mechanisms and between accountability and other values such as flexibility and entrepreneurship (deLeon 1998). Administrative reform is thus not inherently inconsistent with accountability, and accountability mechanisms can be matched to public problems and agency structures that are embedded in the reforms.

In addition, accountability is itself an ambiguous and contested concept irrespective of the effects of reforms. In this paper we will use a rather narrow concept of accountability. Bovens (2007:450) defines accountability as «...a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgments, and the actor may face consequences». The focus here is on whether actors can be held accountable *ex post facto* by accountability forums. One key question about accountability is the problem of many eyes or the '*accountability to whom*' question, which focuses on the nature of the forum. Bovens, drawing on the work of Romzek and Dubnick (1987), distinguishes between political, legal, administrative/managerial, professional and social accountability. We will look at all these types of accountability. The traditional mechanism of upward political accountability to the parliament becomes problematic in a complex state with administrative reforms that deploy a concept of extended accountability, for here traditional accountability is only part of a cluster of mechanisms through which public bodies are held to account (Scott 2000).

In this paper we use these definitions of accountability to investigate how two major reforms in welfare services changed accountability relationships. The reforms in question are the welfare administration reform that Norway passed in 2005 and implemented through 2009, and the hospital reform that was initiated in 2000 and implemented from 2002. The NAV reform merged the national pension administration and the employment agency and established local partnerships with the municipality-based social services. The hospital reform transferred ownership from counties to the state and merged hospitals into health enterprises. We will map formal accountability relations to see whether they were changed by the reforms and how they work in practice.

Our data are taken from an evaluative study of the NAV reform and a large project on the hospital reform. The current study is therefore based primarily on public documents and interviews with central actors in the two sectors. The material from the

NAV reform evaluation is the most complete, as the interviewees here were asked specifically about accountability relations. Altogether 26 administrative executives in the central welfare agency and the ministry as well as political executives were interviewed in 2010. The study of hospital reforms is based on secondary sources and evaluation reports, and also a study of the discourse on the Norwegian hospital sector as expressed in documents from 2002 to 2006, as well as a few interviews conducted with local and regional managers between 2002 and 2006. These interviews were not specifically designed to deal with questions of accountability relations. However, we have been able to supplement with survey data on contact pattern.

First, we present our theoretical framework which consists of descriptive theory focusing on accountability. Second we present the national context as well as the more specific reform context. Third, we describe the formal changes in accountability relations of the reform. Fourth, we address the changes in accountability practice of the reforms along the dimensions of political, administrative, legal, professional and social accountability. Finally, we draw some conclusions.

## Accountability theory

Accountability is an elusive, complex and multi-faceted concept. It is helpful to distinguish between the conceptual question of what is meant by accountability, the analytical question of what types of accountability are involved, and the evaluative question of how to assess accountability arrangements (Bovens 2007, Bovens, Curtin and t'Hart 2010). In this paper we will focus on the second analytical question. Accountability embraces several different aspects: first, there is the question of to whom an individual or organization is accountable; second, there is the question who is accountable; third, there is the question of what one is accountable for; and fourth, the nature of the obligation. This paper addresses the first type of accountability. Public organizations are accountable to a number of different forums that apply different sets of criteria.

Romzek and Dubnick (1987) analyzed the Space Shuttle Challenger accident from an accountability perspective, highlighting the institutional factors that may have influenced the disaster. They state that a narrow accountability concept involves «limited, direct and mostly formalistic responses to demands generated by specific institutions or groups in the public agency's task environment» (Romzek and Dubnick 1987: 228), while a broader concept «involves the means by which public agencies and their works manage the diverse expectations generated within and outside the organizations» (ibid.). Based on the broader concept they outline two important dimensions: whether the ability to define and control expectations is held by some specific entity inside or outside the agency; and the degree of control that the entity is given over defining that agency's expectations. Combining the two dimensions produces four types of public accountability: Bureaucratic accountability denotes a high level of internal control by and accountability towards political-administrative leaders. Legal accountability denotes strong control by and accountability towards an external actor, for example a lawmaker. Professional accountability is internally related, is low on control and deals with

professional standards and expertise. Political accountability represents a rather low level of external control of an agency by different actors or institutions in the environment and is often labeled responsiveness.

Bovens' (2007) research builds on that of Romzek and Dubnick, but extends and elaborates their accountability perspective. He distinguishes between a broad and narrow accountability concept and locates that distinction along a normative/descriptive divide. Accountability in a broad sense is seen as normative because it is often defined as something positive, close to responsiveness. However, since there is no consensus on the standards of accountable behavior – civil servants engage in different and competing types of behavior that may be deemed more or less appropriate according to context – the concept is contested (Christensen and Røvik 1999, March and Olsen 1989). As mentioned in the introduction, the narrower concept of accountability Bovens uses focuses on the obligations an actor has to give information and to explain and justify his/her conduct to a forum and that forum's right to pass a judgment that has consequences for the actor. He says that accountability is by nature retrospective – i.e. a form of ex post scrutiny – but can also be preventive and anticipatory, meaning that it can provide input for ex ante policy-making. Accountability relationships presuppose both that the actor being held accountable will play an active role in providing information about and adjusting his/her behavior, but also that the forum holding someone to account will actively seek information, discuss accountability matters and use the instruments it has to adjust the behavior of the actor.

Building on Romzek and Dubnick's research (1987), Bovens (2007) elaborates on five types of accountability based on different types of forums an actor must report to. He sees political accountability as built on a chain or set of principal-agent relationships, i.e. the voters delegate their sovereignty to popular representatives in elected bodies, who further delegate authority to the cabinet and the civil service. Their accountability then moves in the opposite direction, from the civil service to the cabinet/ministries, from the cabinet/government to parliament and from parliament to voters. In addition, political parties and the media can function as informal forums for political accountability. Thus political accountability can include accountability to the minister or the cabinet within the executive branch as well as to the parliament (Storting) and to the public at large (Mulgan 2003).

According to Bovens, legal accountability is becoming increasingly important in public institutions as a result of the increasing formalization of social relations and because there is greater trust in the courts than in parliament, whether these courts are civil courts or special administrative courts. Legal accountability is seen as the most unambiguous type of accountability, since it is based on specific formal or legal responsibilities.

Administrative or managerial accountability is about making those with delegated authority answerable for carrying out agreed tasks according to agreed performance criteria (Day and Klein 1987). It is exercised by a range of scrutiny bodies that as quasi-legal forums carry out independent and external administrative and financial supervision and control of ministries or agencies. These may be auditors, inspectors, controllers, general offices, ombudsmen, independent supervisory offices, anti-fraud offices, auditing offices, etc. They may be primarily concerned with financial scrutiny or else

focus more broadly on ensuring efficiency or effectiveness, as in performance auditing. Often they are linked to agencification and contract systems, but also to performance management systems, management-by-objectives-and-results systems and to the trend towards managerialism in public administration, labeled as an «audit society» by Power (1997). Contemporary reforms have put strong emphasis on managerial accountability, which means that managers on the one hand have been granted extended autonomy but on the other hand are made more directly accountable for their ability to produce measurable results and to run their organizations efficiently (Wallis and Gregory 2009). Political accountability should be confined to two functions: first, setting objectives; and second, evaluating policy based on an assessment of the results. Managers are left to get on with the rest of the business of government within a system of clear separation of policy making and policy implementation (Painter 2011).

Professional accountability deals with the mechanism of professional peers or peer review. Particularly in typical professional public organizations different professions are constrained by professional codes of conduct – i.e. catalogues of conduct deemed appropriate – and scrutinized by professional organizations or disciplinary bodies. It is a system marked by deference to expertise where one relies on the technical knowledge of experts (Romzek and Dubnick 1987, Mulgan 2000). This type of accountability is particularly relevant for public managers who work in public organizations concerned with professional service delivery.

Social accountability arises out of a lack of trust in government and the existence of several potential social stakeholders in the government or public apparatus. This produces pressure on public organizations whereby they feel obliged to account for their activities vis-à-vis the public at large, stakeholders, or (civil) interest groups and users' organizations, via public reporting, public panels or information on the internet (Malena et al. 2004).

Bovens (2007) not only adds social accountability as a new type of accountability; he also differs somewhat from Romzek and Dubnick (1987) in his categorizations of the other types of accountability. Concerning political accountability Bovens focuses mainly on the chain from the sovereign people to administrative actors, a combination of external and internal elements, while Romzek and Dubnick evaluate this as a more general responsiveness by a public agency to actors and institutions in the environment. Legal accountability is for Bovens more associated with the courts while for Romzek and Dubnick it may also relate to the legislator. Bovens sees administrative accountability as connected to external scrutiny bodies, while bureaucratic accountability for Romzek and Dubnick is internal and related to the political-administrative leadership. Professional accountability is defined in roughly the same way by both.

## The context

### The national context

In Norway there are two partly contradictory doctrines informing accountability relations. First, we have the principle of ministerial accountability which implies that the

minister is responsible to parliament for all activities in his own ministry and in subordinate agencies and units (Christensen 2003). This principle enhances strong line ministries and weak overarching ministries. Specialization by sector is strong and there are weak horizontal coordinative instruments. Second, we also have a strong principle of local self government, implying that local government is responsible for local policy that might be loosely coupled to central government policy. This principle enhances strong municipalities and weak coupling between central and local government. Specialization by area is strong and there is weak inter-governmental coordination.

Over the past 20 years the strong principle of performance management, or management-by-objective-and-results has been introduced, which is a tool for superior administrative bodies to control subordinate agencies and organizations mainly within the same ministerial area (Læg Reid, Roness and Rubecksen 2006). By specifying objectives and performance indicators and establishing mandatory systems of performance reporting the central bodies try to enhance their control over subordinate bodies and increase efficiency and effectiveness. In addition to these three principles there are also strong norms of professionalism, expert governance and evidence-based policy making; *Rechtstaat* values enhancing principles of impartiality, predictability and due process; and strong norms of participation in the policy making process by external stakeholders, interest groups and user interests (Egeberg 1997). The principle of corporative participation has been strong in the Norwegian political-administrative system since the Second World War (Olsen 1983). The connections between these doctrines and norms and the mechanisms of political administrative, professional, legal and social accountability are pretty close.

The commercial parts of the government administrative enterprises mentioned above have all been corporatized, that is, established as various types of state-owned companies, whereas the regulatory parts have retained their agency form. Among the various kinds of state-owned companies that are subject to special law are: government-owned companies (*statsforetak*), government limited companies (*statsaksjeselskaper*), hybrid companies established by special law (*særlovsselskaper*) and governmental foundations (*statlige stiftelser*) (Læg Reid, Opedal, Stigen 2005, Byrkjeflot and Grønlie 2005).

## The reform context

### Social welfare

During the 1980s and 90s clients and civil servants in the welfare administration in Norway became increasingly critical of the fragmentation of service delivery, which was seen as especially problematic for the multiservice clients who had to visit many different public offices to claim their benefits. These actors put pressure on the Storting to initiate changes in the structure of the welfare administration, but were unsuccessful in their efforts until 2001 when a strong enough coalition was formed to ask the government to come up with a unified solution for the welfare administration (Christensen, Fimreite and Læg Reid 2007). The minority coalition government was reluctant to accept this demand and sent a report back to the Storting saying that they

did not support the idea of a unified service. A majority in the Storting was dissatisfied with this answer and replied that the government must deliver a more holistic service. This resulted in the government deciding to establish a public committee of experts to look into the matter. Their conclusion was that the basic fragmented structure was sound, but that the unemployment and social services should collaborate more closely at the local level.

The minister for the welfare administration who came to office in 2004 now headed a ministry that for the first time had all the relevant welfare services in one ministry. Realizing that it was politically impossible to come back to the Storting with yet another fragmented solution, he proposed a compromise that entailed a partial merger. The main goals of the compromise were to get more people off benefits and into work, to offer a more user-friendly and coordinated service and to be more efficient.

The administrative welfare reform was primarily a structural reform, consisting of two crucial elements. The first entailed a merger of the agencies for employment and the national pensions system, creating a new welfare agency (NAV) on all levels (Christensen, Fimreite and Lægveid 2007). The second element entailed the establishment of a local partnership between this new agency and the social services at the local level run by the municipalities. The idea was to locate all services in one place and reduce the number of tasks involved to a minimum. Two aspects of this solution are worth mentioning. One is that it was politically impossible to propose a completely unified welfare administration, because that would have implied that it should be run either by central or by local government, which was not politically feasible. The second aspect is that the legally enshrined mandatory partnership required the support of the local authorities and their central organization, and one way to do this was to allow a dual local management in the welfare offices, making it easier for both actor groups to be represented and also allowing the municipalities to offer more services in local offices, over and above the minimum required. This might be seen as the central state increasing its influence and interfering in local self-government, but it could also be interpreted as local government getting central government to finance more local services.

After the Storting approved the reform in 2005, an interim period of one year followed during which the old organizations continued to run as usual while the new internal structures were being discussed and decided on. The new welfare administration officially began operating in 2006. It was based on a central partnership agreement between the government and the central organization for the municipalities followed by local agreements between the new NAV agency and all the municipalities. The process of establishing local welfare offices in all municipalities took four more years to finish.

In 2008 the reformed system underwent two significant reorganizations. One was the establishment of six regional pension offices, while the other entailed the establishment of county-based administrative back offices. This involved shifting quite a few personnel resources from the local level up to the regional level. The main arguments for this were that regional units provided an opportunity to increase the quality of casework. What this meant in practice was increasing competence and introducing more standardization, equal treatment and efficiency with respect to different benefits, while at the same time giving local offices the opportunity to focus on their two main tasks:

providing information and guidance for their clients and helping the clients to get work. Central political and administrative actors, both in the ministry and in the welfare agency, saw this reorganization of the reform as a major precondition for fulfilling the aims of the original welfare reform. The paradox, however, was that the reorganization potentially undermined the original main reform idea of strong welfare offices in each municipality.

### Hospital reform

Historically it was the municipalities and various local actors that were in charge in the development of health institutions in Norway. The consequence of this was that the hospital system was very fragmented with great differences among regions in accessibility to healthcare. One of the purposes of the local government reform in the early 1970s was to develop larger administrative units in order to establish a more fair and efficient system. It was now the counties that were to take responsibility for the development of hospitals. The rationale was to enhance local problem solving while simultaneously achieving equal accessibility across counties and regions. In time, however, and particularly by the 1990s, the counties came under increasing fire because of long waiting lists for patient treatment, a lack of economic control and failed attempts at achieving a more equal regional distribution of medical services (Byrkjeflot and Neby 2008; Hagen 1998).

In hindsight it looks as if the county regime that existed between 1970 and 2002 was quite unstable, the conflicts between professions, districts, administrators and politicians, and local and central health authorities were recurrent, and various terms such as «rematch» and «blame-game» were used to describe the situation (Byrkjeflot and Grønlie 2005). The question of responsibility was raised several times by government, but with not much success. Other important reform acts were implemented, however, primarily among them activity-based funding of somatic hospitals in 1997 and a patient rights legislation including the right to «free hospital choice» in 2001 (Ot.prp. nr. 12 (1998–99)). These reforms made it even more difficult for the counties to take responsibility for the hospitals, since patients could go elsewhere at the same time as the central government now provided more than 70 % of the funding for these institutions (Hagen and Kaarbøe 2006:331).

The process that would lead up to the transfer of responsibility for the Norwegian hospitals from counties to the central government started in 2000 and in 2001 the decision to reform the hospitals were passed in the parliament. The reform act was thus prepared and implemented in a very fast pace (Herfindal 2008). One of the most important justifications for the reform was to give the hospitals «more clearly defined roles and responsibilities». Rather than be an integral part of the public administration they were now to be organized as enterprises with their own responsibilities as employers and for use of capital and finances, with the restriction that they may not go into voluntary liquidation. «As sole owner, the central government will have unlimited responsibility for and full control of the enterprises» (quoted in Bleiklie et al. 2003: 21.22).

New management principles were introduced for the hospitals based on a decentralized enterprise model, originally with 5 regional enterprises, 33 local health enterprises which integrates 81 former hospital units (Stigen 2005:38). Currently there are 4 regional enterprises and 24 local health enterprises. The local enterprises are owned by the regional enterprises and are responsible for patient treatment, research, education of health personnel and patients. Several health care directorates and agencies were also reorganized in the same period, but these processes were initiated and implemented more or less independent of the hospital reform (Stigen 2005).

On the one hand, the minister of health assumed full responsibility for conditions in the health sector and a new department of ownership was established; on the other, the enterprises were given enhanced local autonomy with their own executive boards and general managers with powers of authority to set priorities and manage the regional and local health enterprises. The reform involved a strengthening of overall central government ownership responsibilities and control, simultaneously representing a decentralized, but also more unitary and hierarchical system of management.

## Formal change in accountability relations

In this section we locate types of accountability in these cases in the context of the theoretical discussion above. In the case of the NAV reform we base the analysis on questions asked in interviews with elites about changes in accountability resulting from the major NAV reform, whereas the analysis of hospitals is based more on documents and previous research. The focus here is on the formal changes in accountability relations.

### Political accountability

Our definition of political accountability concurs very closely with Bovens' (2007). Norway espouses the principle of individual ministerial accountability whereby the minister is accountable to the parliament – the Storting – for everything that goes on in his/her executive administrative apparatus, meaning the ministry and the subordinate organizational levels and units. Within a ministry the administrative leadership is accountable to the political leadership, as are the directors of the agencies and regulatory agencies. Olsen (1983) labels this the «parliamentary chain of command».

In addition to this principle Norway also adheres strongly to the principle of local self-government. Normally these two principles are loosely coupled and some of the main challenges in the Norwegian political administrative system have been about how to link accountability upward to the parliament with accountability downward to the local council. This was a central issue in the NAV reform since two of the tasks – pensions and the labor market – were central government responsibilities while the third – social services – had traditionally been the responsibility of the municipalities.

We differ from Bovens in seeing this parliamentary chain less as an «economic man» set of relationships and more as an «administrative man» set of accountability relationships governed by bounded rationality and based on a structural–instrumental perspective.

One way to frame the question on political accountability is to ask whether the reform had brought about any changes in the relationship between the new welfare agencies and hospitals and the political leadership on the one hand, and in the relationship between the political leadership and the Storting on the other.

#### Welfare administration reform

One important formal change in accountability relations in the welfare agency was the concentration of both pensions and labor market affairs in one ministry, which streamlined accountability relations from the previously loosely coupled and partly competing relationship between different ministries with responsibility for different tasks. Formally, the new NAV agency was established within a rather traditional ministry-agency model, implying a rather close relationship and considerable interaction between the ministry and agency. This is interesting coming after 10–15 years of devolutionary tendencies in the Norwegian civil service in which agencies have moved away from the political executive (Christensen and Læg Reid 2001). One major reason for sticking to a model with considerable potential for political control is that this is the largest central administrative reform ever and a very crucial political area. Normally, the Storting would be rather passive concerning the organization of the central public apparatus, because this is seen as the executive's prerogative. The NAV reform is different in this respect, because the Storting initiated the reform and pressured the executive to come up with a solution, and it has been very active in following up on the reforms following their implementation. This offers potential for what in the US is labeled «sub-government» (Gormley 1989), in this case implying a rather hands-on attitude from the Storting.

The biggest change in formal accountability relations the reform implied was the introduction of the partnership arrangement between central and local government, which was supposed to be an organizational innovation that would resolve the contradictions between the principle of ministerial responsibility and the principle of local self government. The partnership is compulsory by law and mandatory for all municipalities. The law stipulates that there should be one welfare office in every municipality and that the welfare office should be a joint front-line service, implying co-location of the social services administration and the new integrated employment and welfare administration. The welfare office can either have a joint management or a dual management arrangement, with one manager from the municipality and one from the employment and welfare administration (government). From the municipal side the welfare office should as a minimum include financial social assistance, financial advice and the provision of housing for the homeless; in addition each individual has the right to have a social and welfare services plan. These one-stop shops are based on fixed, regulated, binding but also flexible co-operation agreements between the central and the local authorities, which are negotiated between the regional NAV office and the individual municipality (Fimreite and Læg Reid 2009). In addition a purchaser–provider-model has been established between the NAV agency and a quasi-autonomous internal body providing ICT and other services. Summing up, the partnership model introduced by the NAV reform is a public–public partnership comprising only public partners at

the central and local levels. The partnership was envisaged by the reform agents as a «Columbian egg solution» that would simultaneously establish a one-stop shop in every municipality in which all three services were included and accept the present division of tasks and responsibilities between central and local government to fulfill common goals.

The partnership model in NAV is a hybrid of hierarchy and network and tends not to clarify lines of accountability (Fimreite and Læg Reid 2009). A key question in this model is how one can have joint action, common standards and shared systems on the one hand and vertical accountability for individual agency performance on the other. The challenge is to better balance accountability to central government, accountability to the local council and social accountability (Christensen and Læg Reid 2007).

### Hospital reform

In the case of the hospital reform there were significant formal changes in political accountability relations. Ownership was moved from regional elected bodies to national bodies. The ministerial responsibility was for this reason strengthened, and local government accountability abandoned.

The new model, with health enterprises at the regional and local level, was partly inspired by the reforms that had taken place in the NHS in the United Kingdom, but also by reforms in other state agencies in Norway. However, it did also build further on historical traditions in the healthcare sector, where there has been a policy for regionalization in hospital planning since the 1970s. It was the five regions that were first set up in 1975 and made mandatory, as instruments for planning in 1999 that became the basis for the health enterprises that were established in 2002. The search for new organizational forms in the public sector has been an ongoing concern. It has been a particular aim for the Norwegian state to develop a new kind of enterprises, public enterprises that are not part of the public-governmental line of command, but nonetheless are open for political intervention. There is, in Norway, a distinct tradition for 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 owned company 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 («special law 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 (Byrkjeflot and Grønlie 2005). Due to the historically strong links between local communities and hospitals, it seems to have been difficult to establish legitimacy for the new regional enterprises. They were thought of as a buffer between central government and the local hospitals, but local hospitals were accustomed to be able to relate directly to the political leadership and found it burdensome to deal with a relatively weak administrative level as a substitute. These regional and local health enterprises were subject to special legislation through the Health Enterprise Law. They are separate legal entities and thus not an integral part of the central government

administration. The relationship between local and regional boards and local and regional Chief Executive Officer was a difficult issue.

Basic health laws and regulations, policy objectives and frameworks are, however, determined by the central government and form the basis for the management of the enterprises. The regional health enterprises have no medical service functions of their own. Their main responsibility is ownership, planning, organizational matters and distribution of health care services in their region. Thus, they are expected to retain both the role as owner and commissioner. After a brief moment of hesitation, an integrated model was chosen, which meant that, with exception for their relations to private hospitals, both the purchaser and provider roles were taken care of by the hospital enterprises. However, there was an adjustment in the reform in 2005/2006 which meant that the owner role was now organizationally split from the «purchaser» role, separate owner departments were now established in the Regional Health Enterprises (RHE). The actual health services were to be delivered by the hospitals organized as Local Hospital Enterprises (LHE). Enterprise meetings and commissioning letters are important steering devices for the regional health enterprises in their relation to the local health enterprise; equal to the management system at national and regional level.

In contrast to the laws regulating other public sector companies and trusts, the Hospital Enterprise Law specifies a lot more in detail what tasks and issues that have to be approved by the ministry (Lægneid, Opedal and Stigen 2005). A number of steering devices are laid down, either through the Health Enterprise Act (2001) or through additional statutes and documents, such as articles of association, steering documents (contracts), and decisions announced at the annual (later bi-annual) enterprise meeting, also called the ministerial meeting. There is also a system for annual reports from the regional and local health enterprises and a performance monitoring system – with formal reports on finances and activities to the ministry.

Central government appoints the regional board members, while the boards of the local health enterprises are appointed by the regional enterprises. Previous to the reform in 2002 the hospitals were reporting to the county councils and were for the most part governed by boards that were directly accountable to the county. It was an important argument in the reform that there was a need for «professional» hospital boards. This meant that no active politicians could be members of the boards; the only group that had any formal representation was employees. In 2005 the statutes were changed, as part of a change of government from a center coalition to a Red-Green Government. This meant that politicians could become board members, and they make up around 50 % of the members.

There is a built-in inconsistency in both reforms. They claim to empower users and clients, to free managers, to enhance administrative accountability and to strengthen political control by both central and local political bodies. But in reality it is difficult to achieve these things simultaneously.

### Administrative accountability

This type of accountability is more focused on internal administrative processes than political accountability, where the crucial question internally is the relationship between

the political and administrative leadership. A primary means of internal administration in Norway is various kinds of performance management, which in many ways is rather technical.

#### Welfare administration reform

Management-by-objectives-and-results are a main steering tool in the NAV organization, both between the ministry and the NAV agency and internally between the central NAV organization and the local branches. But performance management in Norway is also carried out via the Auditor General's Office, so there is a component of external scrutiny here. In this respect our question to the elite respondents on administrative accountability combined the internal focus of Romzek and Dubnick (1987) with the external focus of Bovens (2007).

#### Hospital reform

In Norway management structures in hospitals became a hot political topic in the first years after the introduction of the hospital reform, as it became mandatory for all hospitals to be organized according to the same principle of management; unitary management. This means that only one manager were to be in charge both at the top level and the clinical level, where there previously had been shared responsibility between nurse managers and medical managers. This was first affirmed through a vote in the Norwegian parliament in 1995, and it has later become part of the health personnel law (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). This was a break with established practice where there was a split between administrative and professional leadership on different levels, and where the various professions, primarily doctors and nurses, were the managers in each their domain.

The idea that management must be conceived 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 (Pilskog 2008). Until 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 already in 2003 and 92 per cent in 2007 (Kjekshus 2009:285).

The Norwegian central health administration was reformed in 2002 and 2003 coinciding with the implementation of the large hospital reform. The board of health supervision was established as an autonomous agency, separated from the Directorate of Health and Social Affairs. Also, there was a general reforming of audit organizations in the direction of creating more autonomous audit agencies, allowing regulation on a more «objective» basis (Lægreid, Opedal and Stigen 2005). In 2004 The Norwegian Knowledge Centre for the Health Services was created, and this center has taken an increasingly important role as a means of developing clinical guidelines and provide premises for quality development, as well as providing hospitals with decision support. The hospital enterprises, as well as the governmental agencies in the health sector play a central role as a commissioner of reports from this center. In cases where there is

difficult to make a decision due to lacking information the enterprises or the ministry may commission a report from the knowledge center in order to legitimate their decisions. In a field where doctors and local actors have become used to act on the basis of their own knowledge, it may be of great help if the decision-makers can justify their choices with a report that show that their decisions are either evidence-based or at least built on knowledge relating to «best practice» (Byrkjeflot and Aakre 2007).

## Legal accountability

The court system's rather low political and administrative status means that Norway deviates from the definitions given by the authors mentioned above of legal accountability as an externally related factor. Norway does not have a system of administrative courts, and few political or administrative matters reach the ordinary courts; instead they are handled in political-administrative decision-making processes. This is slowly changing, partly because of Norway's adaptation to the EU, which puts more emphasis on individual rights.

### Welfare administration reform

In NAV there is a unit for complaints within the central body for special units. These replicate comparable units in the two agencies that formerly constituted the NAV. If clients are not satisfied with a decision made by the complaints unit, they can appeal to a special court which deals mainly with pension cases, i.e. this is deviating from the common pattern. In some cases they can also complain to the Parliamentary Ombudsman, but his/her opinions and decisions are not binding for the central administration. Judicially the NAV is internally accountable, for there is no external judicial scrutiny body that covers the whole of NAV, even though the Office of the Auditor General exercises some of the functions entrusted to judicial watchdogs in other countries; moreover, as already mentioned, the pensions court also has a role to play.

The crucial questions we put to our respondents on the impact of the reform on legal accountability was derived from a more general principle of rule of law. We asked three questions specifically related to legal accountability: one concerned the rule of law and the judicial rights of clients; the second concerned equal treatment of similar cases and standardization; and the third was about how to organize a complaints procedure within NAV. This pertains more to the internal connection between the welfare administration and its clients than to external judicial scrutiny.

### Hospital reform

In the Scandinavian welfare systems the courts have only to a limited extent been used to advance access to specialized health care. The general principle has been that rights of patients are restricted by the resources the society is able to provide (community contract), whereas the courts have played a more important role in countries where the right for healthcare is based on a civil right contract (Norheim 2005, Trägårdh 1999, Molven 2011:49)

However, there has been a rapid development in the patient right legislation, also in Norway during the latter years. Standards for quality have been introduced, along with waiting time standards and guarantees. As part of the Norwegian Patient Act first implemented in 2001 and strengthened in 2004 there has also been introduced free choice of hospital, right to information, access to medical records, right to second opinion, and rights to file a complaint (Kjønstad 2011).

There are few legal requirements related to how the provision of services should be organized. However, there is a requirement that hospitals be organized so that there is a responsible leader on every level, as discussed above (unitary management). Furthermore, every provider is required by law to establish a system of internal control as part of a mandatory system for safety and quality control. There is also a requirement to report incidents that have, or could have led to, serious injuries for a patients to the supervisory authorities (Braut 2011).

## Professional accountability

### Welfare administration reform

Two types of professional competence, representing the professional cultures formerly related to pensions and employment, are covered in the new NAV agency. In addition the professional culture of the social services in the municipalities also comes to bear in the local welfare offices. Historically the pensions administration had a rather traditional rule-oriented culture characterized by a focus on single cases, and this profile did not change much in the run-up to the reform. The employment administration was traditionally a government monopoly managing a lot of resources and a variety of programs designed to help people find a job – a typically social democratic policy feature. During the final decade before the reform, the employment service changed considerably. It underwent a modernization and found itself competing with private employment providers. The social services in municipalities had historically been based largely on discretion and local knowledge and were dominated by social workers, but over time they became more professional and rule-based. In general one may characterize the organization as a machine bureaucracy (Mintzberg 1983), which means that management may exercise a great deal of control over professionals.

### Hospital reform

It has been pointed out that medicine have been somewhat unique in their achievement of a regulative bargain with the state (Hafferty and Light 1995). 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 Norway, an integrated part of the state, which means that professional accountability has been a major form of regulation. The rise of the Norwegian health administration, personified by Karl Evang in the powerful position as Health Director between 1938 and 1972, was an example of an «extension of the medical clinic into the state» (Berg 1997, Nordby 1989)). In this model the medical competence was personal and delegated to doctors in intimate encounter with patients. It has been pointed out, however, that since the early 1980s the medical profession has

lost some of this central position (Erichsen 1995). It is even argued that the hospital reform in 2002 followed as a consequence of a long-term trend towards breakdown of professional autonomy among doctors. The major force for this is medical specialization and the necessary expansion of management functions that followed as a means to keep the healthcare system together (Berg 2010). Other observers emphasize the expansion of patient rights and ideology of consumerism, quasi-markets and the external control instruments that developed along with the rise of an audit culture (Gray and Harrison 2004). The reform may then be seen as part of a shift in strategy in the Norwegian government from a system heavily based on empowering and trusting doctors and other professionals, towards a more patient-centered system. The latter kind of system is to a greater extent oriented towards a «money follows the patient principle» along with patients rights. The role of the patient is supposedly strengthened with a system of free choice of hospitals along with activity based funding, based on the idea of the patient as a customer and a citizen. Both these lines of reasoning may be questioned, however, since the doctors still take a predominant role in the institutions that develop the standards for best practice and clinical guidelines that is used in healthcare services. There are not really many signs of a deprofessionalization, at least not to the extent predicted by these perspectives (Byrkjeflot 2005). Accordingly, it is difficult for management to exercise power over the professional and clinical level in the organization. Hospitals do still work more like professional bureaucracies than machine bureaucracies (Mintzberg 1983).

## Social accountability

It is difficult to map formal changes in social accountability since Bovens' definition refers to more informal kinds of mobilization. In the case of *Welfare administration reform* we asked elite respondents about possible changes in social accountability brought about by the reform focusing on two aspects: their relationship with clients and societal relationships.

In the case of hospital reform, there is a formal change since both regional and local health enterprises have to establish patient commissions. Due to the Health Enterprise Act from 2002. Patient involvement is also stressed in the composition of the boards, although the patient organizations do not have any formal board representation. These methods for patient involvement in the Norwegian specialized health care may not only be seen as an NPM inspired mean to strengthen the power of the consumers (patients), but also as an arrangement in line with the corporatist traditions of Norway, where affected organized interests are integrated into public policymaking (Vrangbæk, Opedal and Rommetvedt 2010).

It seems like the removal of local democratic links led to new kinds of mobilizations, particularly among local stakeholders in hospital development. Several thousands took part in both local and national manifestations during the early phase of the reform. Eleven local action committees were involved in the founding of «the people's movement for the local hospitals» April 6. 2003 (Lindset 2006). Several mayors from municipalities affected by reform plans and also many of the recently disempowered local politicians took a role in the discussions and manifestations that followed. An

important impetus for the institutionalization of the movement was a group of doctors called «motmeldingslegene» from the north of Norway who produces alternative documents to the official white papers. The public sector union, Norwegian Union of Municipal and General Employees (Fagforbundet) have taken a central role both in the nation-wide movements and in the funding of research institutes and in the commissioning of alternative reports to the official evaluations and white papers.

## Changes in accountability practice

### Political accountability

#### Welfare administration reform

The basic question concerning political accountability in the NAV reform is whether the relationship between the political executive and the sector ministry on the one hand and the new NAV agency on the other has changed in reality, even though it has not changed formally. The other relationship is the one between the parliament, the Storting, and the government and the agency. In the case of NAV the elite interviews revealed a number of prevalent attitudes regarding changes in the actual political accountability relationship. First, respondents seemed to agree that reforms had little impact on the policy development function in the sense that it continued to be based in the political executive. Nevertheless, a majority thought that in reality the pattern of influence had changed in favor of the NAV agency. This had mainly to do with the size of the NAV agency and the whole NAV organization (15000–20000 employees), which gave it the upper hand concerning expertise. Moreover, the complexity of this enormous organization made it difficult for the ministry to gain insight and information and to handle that information (see Brunsson 1989). The period 2006–2009 was also a time when the municipalities were very preoccupied with implementing the reform, which put the ministry at an even greater disadvantage. Despite the fact that the political leadership is now steering one instead of three separate administrations and the NAV reform is a salient policy area, the ministry lacked alternative information, making it dependent on the leadership of the agency. Frequent changes of minister also weakened the influence of the political executive.

Second, even though the actual political accountability pattern has changed and respondents saw the NAV agency as strengthening its position, few of them thought this would increase conflict. The political–administrative leadership in the ministry and the leadership in the agency seem to be in close contact and agreement, but, as indicated, the top leadership of the agency seems to have strengthened its role in influencing important decision premises, thereby in reality tilting the unchanged accountability relationships.

Third, even though the performance management system is meant to make a less ambiguous distinction between the political and administrative roles, some respondents said there was more ambiguity than before concerning political and administrative jurisdiction and that the two groups of actors tended to offload responsibility onto each

other («passing the buck»), especially in times of crises. Some of the respondents also thought the director of the NAV agency had been made a scapegoat and had to some extent accepted this role when external criticism had been strongest, implying that the position of director had become politicized, but also that the director had room for maneuver.

Fourth, according to the respondents the Storting has been more active than normal in two different ways. First, it has exerted strong and consistent pressure on the government and to some extent on the agency as well, for example by staging a high-profile public hearing on NAV in the Storting. Second, it has used alternative information from the organizations, allowing users and employees influence through the media. This has shifted the focus more onto single cases and clients and away from the effects of the new system as such, which at times can be frustrating both for the political leadership and for the leaders of the NAV agency. In this respect there has also been a tendency to blame NAV for everything, even issues relating to the municipalities and their social services, over which NAV has limited control, as well as for a number of problems originating in other sectors. Overall, however, despite the Storting's hands-on approach to NAV issues, the respondents seemed to agree that the Storting was also losing influence – as was the political executive – vis-à-vis the NAV agency. This happened despite an unchanged accountability relationship to the Storting.

In theory the partnership model should be a partnership between equal partners, but in practice the central government tends to become the big brother and to have the upper hand in the partnership arrangements. This seems especially to be the case with respect to the many small municipalities, while in the few very large municipalities it seems to be the other way round. The fact that the municipal part of the local office is subordinated to steering from locally elected representatives while the government part is subordinated to the ministerial chain of command leads to a problematic double-steering arrangement at the local NAV office (Fimreite 2010). There are more than 70 different local solutions regarding the task portfolio, which does not make accountability relations easier either (Christensen and Aars 2011). The local NAV offices represent a combination of standardization and local adjustments (Fimreite and Hagen 2009). In practice the partnership does not live up to the expectations of a real partnership and the partnership model reduces rather than strengthens the local room for maneuver (Fimreite 2010).

This practice also has implications for accountability. Seen from a social accountability point of view the partnership model and the one-door approach can be an advantage for users. The problem, however, is that the partnership model blurs political accountability for services, making it difficult for citizens to discern which political level is accountable for what service and hence which politicians should be held accountable in general elections (Askim et al. 2010, Fimreite and Læg Reid 2009). This is a common feature of network-based governance structures (Aars and Fimreite 2005) and the question is whether these kinds of arrangements reduce local government autonomy.

The conclusion we reached from the survey responses is that the political accountability relationship in reality has changed. The NAV agency and its leadership have

strengthened their position both vis-à-vis the Storting, the central political executives in the ministries and local government.

### Hospital reform

Some of the same mechanisms are playing out here as in the case of NAV. Hospitals are rather self-driven, complex organizations and the doctors have a great deal of control over the core tasks. There has been a constant problem with budget deficits. This means that top management in hospitals to a greater extent rely on the ministry and the parliaments to gain stronger control of what is going on at lower levels. It is probably for this reason that the responsibility is kept closer to the health ministry level and not given autonomy to the same extent as in the case of the NAV agency.

A particular problem has been that the boards have had problems with establishing support for restructuring of services. The local resistance have been strong and local boards have been reluctant to support regional plans for centralization of services. It was probably for this reason that there was a change from so-called professional boards to boards with political representatives. In order to avoid conflict of interests it was specified that these politicians do not represent political organizations, geographical areas or other interest groups (Helse og omsorgsdepartementet 17.01.2008). They are proposed by the municipal or county councils, and in order to be nominated they have to be elected to one of these bodies. They are appointed to the boards by the Ministry of Health and Care (in the case of RHE) or the regional health enterprise (in the case of the local enterprises). Although they are supposed to only represent themselves as individuals, this is somewhat contrary to the logic of politics, particularly health politics, where party programs are important and where there is an ongoing debate in the media and in the parliament. Østergren and Nyland (2009) have studied how the board members see their role. They find that there is a great deal of consensus among board members, that they primarily see it as important to take part in strategy development and represent owner in efforts to overlook use of resources. Over time they have given more priority to economic control, however, also because they do not see that there is much room for strategy development both due to lack of resources and lacking mandate to act. They do not maintain much contact with other local stakeholders and therefore it does not seem to be the case that they see their role as representing local interests or stakeholders on the board. The conclusion is that the board members identify with ownership control and that the representation of politicians does not seem to make much of a difference in that respect (Østergren and Nyland (2009).

There are several examples of politicians on boards that as a consequence of their support for controversial restructuring plans have gotten into trouble in their relations with local constituencies. In some cases such politicians have lost out in nomination processes as a consequence of mobilizations against them among party members (NRK nyheter 2010).

In surveys of local boards in 2003, 2004 and 2008, the board members were asked to consider, firstly whether the coordination of the various roles of the state was sufficient. Initially, between 59 per cent at regional level and 69 per cent at local level saw this as a problem (Lægreid, Opedal and Stigen 2005:1047). In later surveys the share that sees

this as a problem has decreased, however. The board members were also asked about what influence various agencies and groups have over decisions in the health enterprise. Particularly in 2003 and 2004 the results were in line with the reform's intention of a de-politicized implementation process. Local community actors such as local action groups, municipalities and counties were thought of as having little influence on the health enterprises' decisions. The user and patient organizations were also attributed little influence.

These results may indicate that the enterprise executives in this early phase had a strong loyalty toward their owner (Ministry of Health), but that they were confused about how state ownership would affect established relations to the state apparatus. Perceptions of influence pattern did not change a lot after the county and local politicians won a majority on the boards (2008 results), but local action groups appear to have gained influence. Most pronounced is the increased influence that hospital employees' organizations had gained in the view of board members. Parliament achieves significantly lower scores in 2008, which may be explained by the fact that there was now a majority coalition in parliament behind the government. Both Parliament and the Ministry of Health is part of the formal control line between the government and the health enterprises, but in the reform design the health enterprises were supposed to have a great deal of autonomy in administrative matters. The autonomy, however, appears to have decreased. When board members were asked to consider to what extent local enterprises were autonomous in 2003, 30 percent completely or partially agreed, in 2004 19 per cent and in 2008 only 12 percent were in agreement with this statement (Opedal 2005, Fjær et al. 2011:26).

One may conclude, as many have done, that it was an unrealistic ambition behind the healthcare reform when it was said that the aim was to keep politics at arm's length from administration and achieve a clear division of labor between various state authorities (Tjerbo 2009, Opedal 2005). Several studies show that local networks of politicians, allied with employees and other stakeholders, had more power over local development in hospital structures than assigned in formal structures. Tjerbo argues that such reforms are highly political and voters are closely monitoring the impact such changes have. Local action can thus have a major impact on decisions and create pressure not only for the regional enterprises and the boards, but also the central authorities (Tjerbo 2009). There have also been many complaints about the growing health bureaucracy and the many agencies in the state administration that intervene in the services and make demands on them in order to demonstrate their role in the running of the daily affairs.

The reform expectations for changes in governance practices were also not reflected in the long run in the documents we have collected and studied in another study (Byrkjeflot and Gulbrandsøy 2011). Between 2001 and 2003, the formal communication between local/regional health enterprises and the ministry indicates that both parties were of the opinion that if steering was becoming too detailed, that would not be in the spirit of the reform. In its annual report for 2001 to the ministry, the Western Health Enterprise (WHE) «sees a need for a simplification with less specific goals». It also seems as if WHE had expected the ministry to give them more freedom to act, than it had experienced so far. The ministry's steering document from 2002 states that «within the goal- and result demands that are created by the owner, WHE will have a large

degree of independence in the use of resources» and that «the program will be developed with the aim of giving even better flexibility to decide how best to solve the tasks». However, in 2003 we find a very long steering document, which contains many detailed demands about specific matters, and since then the number of details that the level above want to report on has continued to increase.

Terminology in steering documents has changed, which Opedal (2005:94) also points out. In 2002 the documents contained many expressions such as «you ought to do (x)», and «have responsibility for (y)», but in later documents the terminology becomes more directive and imperative and the expressions change to «you shall do (x)», and «you must do (y)». Less discretion is left to the enterprises in considering how and whether they will follow a guideline or carry out a given instruction.

## Administrative accountability

### Welfare administration reform

Formally, there seem to have been few changes in hierarchically based administrative–economic accountability as a result of the NAV reform, which means that it is characterized by a rather complex system of performance management and management by objectives, based in letters of intent from the ministry, internal plans and performance systems, and control and reporting systems, like in any agency. But the respondents seem to agree that the reform has changed actual administrative accountability in the direction of increased bureaucratization, although the features they identify and the reasons they give differ.

First, they report that the Office of the Auditor General has become much more active towards NAV than it previously was towards the agencies forming NAV. The Auditor General has about 40–50 people working with different aspects of NAV, which represents a lot of capacity. The respondents seem overall to be critical towards this external scrutiny, saying that it is excessive, too detailed and shifting, too control-oriented and insensitive to the fact that NAV is a huge and complex organization that has made a great effort to set up local offices and implement the reform. It is also worth mentioning that the Office of the Auditor General wrote a very critical report on NAV, which resulted in the above-mentioned public hearing in the Storting. One of its main criticisms was the loose connection between the general goals in the state budget and the objectives and performance indicators formulated in the letter of allocation between the ministry and the NAV agency.

Second, many of the respondents seem to think that internally the NAV agency has had a tendency to create too many staff functions related to control, without clearly defining their roles, hence the increasing emphasis on systems of control and risk steering. The multiple and changing routines are perceived as challenging, even though some of them are actually held to work rather well. Some respondents say that the apparent increase in problems of control is also related to exposing old problems. Result steering has had trouble getting off the ground in NAV. The tendency seems to have been to shift the steering focus from the overall goals of the reform to details of control. Overall, some of the respondents perceive rather loose coupling between the large

central control capacity and actual control activities on the local level. These problems of managerial accountability are also partly due to the lack of an integrated ICT system, which makes it difficult to get systematic and reliable data.

Third, uniform quality standards for the entire organization have failed to be defined. National routines for measuring quality are lacking, and quality varies considerably between counties and local NAV offices. The performance management system measures activities and output more than outcome and there seems to be a loose connection between the overarching policy goals for the NAV in the state budget and the objectives that are formulated in the internal performance management system (Breivik 2010).

Fourth, the local partnership model is rather ambiguous concerning responsibility for the activities of local offices. Because this is a hybrid organization that represents a collaboration between the central government NAV agency and the social services of the municipalities, based in local democracy, it has not, for example, been possible to introduce a performance management system for the municipalities; the principle of local self governance implies that local governments may have goals and objectives that are not in line with those of central government.

Fifth, it proved difficult to get the purchaser-provider model to work, and this arrangement at the central agency level was dismantled after a short period. Sixth, building up regional level pension and management units at the expense of the local NAV offices and the partnerships has strengthened administrative accountability relations. Transferring personnel as well as tasks from the local partnership level to the regional state government level also tends to strengthen administrative accountability relations.

Summing up, the reform seems to have brought increased bureaucracy in control and scrutiny systems designed to secure administrative accountability, concerning both the number and type of control systems and personnel and administrative capacity. It is, however, difficult to get a simple management-by-objectives-and-results system to work as a steering tool for such a large and complicated agency as the NAV.

### Hospital reform

Parliament has increasingly positioned itself as an important controller of the health enterprises. There has been an increasing amount of MP questioning. This has brought central elements of the enterprise model under pressure (Opedal and Rommetvedt 2005). The distribution of responsibilities between the different levels of the healthcare system has been affected by the new audit routines and the many agencies involved in audit practices. One reason for this is the increased need to revise and coordinate tasks and responsibilities for state institutions other than the department and the enterprises that three agencies, in particular are important: The Office of the Auditor General, The Norwegian Board of Health Supervision, and the Directorate of Health and Social Affairs. These agencies represent the formal organization of state control (Stigen 2010).

The Office of the Auditor General has increasingly been involved in audit of the hospital enterprises. Its activities include both economic and administrative audit, control of ministerial dispositions in relation to parliamentary policy, and general audit

of policy implementation. For instance, control with health expenditure and efficiency has been a theme (Riksrevisjonen 2009), just as the implementation of the reform and coding practices in relation to activity-based funding. The Auditor General provides fuel for both political debate and action. The structural status of the Auditor General makes their findings directly relevant to parliament, ministry and ministers, creating more room for the involvement of national actors in quite detailed matters that the enterprises originally were responsible for. The Directorate of Health and Social Affairs' role is central in ensuring the implementation of law and policy on healthcare issues. Like the health ministry they issue annual letters of commission to the health enterprises.

The Norwegian Board of Health Supervision engage in direct monitoring, surveillance and audit of activity in healthcare, both in terms of general practice and single cases. Its activities are often directly related to law, for instance in order to secure patient rights or deal with malpractice. Their activity may result in direct sanctioning or prescriptions for change and implementation of measures. Langeland (2008) has observed that the hospital reform has created a more complex organization to supervise and she finds that the board now emerges as a more punishment-centered and authoritative body and that there is less emphasis on guidance and trust-related measures. Whereas there in the old system were at least some top level managers and chairmen of the boards that had been in position over a longer period, there are hardly any such managers in the new system. Among the 60 top managers that had been entering in the new posts in 2002 there were only 5 that were left in 2009 (Mordal 2009). Managers have been leaving their posts as a consequence of scandals or as response to intervention from politicians. An investigation found that more than half of the health enterprises had gotten a new economics director in 2007 or 2008, and that an almost similar number of enterprises had also changed their CEO (Riksrevisjonen 2009).

The Norwegian Knowledge Centre for the Health Services, which was the result of a ministry-initiated merger of a set of semi-autonomous organizations in 2004, has as its mission to gather and disseminate evidence about the effect and quality of methods and interventions within all parts of the health services. The uptake of such evidence and the implementation of the best methods and technologies among healthcare institutions has become an increasingly important part of the health politics. The center is organised under the Norwegian Directorate of Health, but is scientifically and professionally independent (Byrkjeflot and Aakre 2007).

Although operating on different levels and answering to different institutions, the interplay between these agencies for auditing, administrative control and setting of knowledge standards create accountability dynamics of increasing importance to the governance of the hospital system (Neby 2009).

Generally the performance management system in practice seems to be a mixed system in which the political executives reserve the right to intervene when things go wrong or in politically sensitive cases. The formal performance management system seems in practice to allow a broad variety of actual behaviour (Christensen, Læg Reid and Stigen (2006).

## Legal accountability

### Welfare administration reform

First, several of the respondents underscored that the reform had revealed the problems of the rule of law and quality of the casework in the old system. This came about through the reform's introduction of less ambiguous rules and less discretion and, as mentioned above, more control systems and activities. The downside is more complicated rules and control systems. There is also some doubt about whether increased formalization is enough to bring about equal treatment, and some respondents pointed to geographical inconsistencies in the treatment of apparently similar cases.

Second, many of the respondents thought the reorganization of the reform in 2008, which established county-based back-offices, had improved the rule of law and made the treatment of clients more equal. The argument was that with fewer units, around 25 units on the regional level instead of 430 local offices, it had become easier to benchmark. Larger areas of competence also improved the situation for clients, because it made it easier for the providers of different types of benefits to exchange information and hence to provide more equal treatment. In addition it is now possible for the leadership to exert pressure in this direction and make employees more aware of the importance of equal treatment. Respondents also pointed out those common method-related instruments were required for the discretionary handling of cases and that employees needed to be trained in this area, particularly with respect to local social services.

Third, some of the respondents were concerned about the complaints system in NAV, i.e., with how easy it is to complain and how the complaints mechanism is organized. Some pointed to the fact that a good application process would provide more legitimacy when clients complained; while others emphasized that more control systems might be seen as negative by clients, particularly those whose applications were rejected. There has been some discussion about whether a regulatory agency or an ombudsman is needed in the welfare organization for centrally based governmental services, but this discussion has yet to be concluded, although there is already an ombudsman for locally based welfare services. The Storting has contributed to the politicization of this question, because it is preoccupied with the treatment of single cases, as revealed in the complaints process, which showed system problems.

Summing up, judicial accountability has changed as a result of the restructuring and increased focus on control and the formalization of the complaints process brought about by the reform. Overall this is perceived as enhancing the rule of law and equal treatment of clients. Respondents also attributed these effects to the establishment of country back offices.

### Hospital reform

It is difficult to say exactly how the formal changes in organization of hospitals relate to actual changes. However, it is fair to say that the enterprise model aimed more at empowering patients in their role as users rather than as citizens. This was observed in one of the evaluation reports, and it was seen as one of the strengths of the reform that

it had actually enabled a move in this direction (Evalueringssrapport 2005). A central device for this was the patient commissions. These commissions have been evaluated and it was found that the influence was strongest at the regional level, whereas there were problems with gaining any influence on the clinical level in the local enterprises. It was primarily patient groups with complex diagnoses that were given priority in these commissions. Routines still remained to be institutionalized that could make a difference in actual treatment processes (Andreassen and Lie 2007)

Like in the NAV case there has been complaints about the complexity of the system, as reported in the section on administrative accountability. There might also be a contradiction between an emphasis on rights and an emphasis on fairness and equality. For instance, during the first years after the hospital reform the waiting lists became shorter, but it was the patients with diseases that were less serious and for this reason more easy to treat that were given most priority (Askildsen et al 2007). Partly for this reason there has been a renewed emphasis on the issue of prioritization and how the law may be used to prioritize the groups that are most in need of treatment. There are only a small share of the patients that actually make use of the right to choose hospital and it is not likely that it is those most in need of treatment that make use of such rights.

## Professional accountability

### Welfare administration reform

Most of the respondents describe a rather turbulent and challenging situation for professional accountability in NAV after the reform. Overall they agree that there is a need to join-up the different professional cultures and that this process is likely to be beset with tensions. They disagree, however, about what are the most important aspects of this and whether there are reasons to be optimistic or pessimistic about the prospects for developing a new professional culture.

The optimistic take is that the reform has led to more focus on professional knowledge and accountability and that there are bound to be professional synergy effects of such a merger or collaboration between professional cultures, even though the process has yet to be completed. A large organization may also benefit from having some tension between different professional groups and tasks. Tensions will also differ depending on how heterogeneous some units are professionally, and there has been some talk internally about creating a common NAV education.

The negative arguments are different. Some say that developing a general professional ideal is unrealistic in an organization handling 55–60 different tasks or sub-services. There has also been some conflict among professional groups about the organizational and professional positions in the new organization. Professional groups from the former pensions and employment administrations have had problems focusing sufficiently on professional development, tending to fall back on traditional methods and professional approaches. Professionals in the NAV agency seem to mistrust the professionalism and problem-solving capacity of the local social services. This may be because the partnership model is ambiguous about how to develop the professional aspects. A strategy for competence development seems to be lacking.

While the respondents may disagree about the effects of the reform on professional accountability, they also perceive some parts of the new organization as functioning well in this respect, while they see others as struggling or not making a sufficient effort.

### Hospital reform

There is in the Norwegian system a great deal of doctors that now take a central role in managerial positions (Torjesen, Byrkjeflot and Kjekshus 2011, Hasselbladh and Bejerot 2007). It thus seems like there is more of a trend towards hybridization in the managerial ranks in hospitals than in welfare administration, where hybridization takes more place at the professional level and in the local offices. One indication of a movement away from the established way of organizing hospitals, i.e. through professional accountability is the strengthening or rise of a new set of intermediate actors mentioned above; e.g. the Norwegian center for the health services and the Norwegian Board of Health Supervision. Several studies show that despite the strong emphasis on organizational control over professions in recent reforms, 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.

Jespersen (2008) found that professional accountability was more challenged by new instruments for quality control introduced in the Norwegian health service than in Denmark. The influence of the professionals in accounting for quality was decreasing. Aasland et al. (2007) found that a majority of medical professionals thought that the hospital reform had not reached its major goals, and that the accountability relations had not become less opaque after the reform. This negative attitude among doctors in relation to the hospital reform is interesting in light of the support given by doctors in the initial phase and also the high wage increase they received initially (Byrkjeflot 2005).

## Social accountability

### Welfare administration reform

First, concerning the relationship to clients, some respondents pointed out that the reform had made the situation more complicated for users because units, employees and tasks had been moved around. This is basically seen as a disadvantage for the clients, because it destabilizes the employee-client relationship, even though some users may benefit from changing their contacts. However, the larger units implied by the reform may eventually restore stability.

Second, the merger or collaboration of three types of welfare services is seen as improving competence and increasing the probability that clients' needs will be fulfilled. The needs of clients have become more important in the new organization, because that is the crucial relationship for measuring the effects of the reform. User surveys are used more intensively than before in NAV. Face-to-face contacts are thought to have improved, while telephone services are struggling.

Third, there is agreement that multi-service users are better off after the reform, i.e. one of the main aims of the reform seems to have been fulfilled. But there are more doubts about how the users of only one service are coping in the new complex system.

Fourth, there seems to be some disagreement about how the reform has changed the relationship between the NAV agency and the users' and employees' organizations, although most respondents judged this as negative. Some few respondents stressed that contact was closer after the reform than before, while others thought the organizations had lost influence, partly as a result of their contacts with the Storting and their focus on single cases, and the fact that the ministry and the agency tried to avoid involvement in single cases. There is a forum for contact with the organizations, but it is not used much. The dialogue with stake-holders in the labor market – the large employers' and employees' organizations – seems to have weakened, and NAV's function as a societal actor in this respect is not strong.

Summing up, respondents paint a rather mixed picture with respect to the reform's effects on social accountability.

### Hospital reform

It became apparent that both the new regional health enterprises and the governmental agencies and committees that were responsible for the reform plans had underestimated the challenge from the various local movements listed above (Byrkjeflot and Gulbrandsøy 2011). Already in 2003/2004 there was a movement towards involving stakeholders more in restructuring processes. In some cases new institutions were developed, such as in the case of the new hospital enterprise Innlandet, who created something called «samfunnspanel» (society panel) in order to involve municipalities and other local stakeholders in projects for restructuring (Tjerbo 2009). The new red-green government had stated in the so-called Soria-Moria declaration (2005) that no local hospitals would be closed as a consequence of the plans for hospital restructuring. This statement was repeated after the election in 2009 when the red-green coalition continued in government. This does not mean that the controversies around local hospitals were not kept alive, however. Quite to the contrary, as it became apparent that the government would not take a stand in the discourse about how to define the term «local hospital», the conflict level again increased. The local opponents built on an established practice when they said that a health institution could not be defined as a hospital unless it had both a birth clinic and a unit for acute surgery. This definition of a local hospital was constantly challenged by actual plans presented by local hospital managers. By not making the definition explicit the government was free either to intervene or not to intervene in such processes. Both politicians in parliament and in government have been vulnerable to local protests, and it was often unclear whether they were ready to accept the consequences of their own demand for balanced budgets in the Regional Health Enterprises (Tjerbo 2009).

## Discussion

As mentioned, the formal accountability relationship between the political leadership and the NAV agency has not changed as a result of the reforms, but actual political accountability does seem to be changing nonetheless (Table 1). In the case of the hospital reform the formal accountability relationship has changed but actual accountability relations seems not to have changed to the same extent. Why is that? One important factor is the different nature of what is produced in the two sectors. In the case of NAV the emphasis is more on administrative services and money transfers based on standards and rights. This means that the administration is more powerful, and that the organizational form is most similar to what Mintzberg has called machine bureaucracy. In the case of hospitals the core function is treatment of patients and this gives the medical profession and the local level a powerful position. The organizational form that comes to mind is professional bureaucracy (Mintzberg 1983). In the case of NAV the size and complexity of the administrative apparatus (Egeberg 2003) makes it rather difficult for the political leadership to follow up on the reform and makes it more dependent on the NAV leadership. The political leadership faces the paradox to which Brunsson (1989) pointed, namely that politicians in modern societies increasingly lack information about and influence over what is going on in subordinate agencies and public companies but still often get the blame when things go wrong. The government comes in for a lot of criticism from the Storting and the media, which makes it more dependent on the NAV leadership and hence tempted to blame the NAV for shortcomings.

In the case of the hospital reform it seems that there is a strong pressure for continuous reform due to the strong emphasis on healthcare in the media and thus also in the general political discourse. It is important for any modern government to demonstrate both its ability to bring the cost growth under control, while also responding to increased public demands for healthcare services and fast and efficient treatment in case of emergencies. In this sector it is still the lack of steering that is seen as a problem rather than the opposite. The use of market mechanisms is not necessarily seen as a means to delegate responsibilities to non-state actors, but rather to strengthen the role of the state and the patients simultaneously. Even though most recent reforms have strengthened the steering capacity of both the ministry and the central bureaucracy, the hospitals are fast changing and complex systems and in this case it means that doctors and professional networks may still keep a strong position in the system. One reason for the emphasis on decentralization may be that the government wants to establish a more loyal local administration. By establishing a hybrid management structure where doctors and nurses take the responsibility as managers, it is easier to hold them accountable also for what the management does on behalf of the organization. There is not a similar drive to develop a hybrid between management and professionalism in NAV, where the emphasis is more on establishing a local office which integrate expertise across the three previous sectors. Furthermore, in the choice between networks and hierarchy there is more of a need to strengthen networks in the NAV reform, whereas the strength of the professional networks in hospitals means that there is a greater emphasis on raising hierarchies in that sector.

At the same time the hospital reform has created a representation vacuum at local level which allows for the expansion of local social movements and mobilization of stakeholders which have been able to block major initiatives for restructuring. Although the enterprise model has been adjusted to allow for a clearer division of responsibilities and a greater emphasis on representation (in the case of the boards) the consequence has been an accountability overload for the government (Schillemans and Bovens 2011). In reality the balance promised in the reform between political steering in matters of principle and administrative steering in matters of detail has not been found.

Political accountability is also influenced by the institutional environment – i.e., the Storting and the media's primary focus on symbol-ridden single cases and problems that make them blind to the complexity of the reforms in question and the time required to get systematic structural changes up and running.

In both reforms the element of political accountability in local self-government poses a challenge. As already pointed out, the new formal partnerships introduced by the NAV reform have brought about a formal change in the relationship between central and local government. The current NAV system is a hybrid organizational solution, in which local welfare offices become subordinated to both central and local government – a dual hierarchy in other words. Our conclusion based on the interviews is that overall this new solution has changed real accountability relationships in favor of central government, simply because of its size, resources and influence over the implementation of the partnerships. There was some variation in the overall trend, however, with local NAV offices in larger cities becoming generally more influential vis-à-vis the center. In practice this means they make fewer attempts to coordinate and meld services. There is likely to be a similar movement in the field of healthcare, since the intention with the new cooperation reform is to create a system for increased cooperation and partnerships between municipalities and health enterprises.

#### Administrative accountability

Regarding *administrative accountability*, here there have been formal changes in relation to the use of control bodies and user committees in the hospitals. At the same time, many respondents doubt whether all these systems are really working and believe that all that has emerged is a rather symbolic meta-system. The impact of the institutional environment has been to increase control, since it is important for NAV to show the environment, and especially the Office of the Auditor General, that it cares about control, even though a complex organization like NAV finds it quite difficult to fulfill administrative-economic control aims in practice. One reason for some meta-control may be that the administrative culture in the agency has problems with a control-oriented reform implementation.

#### Legal accountability

In the case of NAV, by improving and cleaning up the old system the political-administrative leadership has apparently enhanced its judicial accountability. Pressure from the environment, especially the Storting, is also part of this equation. The creation of county back-offices has raised awareness and competence in this area. Developments

in other sectors seem to have some relevance in the discussion about whether to establish a regulatory agency or an ombudsman for central governmental welfare services. In the hospital sector arrangements with statutory rights and guarantees have increased in scope, and it is difficult for either the lawmakers or the user of services to grasp the effects of these rights. It may be difficult to avoid ending up doing something illegal in one way or the other, as demonstrated by the discussion about corridor patients in psychiatry. The prime minister has been criticized for not fulfilling promises on time limits on cancer treatment, but it turned out that it was a plan not a promise or a guarantee. Sometimes such guarantees are issued in campaigns and in order to have reforms passed, this means that they have no legal backing, but in a discourse dominated by rights many patients will take notice and some of them will interpret it as a right. Parallel with the hospital reform several new statutory rights and guarantees have been introduced. The formal change has been less apparent in the case of the NAV reform.

#### Professional accountability

The picture regarding *professional accountability* is that employees simultaneously cling on to the traditional professional culture and methods and try to adapt and develop something new. In the case of NAV a structural merger of two agencies together with the local partnerships gives rise to pressure to create a new culture. However, there is considerable variation between units and employees, with some continuing to work roughly as before while others are engaged in something new or are experiencing a complex combination of professional cultures. Path-dependency may dominate in both cases. While it may be thought of as necessary to create a common education for NAV and also new kinds of specialties in hospitals (e.g. geriatrics), these have been thorny political issues.

#### Social accountability

Regarding *social accountability* it appears that the structural changes introduced by the NAV reform have created greater structural complexity. While this is certainly problematic for some users, the increased focus on multi-service users seems to have been a success, having been given strong priority by the ministry, the NAV agency and the Storting. This is also symbolically important for all these actors and implies a cultural change internally. NAV's social role vis-à-vis other organizations seems to have weakened. This is due partly to the NAV's rather inward-looking focus in implementing the reforms, but also to the uncooperative attitude of external organizations. These have exerted environmental pressure, expressed by their use of the media and the Storting to portray a crisis in NAV, and they have also tended to focus on single cases, which do not further collaboration. In the *hospital reform* there has been an emphasis on cutting waiting lists and create more efficiency through activity-based funding and this has improved conditions mainly for one-service clients with unambiguous diagnosis, whereas multi-service clients with less clear diagnosis, particularly the elderly, has had a harder time finding their place in the new system. The voice of patients has achieved formal representation, but it is not clear that either local citizens or patients have much

of a say in the actual decision-making processes relating to local health systems. As a consequence the focus has mainly been on the many stakeholders mobilizing against restructuring of local hospitals.

Summing up, understanding changing accountability relations seems to involve a complex and dynamic logic. Changing accountability relations must be construed as a complex interplay between deliberate strategies, cultural features and external pressure.

As shown by Table 1, the overall picture is that the reforms have to a varying extent changed the various types of accountability in formal terms, but that it has had an impact on accountability relationships in practice.

**Table 1.** *Accountability changes as a result of the welfare administration and hospital reforms.*

	Formal changes in accountability	Actual changes in accountability	Reported problems in field
Political accountability – the principle of ministerial responsibility	NAV: No HR: Yes, change in ownership, and increased local administrative autonomy means that ministry has more influence in matters of principle, whereas details are to be left more to Health enterprises	NAV: Yes, NAV-agency more influence HR: Political involvement stronger both in matters of principle and detail but medical profession and local units in system still strong	NAV: agency large and complex. Ministry lacks information and insight. More grey zones in political-administrative dimension. Starting more active. HR: strengthening of both central government and bureaucratic capacity, but roles are not clearly defined.
Political accountability – the principle of local self-government	NAV: Yes, mandatory partnership agreements HR: abandoned, as ownership transferred from counties to state, local politicians later appointed to boards	The central government has a strong position in the relationship in both cases, but even more in the hospital reform	NAV: Difficult to fulfill the idea of equal partners. Squeezing local self- government HR: Difficult for politicians at hospital boards to define their role
Administrative accountability	NAV: Overall no, but more scrutiny from the Office of the Auditor General HR: Yes, unitary management and a division of responsibility between ownership and commissioning. Intensified control activities	NAV; More resources for control and bureaucratization of control systems HR: also more emphasis on control, but more emphasis on market mechanisms, private providers and boards in order to achieve rationalization, and budget control	NAV: Increasingly complex control systems Problems of goal-focus, quality and responsibility HR: The strong focus on economic efficiency simultaneously with a growth in audit and market instruments has created complexity in control systems that makes it difficult to develop legitimacy and give priority to quality at point of service delivery
Legal accountability	NAV: No HR: more emphasis on patient rights, guarantees, user influence and free choice	NAV: Yes, more rule of law and equal treatment HR: Free choice of limited use, patient rights difficult to make use of, user representations of limited value, difficult to decisions	Free choice and patient rights seen as either symbolic myths/ideology or instruments for progress. Relates to controversy around market mechanisms Number and scope of statutory rights and guarantees have increased, Difficult to get overview, and estimate interaction effects Increased risk for breaking with legal statutes or guarantees
Professional accountability	NAV: Yes, merger of three agencies and professional communities HR: Yes, but more limited, since mainly relating to professional access to management positions	NAV: Yes, challenges of merging or collaboration between professional cultures HR: More external control of professional performance, but same instruments may also be used as means for self-control	Divided opinions relating to appropriate role of professions and professional knowledge in regulation and quality control of welfare services and healthcare The strongest professions (i.e. medical doctors) are also most successful in establishing power position outside of welfare services and in developing own instruments for professional (self) regulation

	Formal changes in accountability	Actual changes in accountability	Reported problems in field
Social accountability	NAV: Yes, for clients and patients No, for societal relationships  HR: Yes for users, no for citizens and societal relationships	NAV: Yes, better for some clients Yes, societal connections weakened  HR: Local social mobilization as substitute for loss of local representation	NAV: Better for multi-service clients, more ambiguous effects for one-service clients. More focus on client needs.  HR: Better for one-service clients, more ambiguous effects for multi-service patients  Both: Poorer relationship between societal organizations and government

The elite respondents in NAV seem to agree about many of the changes in political, administrative and social accountability, but they are more divided with respect to judicial and professional accountability. The same kind of divided opinions may be observed in the discussions relating to the hospital sector.

There are three main problems of accountability in modern representative democracies (Day and Klein 1987). First, the institutional and organizational links between political accountability and managerial accountability are often loose; second, political processes often do not generate the kind of precise, clear-cut objectives and criteria necessary for managerial accountability to be a neutral and value-free exercise; and third, the organizational structure is often such that the managers accountable to politicians cannot answer for the direct action and performance of the service providers. The picture is further complicated by the existence of professional, legal and social accountability, making accountability relations even more complex.

We argue that the reforms in question do not necessarily reduce these problems. The role of political leaders is ambiguous in both cases: elected officials have a role as strategists in defining the long-term goals of the public sector and assessing the results, but at the same time they are expected to give considerable discretion to operative agencies. Public services providers could eventually receive information about their performance directly from customers without having to go through elected representatives. If elected political leaders have limited control over the public administration, is it then reasonable to hold them accountable for the actions of the public bureaucracy? And if elected officials should not be held accountable, then who should?

The NAV reform and the hospital reform thus seems to have made accountability a more ambiguous and complex issue. A central question is: Who should be held accountable for the conduct of complex public organizations where the problem of 'many eyes' is highly relevant? Moreover, are executive politicians willing or able to adopt the role of strategic managers envisaged for them? In both the NAV reform and in the hospital reform there has been a shift in accountability from the political to the managerial sphere and from input and processes to output and outcomes. De-emphasizing input and process and emphasizing outcomes and output does not necessarily mean that government administrators are more or less accountable. The conceptual distinctions drawn by the reform with regard to the roles of minister and chief executive are amply clear on paper but less so in practice.

## Conclusion

Overall, the reform of the welfare administration in Norway has led to rather limited formal changes in the majority of the five accountability types. The changes have been more significant in the hospital, particularly affecting political accountability, but in most other areas there have been changes, although more limited in a formal sense. In the case of welfare there have been limited changes in administrative, legal and social accountability. The most obvious formal change was the introduction of the partnership model, altering political accountability relations at the interface between the principle of ministerial accountability and the principle of local self-government. The only unambiguous formal change was related to professional accountability. In practice, however, changes came about in nearly all the different types of accountability.

In the case of the hospitals rather a new mix of governance has emerged that has strengthened the role of central government but this does mean that it is possible for central government to steer the sector in any rational or instrumental way. If we include the other reforms that have been undertaken we see that there have been changes in almost all of the five accountability types in the hospital sector during the last 10 years.

Local health institutions experience their relationships with the health and care ministry and related agencies as a challenge. For instance, a survey conducted among leaders in the regional and local health enterprises in 2003 and 2004 shows that about half of the respondents conceive of control signals from the parliament, the ministry, the directorate and other supervisory bodies as contradictory (Opedal 2005:99). In 2004 almost half of the respondents found the steering from the ownership unit unpredictable. Nearly half of respondents claimed that the Directorate of Health focused too much on details (Læg Reid, Opedal and Stigen 2005). However, there are only minorities who think that the health authorities do not have sufficient authority, and they find that there is no doubt about the division of responsibilities between regional and local health enterprises.

It seems to be a common view that the health bureaucracy has strengthened its role, but that the distribution of the different roles (ownership, commissioning, control, funding, advice and guidance) still makes responsibilities unclear not only to the regional and local health enterprises, but also to politicians and voters. This is also reflected in the observation that the opportunities for users to influence decisions within the various service areas have not improved a lot with the formalization of user committees on the local and regional level. Furthermore, it is not clear that the return of politicians at hospital boards have improved on the democratic deficit many have felt that exist on the local level, since it is not clear in what way or respect these board members can be held accountable to local citizens.

Both the health enterprises and the health bureaucracy have become more professionalized and powerful as a consequence of the hospital reform. The predominant focus has been on cure rather than care and one-service rather than multi-service patients. The professionals and managers in hospitals are not trained or mandated to focus on primary healthcare needs and means for health promotion. The Scandinavian healthcare systems have been regarded as being hospital-centered and the hospital reform has strengthened this focus. Coordination between health institutions in

order to promote a broader focus has become a major challenge, and the government launched a coordination reform in 2009 that aim at strengthening primary care and improve cooperation between municipalities and hospitals.

In the case of the NAV the formal political accountability system stayed the same at the central level, whereas it was changed in the case of the hospitals. In NAV the political leadership lacked the resources and capacity to deal with the size and complexity of the agency and its subordinate levels. The political leadership also became passive towards the NAV agency, partly to avoid blame. At the same time, as the provider of the majority of services and resources in local partnership offices, the central level strengthened its influence vis-à-vis the local political level. In the case of the hospital reform the political leadership got involved in a struggle to restructure the structures of hospitals. The early reform plans mobilized strong resistance from the local level, and since there was no local forum that the local politicians could be held accountable by, these politicians were freer to take a stand against the centralizing tendencies in their own party.

The changes in administrative accountability strongly reflect how different actors have enacted their role since the reform, particularly with respect to control. The Storting has pressured the political executive to act on control, the Office of the Auditor General has put a lot of effort into controlling both the activities of the NAV agency and the hospitals, partly urged by the Storting, and there has been an increasing internal focus on control in the hospitals and the NAV agency. All this adds up to a very complex system of administrative accountability.

After the reorganization of the reform, including the establishment of regional back-offices in the case of NAV, role enactment was geared more towards ensuring rule of law and equal treatment, which changed judicial accountability in reality. This was also promoted by larger units, larger professional milieus and better quality case-work. In the case of the hospitals where one profession, the doctors, is predominant, quality has been left more to professional bodies.

Role enactment is also important for certain aspects of the weakening of social accountability. In NAV employees' and users' organizations together with the media and the Storting has focused a lot on problems with single cases, which has leads to a mismatch with the more systemic features of the NAV agency. In the hospital sector there have been a constant focus budget deficits and also several scandals relating to the use of coding in order to increase income as well as mistreatment, corridor patients and illegal working conditions.

We also see some direct influence on actual accountability relations of the formal changes brought about by the reform and its reorganization. We have already mentioned the effects of the new mandatory partnership, but the merger itself – entailing the merging of three professional cultures into one – has also affected professional accountability. In the case of hospitals the new management systems have created potential difficulties for cooperation, particularly between nurses and doctors, but the professions seem to have found a way to keep the old division of labor with minor adjustments in boundaries between their respective jurisdictions. In this field there are many professions involved, at the same time as there are constant changes in technology which affect the established division of labor, however.

Major administrative reforms like the NAV reform and the hospital reform have to be assessed in relation both to governance representativeness and to governance capacity (Christensen and Læg Reid 2011). The first concern is closely related to political accountability and focuses on measures designed to strengthen representation of citizens' beliefs, attitudes and opinions in the policy-making process. This question has an external focus and concerns citizens' effectiveness and user participation and influence. The second concern has a bearing on administrative accountability, efficiency and to what degree social developments are affected by government decisions and public policy programs. This involves steering capability and public sector institutions' capacity to act and has a stronger internal focus. The question is whether governance is efficient and effective. Our argument is that the study of administrative reforms needs to move beyond the technical–functional flavor of administrative reforms with apolitical language.

The main challenge is to find organizational forms that enhance both the representativeness and the capacity of governance. Often there is a trade-off between the two (Dahl and Tufte 1974): reforms intended to enhance one aspect tend to harm the other aspect (Mattei 2009). Experiences so far from the NAV reform and the hospital reforms indicate that this is a tall order (Fimreite 2010, Tjerbo 2009). Following Scharpf (1999), our analysis shows that input-oriented representativeness and output-oriented effectiveness are both essential elements for democratic self-determination. Input legitimacy of electoral arrangements and output legitimacy of policy service delivery are both important components of sustainable democratic arrangements, and successful administrative reforms in representative democracies have to take both features into account. There has been a shift from input democracy towards output democracy in contemporary reforms, weakening political accountability and strengthening managerial and social accountability, but this transformation is by no means a panacea for the ills of contemporary democracy (Peters 2011).

The accountability picture is even more complicated. We are facing a complex and compound welfare and healthcare administration (Olsen 2007) that is held accountable to different actors. Instead of choosing between different accountability mechanisms we have to treat them as supplementary and complementary in a mixed political order that combines and blends different accountability mechanisms (Olsen 2007). We are facing a multiple accountability regime in which the different accountability mechanisms do not substitute for each other (Schillemans 2008) but are redundant rather than segregated (Scott 2000). Calling officials to account means inviting them to explain and justify their actions within a context of shared beliefs and values (March and Olsen 1995), which implies a dialogue between officials and those to whom they are accountable.

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