

The Norwegian hospital system: New governance mechanisms, new principles?

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Abstract

In terms of governance, this paper is an attempt to assess the current situation in Norwegian specialized healthcare. The paper departs from the many reforms in the sector over the last couple of decades, which so often has been used as a backdrop for New Public Management-oriented research on the hospital system. Here, we explicitly try not to engage in the NPM discussion, in favor of a more general dive into the “governance situation” at the systems level. The aim is to provide a description the Norwegian regime in terms of governance theory, coupled with the peculiarities of healthcare.

The central argument is that a description of the governance regime of the Norwegian hospital system will have to include many of the generic ideas in the governance literature, such as hierarchic, market and network modes of governance. In essence, we conclude that the description would be one of a hybrid governance form, in a setting where complexity is a predominant feature. In addition, however, we argue that there are peculiarities to (Norwegian) healthcare that needs to be included – such as a retrospective orientation, a significant drive for transparency, and a connection to the general traditions of the public sector.

Keywords: Governance, governance modes, principal logics in specialized healthcare, control and autonomy, reform, transparency.

Introduction

Through the last couple of decades a wide range of reforms and other measures have been implemented in the Norwegian hospital sector. Changes concern just about every aspect of organization, finance, medicine and governance. Most recently, the Norwegian hospital reform¹ of 2002, affecting both the structural and operational relationship between the state and the hospital system. The short description of the hospital reform would focus on the state taking over hospital ownership, the creation of health enterprises, and the removal of the counties from specialized healthcare. There's more to this picture, however, as quite a few measures have been introduced in addition to the reorganization of the hospital system: A series of "new" mechanisms for governing the hospital sector have been introduced in part prior and parallel to the hospital reform. These measures range from DRG reimbursement systems to national quality improvement schemes, from changes in responsibility and accountability structures to extended patient choice. Quite commonly and in general terms, these change processes are often described as processes of marketization, decentralization or depolitization. The overall picture most widespread in describing these changes is the New Public Management (NPM) portrait. However, as argued elsewhere (Byrkjeflot and Neby 2005b, Neby 2004), NPM is not always sufficient in describing and explaining changes, because there are historical and contextual factors that clearly influence the development of the system. Instead of focusing on or departing from the NPM ideas, this article aims at outlining the more principal features that follow the introduction of new governance mechanisms to the Norwegian hospital sector. We focus on the relationship between the hospital sector (the local and regional health enterprises) and the state (represented by the Ministry of Health, government, parliament and other institutions on the national level relevant to the hospital sector in terms of regulation or policy). Arguably, the regional and local health enterprises (in effect, the hospitals and the formal "apparatus" of specialized healthcare) could be perceived as part of the state. It seems appropriate, however, to distinguish between the central administration and political actors on the one hand, and the hospital sector as a particular domain of the welfare state on the other. This is grounded in the hierarchic capacities of the central state institutions, which of course allows the introduction of regulatory mechanisms to the hospital sector.

This wide selection of regulatory, structural and operational measures seem to have created a new "governance situation" in Norway, where issues of politics, healthcare functions and structure are closely intertwined. In relation to U.S. health and governance issues, and ahead of all conceptions of NPM, Lawrence M. Mead in 1977 made a comment that so strikingly seems to be of current interest to the Norwegian situation:

"In theory, control should be achieved by either delegating care and spending decisions to health professionals or by market allocation. But for fundamental as well as practical reasons, neither of these mechanisms has restrained costs adequately. Hence, explicit public control seems inevitable. (...) Success will depend on resolving the resulting political tensions. (...) Public control should be structured to facilitate resolution of these tensions" (Mead 1977:39)

¹ The Norwegian hospital reform of 2002 has quite a few labels, all relevant to the governance discussion. It is by many referred to as the *ownership reform*, as ownership of local enterprises/hospitals was transferred from the counties to five regional enterprises owned by the Ministry of Health. However, others have commonly used the terms *responsibility reform* or *accountability reform* pointing to new distribution of responsibilities and accountability, and even *management reform*. The term *hospital reform* is preferred here, since so many facets of organizational activity and structure is included – and to underline the fact that the reform only relates to specialized healthcare.

Availability, universality, equity (and perhaps also quality) have been aims for Norwegian healthcare for years, and continue to be so. Maintaining these aims also means maintaining some form of public control over the development in healthcare, which implies challenges of the sort pointed out by Mead (1977) – although for the U.S. case almost three decades ago. Still, the organization of healthcare, the relationship between the state and the hospitals, and the concrete measures used to regulate healthcare have changed through the introduction of regulatory mechanisms differing from the “standard” hierarchical scheme. In Norway, there has been an expressed move away from speaking of hospitals as a matter of public administration, towards characterizing the entire sector in terms of markets, management and enterprises. This is not just a matter of rhetorics or linguistics, however, as new measures are introduced and further changed and challenged over time – whether they are part of international trends or specific national developments. Questions are if the introduction of these new governance mechanisms to the hospital sector and the following changes has created fundamentally new ways for the state and the hospital system to interact, and whether or not these measures are based on principles that we often do not directly recognize in the traditional preconceptions of healthcare and hospitals. What can we say about the general relationship between the state and the hospitals in light of these new regulatory mechanisms? In other words, the idea is to investigate the contents and principles of the (new) regulatory mechanisms introduced to the relationship between the state and the hospital sector in Norway.

The empirical backdrop for making an analysis of the governance principles constituting the Norwegian regime are the many reforms introduced in specialized healthcare through the last ten years or so, in practice a virtual smorgasbord of measures. In particular, the new financial arrangements of the late 1990s, patient choice legislation, the concept of unitary management, evidence based medicine (EBM), health politics, and ownership/enterprise reforms are of interest to this paper. The selection of measures is made with the aim to create a broad picture rather than a meticulous analysis of singular changes. However, focus is also directed towards state institutions, actors and processes related to the hospital systems in other ways than ownership – for instance audit agencies and popular movements’ initiatives towards health politicians. The outline of the paper is as follows: Firstly, the theoretical approach and analytical categories are outlined. Secondly, the primary features of the present relationship between the actors in the specialized healthcare system are outlined. This is followed, thirdly, by an assessment of transparency dimensions, such as evidence based medicine, audits and the general strive for transparency. Fourth, we discuss the present situation with regards to the theoretical perspective on governance, before making a few concluding remarks.

Theoretical approach

If we are to analyze governance in terms of principle, we need analytical categories that are founded in theory suited for this purpose. Here, we depart from fairly general and open theoretical accounts on governance. First of all, the term *governance* needs to be understood. Commonly left undefined (Peters and Pierre 1998), the idea of governance relates to the elements involved in sustaining, working and developing relational systems. Colin Crouch put it this way: “Governance is best understood as: All means by which the behavioral regularities that constitute social institutions are maintained and reinforced” (2004:105). There is more to this, however, as governance clearly differ from system to system and between countries and sectors. A fairly common typology for describing and understanding different governance

regimes is a division into four modes,² namely the community, market, state and association governance modes (Campbell, Hollingsworth and Lindberg 1985, Hollingsworth, Streeck and Schmitters 1994, Streeck and Schmitters 1985) – a scheme successfully utilized by Scott et al. (2000) for analyzing development in the San Francisco/Bay Area healthcare. These four approaches generally cover governance structures and their general functional logic, and an argument in this paper is that a focus on the principal element or rationale of the actions within specialized healthcare is needed to fully understand the concept of governance in this context. In line with Alexander's (1988?) argument on focusing as much on action as structure, on multi-dimensionality rather than simplicity, I will try to provide a description of both the structural arrangements of governance and its normative contents. For instance, markets are not only a way of structuring governance, but also logics or principles of action connected with normative political ideas and ideology. Thus, the theoretical ambition of this paper is to use the governance typology argument to investigate the eventuality of "deeper" changes in the form of new types of interaction between states and hospitals. In treating governance as some form of regulation, and following Abbot, I would like to claim that "...jurisdiction has not only a culture, but also a social structure" (1988:59). Perhaps, there's also a principle, a rationale or logic that constitutes a normative – and maybe political – core around which the construction of measures is aligned. In other words, it is assumed that the hospital sector has characteristics that are specific to the sector, and that these characteristics in turn mark the functional logic of the governance of specialized healthcare. This means that the peculiarities of healthcare need attention.

These peculiarities, certainly in Scandinavia and Norway, include the obvious connections and close relations between the state and healthcare, welfare state ideas, the complexity of the professions' positions and actions in the system, the development of new financial and accounting systems, the odd relation between users and providers of healthcare, and certainly the racing development in medicine as a field of knowledge. In addition to this, there is the general neo-liberal development in public sector governance efforts, often referred to as New Public Management. Norwegian healthcare is, almost by definition, a public sector matter, and thus the impact of general trends in the development of public sector might apply to the hospital sector as well. Understanding the governance modes (and the potential changes in them) of Scandinavian hospital systems differs from the U.S. cases so thoroughly described by Scott et al. (2000) in that state involvement – or at least the involvement of public and political bodies – has a much more active and integrated character. This means that classifications, descriptions and analyses have to account for questions relating as much to politics, policy and polity as to markets, managerialism and healthcare itself. As a starting point, furthermore, it is assumed that this difference is not only a case of being at different stages in time, although Norway by many is perceived to be a reluctant and often slow reformer. Rather, we think that the political element is indeed symptomatic of the general character of Norwegian healthcare, deserving to be treated in its own right. Hopefully the theoretical idea of governance modes is helpful in describing the changing nature of the governance of Norwegian specialized healthcare. Of course, some of these elements are at the heart of this article's substance. The idea is that healthcare displays or at least accentuates quite a few characteristics that are particular to the sector. As healthcare (primary and secondary) not only is located at the core of the Norwegian welfare state together with social services, the impact of the services provided by the healthcare system is direct and often

² The labelling of these governance forms differ somewhat between different writers, for instance exchanging *state* with *hierarchy*, *community* with *clan*, and *association* with *network*. Their essential meaning largely remains the same, however, at least as long as this basic four-way distinction is maintained.

physical. This means that the complexity of healthcare should be reflected in the governance mode we eventually end up describing.

Departing from this, a brief and slightly caricatured account of the four standard governance modes is useful in appreciating the idea of governance as a way to describe the interplay between states and hospitals, and to create analytical categories. First, the *hierarchical* or *state* mode is in many ways a model depicting fairly conventional ideas about the state and public institutions. The idea is that the state through its central command capacity shapes the entire environment surrounding the institutions in question (Crouch 2004³). Finances, resource allocation, function and structure is a matter of the central state utilizing formal and vertical administrative channels, directly signaling requests and commands. State capacity is instrumental; the contents of politics and institutionalized values beside those of the state are downscaled in terms of perceived importance. The basic notion is that "...governmental agencies exercise legitimate control over specified areas under a rule of law and backed by the power of coercive actions" (Scott et al. 2000:173).

Secondly, there is the *market* governance mode, where different actors compete with each other for resources and where exchange mechanisms are a matter of contractual relations (Ibid.). The relation between actors is driven by supply and demand; products, services, resources and even decisions are communicated through purchase and provision capacities (Crouch 2004:107). This means that relations are largely horizontal, although the market allows strive for resources, wealth and, ultimately, power. This picture is one of the neo-classical market economy, although coupled with assumptions of the actors' limited ability to act as if part of a perfect market economy.

Thirdly, a *community* or *clan* governance mode can be described. The essential idea is that actors engage in interaction with each other on the basis of trust and respect (Scott et al. 2000:173), implying that legitimacy in some form is a central feature in this mode. Informal relationships are important, just as custom and tradition, dialogue and interlocking relationships. Resources are embedded within the clan/community, and thus have fairly low mobility. Relations are largely horizontal and define the community's contact with the external environment (Crouch 2004:106), which must be associated with the idea that the motives for governing action are elements of identification, meaning and the common good.

At last, the *association* or *network* model departs from the idea that "functionally defined interest associations [have] a monopoly status within a sector" (Scott et al. 2000:173) – such as doctors' associations controlling the contents and development of clinical knowledge and practice. This allows for normative-legal control over a specific jurisdiction, internal to the association or network. A driving force is the interests of associations and networks, as actors engage in developing "pacts" with each other (and across sectors) based on mutual recognition and entitlement (Streeck and Schmitter 1985:3-12).

Whether principal changes in the approach to governing healthcare actually has occurred depends on whether a new rationale or logic has been introduced in and accepted within the organizational fields of the systems – in replacement or addition to "the old ones." Keeping in line with Scott et al. (2000:349), the theoretical benchmark criterion for such change must be that actors now not only do things differently, but that they do different things. If they do so,

³ Crouch (2004:105-109) provides a more supplemental description of in all seven governance forms – taking a broader stance in underlining the "essentially hybrid nature of governance". This argument is appreciated in this paper.

then we may start consider the actual contents of these new rationales for governance. If they simply do things differently, we may witness more hybrid forms of governance or at the most new forms developing. On the basis of this brief theoretical account, the main task at hand is to investigate what the overriding governance principle for Norwegian specialized healthcare is: Hierarchy, market, clan, or network? Can we identify some hybrid version of these modes, or is there perhaps something new to the governance of the Norwegian hospital system?

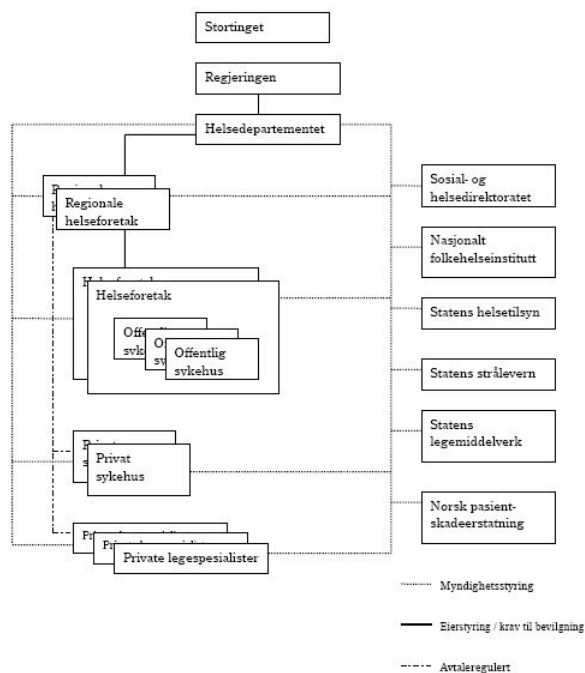
What is the Norwegian “governance situation”?

In describing the situation of the Norwegian hospital sector, we find it useful to provide a description along the following five areas: Structural arrangements, economic features, politics of health, the role of medicine (in broad terms), and the role of the population/users. These areas are chosen on the background of their relevance to the governance of the Norwegian hospital sector. Structure is relevant as the 2002 hospital reform had large implications for the organization of the entire sector. Economy matters because new ways of reimbursing hospitals change the incentives for different types of action, and because expenditure constitutes an important theme in health politics. Health politics become important as the central political initiatives are directly connected to the hospital system through state ownership, but also because the arenas for politics concerning health has changed somewhat. As for the general term of medicine, we refer to the professions of healthcare, the development of medical knowledge and technology – for instance through the EBM movement. When it comes to the users or the population, they play a role as the very foundation for health services (without patients, no need for healthcare), and as political citizens. Of course, different distinctions or dimensions could be utilized, for instance by focusing more explicitly on the medical profession or single cases of regulatory activity. This is deliberately not chosen here, as the aim is to account for specialized healthcare as a whole rather than in detail.

The perhaps primary features, certainly the most visible, of the Norwegian system of specialized healthcare are connected to structural arrangements: After the 2002 hospital reform, counties were structurally and politically removed from the system. Instead, the hospital sector was organized in terms of enterprises at two levels, under state ownership. The ministry’s own outline of the system clearly indicates hierarchic ownership relations (see Fig. 1; the bold, unstapled line indicates “owner steering”). The “chain of command” – which in substance is political – starts with the government (ultimately accountable to parliament), above the health ministry. Subordinated the ministry (through the department of ownership), we find the regional enterprises – and at last the local enterprises. However, other state agencies have rights to exercise authority as well (seen at the right in the figure), including directorates, institutes of public health, auditory agencies and drug administration. At last, there are private hospitals and specialists under contract with the regional enterprises.

Figure 1: The organization of the central health administration – in relation to specialized healthcare (Source: Ministry of Health official website)⁴

⁴ <http://odin.dep.no/hod/norsk/tema/sykehus/organisering/042031-990086/dok-bn.html> website checked May 12th, 2005.



The local enterprises are usually comprised of several hospitals and other units – meaning that the idea of hospitals as something distinct to local communities and connected with clear geographic locations is challenged. As of 2005, the five regional enterprises in turn own a total of 33 local enterprises – which again are comprised of in all 81 single hospitals or hospital-like units (Opedal et al. 2005:51). However, it is the enterprises, and *not* the single hospitals, that are the separate legal entities (Helseforetaksloven 2001). Ownership is formally exercised through boards (Hegrenes 2005) – resembling the boards of private corporations. These boards in part represent the formal functional side of state ownership, replacing the “local-political” system with county ownership and responsibility. This may also have created a larger distance between the local populations and “their hospitals” in terms of political influence, as neither the local nor the regional enterprise boards are open to civil influence the way county politicians were through elections. Importantly, this does *not* mean that politics were removed from the system. The ministerial responsibility for specialized healthcare is accentuated, or at least made more visible, quite simply through the Ministry of Health’s ownership of the enterprises. The regional health enterprises’ general assembly in practice consists of the health minister, allowing for considerable possibilities for direct instruction. Also, the parliamentary mechanisms restrain governmental capacity (certainly in the case of coalition, minority governments), as the exercise of ownership is placed at the national political level.

However, one of the hospital reform’s ambitions was to create more autonomous organizations in the hospital system, implying that the minister should only “instruct” the enterprises in matters of principal importance (Sosial- og Helsedepartementet 2001). It has been argued, however, that this control-autonomy balance is both unstable and ambiguous (Lægreid, Opedal and Stigen 2003). At the same time, the organization of healthcare institutions is supposed to be more geared towards achieving goals and improving performance than connecting with the politics of health – at least in principle. This allows for a discrepancy: As the counties were removed from the governance chain and the new enterprise model established to make healthcare better and more cost efficient, the organization of central administrative functions and the relations between central political actors became proportionally more imperative to the functioning of the system – but also

more complex and unclear in parliamentary terms (Opedal et al. 2005). In effect, the “structural depolitization” of healthcare at the regional level has made central political relations more important.

This also means that there seems to be a discrepancy between the ambition to create relatively autonomous enterprises on the one hand, and the room for political intervention and control at the other. Interestingly, this contradiction seems unavoidable, as much of the political activity concerning the hospital sector was relocated at the central level through the reform. This may be a consequence of three aspects: First, direct state ownership makes the hospital sector an ideal arena for politics in terms of position and opposition, symbolic action and party politics. Secondly, local political actors need an entry point to the system, and the removal of the counties may have led to an increased engagement by single MPs acting on behalf of their electorate. Thirdly, it seems the media is more than willing to engage in single cases that politicians cannot ignore, especially as the health minister and government now are directly accountable to parliament as criticism enters the political debate.

At the regional enterprise level, there’s also an ambiguity in terms of roles and in relation to the state as owner. On the one hand, their task is to ensure the follow-up of policy. As responsible for local enterprises they attend to the needs of the patients or the population on the basis of a “provider order” placed by the health ministry. On the other, there’s an internal focus towards developing and improving the underlying organization of local enterprises in terms of performance, economy, management and so on. In many ways this ambiguity reflects the problem of purchaser vs. provider responsibilities (although there’s no formal purchaser-provider split), especially when coupled to ever-present accountability issues for politicians in office. This means that the organization of the relationship *between* the state and the enterprises, and not just the changes at the individual levels, are significant to the understanding of the new system. Schematically, we can distinguish between the formal hierarchic and contractual relations on the one hand, and the more informal networks and trust-based relations on the other (Christensen, Lægveid and Stigen 2004, Hallingstad 2004, Opedal et al. 2005). Both these ways of structuring the state-enterprise interaction have become important, allowing for political influence to find its way through the system without being a matter of formal instruction. The formal organization of local health enterprises “outside” the political arena (as the regional enterprises are the formal connection to central politics) stands in contrast to the previous county model.

Furthermore, the financial arrangements that have gone through a metamorphosis from direct and detailed state grants administered by the counties, via block grants, to more market-like arrangements where economic considerations are coupled with patient rights. Developments connected to such principles as evidence based medicine, DRG-systems, activity based funding, and patient choice allows for a financial system in healthcare that is not only about determining the size and direction of cash flows. Just as much, the financing of specialized healthcare has become intertwined with the functional parameters of healthcare – so visible in the coupling of patients’ rights to choose between hospitals and the principle of activity based funding. Taken together, this gives associations towards a (quasi-) marketization of Norwegian healthcare (Byrkjeflot and Neby 2005b). This of course relates to the patients – or users – of healthcare and political aims toward quality. Performance measurement and the use of indicators, in terms of economy, production and quality, has become increasingly important as there seems to have been an increased and parallel focus on cost containment on the one hand and on single issues and cases through the media on the other. For instance, there are recent examples of single patients who, through the media, have communicated what is popularly

perceived as poor judgments by the health enterprises (and a political problem) in terms of patients' right to treatment taken together with economy – making single patients important to the central political discourse on health.

Norway has not yet introduced clean-cut purchaser-provider models for the financing of specialized healthcare, although a resembling division of responsibilities can be detected in the descriptions of the relationship between the state, the regional and the local health enterprises. Instead there is explicit mention of a division of roles, but no formal economic contractual arrangements in terms of the purchasing and provision of health services. Interestingly, although the responsibility-accountability theme can be traced through much of the political debate on healthcare in Norway, the specific focus is often on availability of services and loss of political control over the economic situation. The economy of specialized health seems to surface primarily as complaints from the healthcare sector itself and or direct criticism of single enterprises (who are supposed to cut costs). While MPs tend to demand more money (or measures that invariably will increase costs) for specific areas, the government is criticized for not being able to contain health expenditure. Part of this contradiction seems to stem from the new rules for accounting that were introduced with the enterprise model, making financial dispositions both more visible and accessible to authorities external to the single organizations.

In many ways, this complex situation reflects much of the political debate on specialized healthcare – both in the media and in parliament, opposite the government in office. This is at the expense of the structural arrangements, which do not seem to have the same appeal or media interest – unless service provision is somehow threatened (for instance related to emergency and maternal services in remote areas). A related and recurrent theme in Norwegian health politics is geography and equity (Neby 2003), which seems to aggregate political attention on all levels. It seems this connects to ideas on the comprehensive welfare state, which in many ways extend well beyond providing basic services. Health policy can thus be used for pursuing alternative political aims, such as maintaining settlement in scarcely populated areas and strengthening the foundation for rural economic activity. Regional and local politics is still important, although it travels through new channels towards the state than it used to. The tendency towards civil political mobilization and construction alliances between users, professions and engaged politicians in cases where local services are threatened, illustrates a paradox with the enterprise model and the “new” Norwegian politics of health: Increasing the local enterprises' autonomy has given them more freedom of action, but at the same time new opportunities to withstand or resist regional and central demands for efficiency and reduction of costs (Opedal et al. 2005:177).

In addition to these elements of structure, economy, politics and the “political role” of the population, the role of public scrutiny and control needs to be mentioned. It seems that parliament to an increasing degree has positioned itself as somewhat of a “controller” of the health enterprises. This has perhaps mainly come about through the increasing amount of MPs' questions to ministers and government, and an eagerness to make sure that the Minister of Health acts in accordance to the frames and decisions of the Storting. Furthermore, it has been claimed that the political consequences of the new structural arrangement are that the principal elements of the enterprise model comes under pressure (Opedal et al. 2005:101, Lægreid, Opedal and Stigen 2003): Too much involvement by central government could compromise the distribution of responsibilities between the different levels of the healthcare system, while a passive approach could compromise the government's relationship to parliament.

Audit, transparency and civil society

The organization of the Norwegian hospital system is not only a matter of the relations between the enterprises and the ministry/central political level, however. The general healthcare organization of the Norwegian state includes a variety of agencies and authorities. As healthcare is not just a matter of doctors, patients and treatment, it is equally a matter of politics, economy, regulation, law, and public health. In relation to the implementation of the hospital reform, as the Ministry of Health assumed ownership of the hospitals, a need to revise and coordinate tasks and responsibilities for state institutions other than the department and the enterprises emerged. Perhaps especially important, three agencies involved in different kinds of audit and regulation are important to the discussion in this article: The Office of the Auditor General (Riksrevisjonen), the Health Audit (Helsetilsynet), and the Directorate of Health and Social Affairs. In many ways, these agencies represent the formal organization of state control activity, in the political, operational and legal sense, respectively. As we shall see, the picture is more complex than that, however.

The Office of the Auditor General is the parliament's agency for audit and control. It is independent from the rest of the administration, controlled by and reporting directly to parliament. Its activities include both economic and administrative audit, control of ministerial dispositions in relation to parliamentary policy, and the reporting of control and auditory activities to parliament.⁵ For instance, control with health expenditure and efficiency has been a theme (Riksrevisjonen 2003), just as the implementation of reform has been (Riksrevisjonen 2002). In many ways, the Auditor General works as a semi-independent information provider for the parliament and it thus provides fuel for both political debate and action. The Auditor General has also become increasingly engaged in specialized healthcare, for instance through placing demands on the construction of the new enterprise legislation (Christensen, Læg Reid and Stigen 2004). The structural status of the Riksrevisjonen 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 (Opedal et al. 2005). The Directorate of Health and Social Affairs' role is in principle to ensure that public health is promoted in the best manner possible by providing professional/political guidelines and counseling on measures and policy from the central level, by establishing norms and standards, and by being a resource for the other actors in the system and the general public (Helsedepartementet 2004). Furthermore, the directorate is central in ensuring the implementation of law and policy on healthcare issues. The Health Audit is more "specific" in its approach, as they engage in direct monitoring, surveillance and audit of activity in healthcare, both in terms of general practice and single cases.⁶ Its activities are often directly connected to law, for instance in case of breaches in patient rights or malpractice, and has a character of "hard regulation" as the Health Audit's activity may result in direct prescriptions for change or implementation of measures.

Although operating on different levels and answering to different institutions, the interplay between these auditory agencies and the rest of the system portray transparency dynamics that seems to have become increasingly important to the governance of the hospital system in Norway. For instance, single cases are brought up in parliament, acted on by government, followed through by the directorate and audited by the Health Audit – sometimes in this order, other times in a more parallel fashion – as in the so-called Dentosept scandal in 2002

⁵ <http://www.riksrevisjonen.no> website last checked May 12th, 2005.

⁶ http://www.helsetilsynet.no/templates/ArticleWithLinks_5478.aspx website last checked on May 12th, 2005.

(Neby 2003). In this case, patients became ill and a few died because of some infection stemming from unhygienic mouth brushes produced by a small Norwegian medical supply company. It created a situation where action was necessary, and where there was room for portraying an image of a well-functioning system. This created room for political engagement, auditory action, and the creation of guidelines. Prerequisites for these actions are information and communication across institutional borders, and an idea that events are necessary to be acted upon. This shows how transparency, making facts, measures and regulations visible and portraying action capability, is essential to both reactive and proactive action. The media debate following the scandal focused on accountability issues, which points to the role of auditory agencies in relation to politics.

Increasingly, the parliament relates to information coming from other sources than the government, for instance media, audit agencies or even lobbyists. The number of questions regarding hospitals and health enterprises to government in parliament has increased from about 60 in 2000 to 106 in 2004 (Opedal et al. 2005:70). This active parliamentary interest in specialized healthcare is perhaps an obvious consequence of the centralization of hospital ownership, but, nevertheless, the information providing the backdrop for the questions has to come from somewhere. Thus, this increased activity could indicate that transparency dynamics, in the wide sense, has made national health politics somewhat auditory in nature: Opedal et al. (2005:71) provides quite a few examples on how single cases generate questions that often relate to the parliamentary intentions with the hospital reform, based on post factum accounts on more or less principally important issues. The information providing the backdrop for the questions is multifaceted, but there are cases of audit reports, local political actors' lobbyism, media focus and general public debate in quite a few of these questions. The large quantity of available information on issues in specialized healthcare has two faces: It is partly a product of the move towards a more transparent (and thus more audible) system, somewhat "internal" to the state-centered organization of the system. However, it is also part of an increasing focus on healthcare issues in public debate that is more "external", in the sense that the media and local/regional political actors (that previously were formally included in the governance of the hospital system) direct their attention towards the central level in pursuing specific interests.

An interesting fact, also documented by Opedal et al. (2005:78), is that the contact pattern (formal versus informal) between the management of the enterprises and the central actors varies. The contact with the ministry, the directorate and the Health Audit is reported as being markedly more formal than their contact with actors in parliament. At the same time, the managers have *more* contact with parliament (43% reported such contact) than any other central actor, and perhaps there is a reason for this: "In other words, we see that the enterprise managers to a significant extent go outside official channels and straight to the Storting with their errands"⁷ (Ibid.). This could be interpreted as if the new enterprise structure creates room for pragmatism; if you need something from the government, you can actually approach the one instance that has influential capacity: There is a hierarchic character to parliamentarism when the government in office is a minority, coalition government. However, this could also be interpreted as an "informal audit mechanism" in function, as the link between the enterprises and the Storting is growing closer at the expense of government.

Transparency also has another face, as it is not only a matter of the exercise and relations of governmental accountability, but also a matter of knowledge and medical development. The

⁷ Original quote, in Norwegian: "Vi ser med andre ord at lederne i helseforetakene i betydelig grad går utenom "tjenestevei" og rett til Stortinget med sine ærender."

idea of evidence based medicine (EBM) is central to the transparency development in this sense. As both medical development and costs are in a racing development, the EBM movement gives the application of new medical ideas and practices a more assertive set of “rules” to relate to. Somewhat simplified, the principal logic is that the implementation of knowledge should be based on scientifically proven results. Science and the publication of research (in the wide sense) – the accumulation and spread of knowledge – become important to the development of specialized healthcare, in the sense that information on what is actually based in evidence needs to be accessible for the decision-makers in healthcare, whether the individual doctor or institutions with more overall responsibilities. Interestingly, as EBM is readily accepted as a principle by the public healthcare institutions, the EBM idea comes from the inside of the healthcare sphere and not from “the state” (Lundbäck 2002). Thus it has two noticeable characteristics: First, EBM makes “medicine” and medical knowledge more transparent to the outside world, for instance politicians and the public, through the establishment of “rules” for medical behavior. This could be seen as an opening up of a domain that traditionally has been under the medical professions’ property, yielding a potential for a weakening of the medical professions. Second, the acceptance of the EBM idea has allowed for a change in logic in the public healthcare sphere. The state now can accept autonomous decisions by actors in the medical sphere, since the background for the decision is (or at least is supposed to be) scientifically proven to be “good”. And who can argue against what is “good” and of proven quality?

EBM should ideally lead to the implementation of “best practices”. The measurement of quality and performance is another way to ensure that health services are up to standard, by way of illuminating weaknesses and strengths in terms of predefined parameters. Quality measurement is tightly connected to the idea of patient choice, however, which relates directly to ideas on markets in healthcare (Østergren 2004). The EBM development could be seen as parallel to this, if we accept that medical researchers compete for attention in terms of being deemed as “best practice”. *Defining* “the best standard” is potentially as important as scrutinizing quality indicators, in order to investigate whether practice meets the standard. What we see, on the one hand, is that the transparency drive in part is connected with competition as a principle. This is interesting, on the other hand, considering the transparency connected to more traditional audit activity, which seems to have a clearer element of hierarchic control. Furthermore, EBM represents a knowledge regime that differs from the usual governance-through-control idea associated with audits. Through the idea of EBM, the autonomy that seems to benefit medicine as a field, stands somewhat in contrast to the more conventional and state-oriented idea of audits as mechanisms for control. However, both these transparency dimensions could be seen as governance efforts.

Transparency can be a wide term, however, relating to political activity not formally a part of the system. As the audit results, performance measurements, political and administrative decisions are made accessible to the public, civil society reacts. There has been several cases of this related to the hospital reform, most of which are locally oriented (although sometimes nationally organized) towards the shutting down of emergency rooms, maternity wards or reduction of local services (Byrkjeflot and Neby 2005b). These local political actors frequently approach the parliament (in order to make “their MPs” to act towards government), the media, and even both the regional and local enterprises. The nature of these approaches varies from case to case, but nevertheless shows that this “informal democracy” plays an important role – if nothing else, it is important to civil society itself and more generally as a legitimacy issue.

A hybrid regime – or something new?

To start with the latest section, the transparency/audit dimension certainly seems ambiguous, yet relevant, in terms of governance, and needs to be set in relation to existing theoretical ideas on governance. Traditional audits can relate to several of the governance modes that we outlined earlier. Audits are in part a prerequisite for control, which in turn implies that there is a hierarchic nature to the relationship between those who perform the audits (such as the Health Audit), those who are audited (enterprises), and those who utilize audit information to exercise governmental capacity (political institutions, the health directorate and so on). Information stemming from audits serves as a foundation for legitimate (or at least legit) intervention by actors with the proper hierarchic capacities. The idea of markets is also connected with this: Quality indicators and performance measurements is a way of creating the information regime that is needed for a functioning market, whether or not we are in fact speaking of a quasi-market (Byrkjeflot and Neby 2005b). EBM has a capacity resembling the nature of quality indicators, although not directly related to the idea of markets. As medical decisions are based on evidence, it will supposedly lead to better quality in healthcare. However, this is not necessarily founded in the idea of the market, but rather in a specific approach to organizing and utilizing medical knowledge provided from advocates of the medical society.

In many ways, making structures, processes, action and decision-making transparent means creating a new basis for the exercise of power, as controlling and utilizing information is essential. A consequence often commented upon in this respect, is the development of post factum governance efforts, more reactive than proactive. The increasing use of evaluations, performance measurements, public hearings and the tendency towards politics being more case-oriented (as a function of media interest and attention), means that after-the-fact control becomes an important approach to governance. The notion of the “audit society” (Power 1999 2000, 2003) is perhaps suitable, if the autonomy that is given subordinate actors depends on post factum scrutiny by central political actors. In a wider sense, the general handling of information is also a form of audit. For instance, EBM is in practice an audit of medical knowledge, assessing its “value” in terms of best practices. This means that EBM, if accepted and encouraged by the state, can be viewed as some form of pre-audited, quality-checked input to a system under public scrutiny, reducing the probability of negative developments in healthcare. In terms of information handling, then, autonomy is yielded towards the medical society – substituting the loss of autonomy that has been expected as a consequence of the structural reorganization of the Norwegian hospital system, for instance through the opening-up of managerial positions to candidates without formal medical competence and the introduction of more business-like organizational models.

At the same time, the state take-over of the hospital sector indicates a relatively clear hierarchic organization of the hospital system, with the involvement of central level politics and politicians at the core of governance efforts. As is implicit throughout the paper, this involvement in part relies on the discussed transparency dynamics, whether we refer to auditory practices, EBM, media coverage or reactions from civil society. Although detailed intervention by statement is supposed to be limited to cases of principal importance (Sosial- og Helsedepartementet 2001), evidence supports the notion that information (whether neutral or biased) on cases portrayed as critical makes central-level politicians engage in detail on a larger scale than intended by the reform (Opedal et al. 2005). This may in turn mean that transparency, a prerequisite for market-like governance, also facilitates hierarchic intervention.

Financial and managerial arrangements support this notion, for example by the financial reimbursement of health enterprises on DRG-basis and the use of boards and result-oriented contracts for managers. The DRG system makes financial transactions visible in a new way, the boards are accountable to the owner (for expenditure, amongst other things), and managers can be monitored in terms of means-end accomplishments. However, this system of hierarchic checks and balances combines with market-like governance, as for instance activity based funding, quality measurement and provider responsibilities are necessities of a well-functioning patient choice system. It seems that at the very least, we can speak of a governance regime that combines a hierarchic logic with the principles of market ideas and professionally based knowledge assessment.

The ambition to create a more autonomous organizational system came at the expense of the counties, and in principle provided the hospital sector with opportunities to resist demands for efficiency and cost containment (Opedal et al. 2005). Seemingly invariably, the local and regional enterprises' quest for maintenance and even increase of expenditure coincide with the interests of the population, at least as expressed by the many local groups of activists defending "their own" hospitals, services and institutions. Often, there's a clear geographic dimension to these discussions, explicitly connected with a general discussion on equity and universality as a prerequisite for the relationship between the modern Norwegian welfare state and its citizens. Of course, this is a matter of democracy: The counties were regionally oriented democratic institutions, and the civil society activities so evidently present after the hospital reform can be viewed as a democratic expression connecting the local political aspect of hospitals with national health politics. The centre-periphery dimension has been central to Norwegian politics in a more general and historic perspective.

In assessing the particular development of hospital governance in Norway, then, it seems we also need to understand the broader picture of Norwegian governance with reference to both the general public sector and international development. Although quite a few perspectives and starting points could be utilized for this, there is one specific dimension that comes to mind: The Norwegian (reform) tradition for state owned companies by creating semi-autonomous organizational forms in coupling with a maintenance of hierarchical state capacities (Christensen 2003). Another is the use of audit as a means for control – but this we have already mentioned.

Firstly, there seems to be a belief that certain organizational forms are more suited to resolve challenges than others, especially those that lie outside the traditional, central administrative perimeters of the state, whether these challenges are tasks to be resolved, of political importance, rhetorical-symbolic importance, or for capacity problems. The central idea seems to be that it is possible to solve problems and meet challenges through organization – implicitly creating a strong belief in structural arrangements and preserving hierarchical capacity. The wide range of public enterprises in different areas seems to indicate that organization, furthermore, is a matter of the task at hand, or more precisely a plausible, rational solution to challenges from new developments and the aspiration to be "modern". The current government even has a "modernization ministry" in charge of the overall modernization of public sector. In healthcare, this could be exemplified by the state owned and ministerially controlled health enterprises (inspired by private sector companies) relating to citizens *as if* they are users or customers, rather than as voters. The idea of public (and state-owned) enterprises and companies is not new in Norway, although most such organizations have been more peripheral to the welfare state itself. For instance, Statoil provides the state with large revenues and a financial basis for welfare expences, and the

previously 100% state-owned Telenor provided the population with telecommunication services - but neither are occupied with “welfare business” in the traditional sense.

Secondly, an important point to be made is that although we could describe most of the measures introduced in the later years as some form of a Norwegian NPM-interpretation, the picture is more complex. A recurrent argument in institutional accounts on NPM is that the NPM-specific features somehow are translated, mediated or merged with already existing traditions, creating hybrid systems that often display both features of clean-cut NPM thought and more traditional, historic administrative forms (Sahlin-Andersson 2001). Although interesting in itself, the translation perspective on NPM usually focuses more directly towards the interplay between NPM-specific features and historic-institutional traits, than towards the very nature of the existing regime. In healthcare, for instance, the implicit values connected with the medical profession, the population’s role as both patients and citizen, and the equity/universality debate suggest that the ideas connected with NPM aren’t sufficient in describing the development of new governance regimes. One of the deliberate aims of this paper has been to assess the specialized healthcare system (at the national level), without taking the NPM approach. Of course, the empirical backdrop would be the same – but perhaps it is more interesting to discuss the possibility for new governance modes than to discuss the NPM-or-not question?

A development commented upon by many is the emerging tradition of the state as service provider, emphasizing efficiency and quality of service (Hood 1998). Another perspective, which departs from the NPM-oriented perspectives in treating healthcare as something distinct, is the idea of the “healthcare state” (Freeman 2000, Freeman and Moran 2000). In this perspective, healthcare becomes the core or center which welfare issues revolve around – both in terms of services and politics. Financial challenges are abound, and the rising costs ever increasing. At the same time, healthcare becomes a defining dimension to the conception of the state itself; patients as such are citizens with rights as much as they are user or consumers of healthcare services. Thus, the overall argument is that healthcare has become perhaps the most important characteristic of the modern welfare state; not just in terms of size, but in the same way as theory on states originally was oriented towards territory, jurisdiction and construction of polity.

Taken together, this means that the governance rationale of the Norwegian specialized healthcare system is connected to a wide set of dimensions that do not necessarily point in the same direction. Although there has been some “marketization”, hierarchy still exists. Although broad plans are utilized and autonomy is granted towards the enterprises, both the administrative and political control functions increase in importance. Even though the counties were removed from hospital governance, the geographical and the local political dimension remain important. Professional influence has been challenged, but not significantly – and the medical community has found new ways of defining their role. Transparency becomes an increasingly apparent characteristic of many of the central features of the hospital system, in relation to state control, medical development, and democracy. Hospitals and health are hotly debated in politics at all levels and in the media, influencing the parliamentary relationship between institutions at the central level. And simultaneously, healthcare is in general becoming increasingly important as a prime feature of the state itself – it is not just one of many activities, it is perhaps the main service provided to the population. How should we understand this?

Conclusions

An aim of this paper has been to “...identify the different ways in which recent changes are constructed and see if we can place these constructions in long-standing but continuously evolving traditions” (Bevir, Rhodes and Weller 2003). What we see is that in many ways, the matter of hospital governance in Norway is “business as usual”: There’s still considerable localism connected to the idea of the hospital, specialized health engages central politics and spurs in part detailed governmental intervention, and much of the attention towards specialized healthcare is generated through civil society. Although there have been substantial structural changes – and we have to describe the lay-out of the system quite differently – central steering efforts are not restricted to principles and broad plans.

The changes made in structuring, financing, organization of medical knowledge and the role of the patients indicate a turn in a different direction, however: Transparency dynamics have become central to the functioning of the entire system. This is so whether we speak of the DRG system (which connects expenditure with medical diagnosis), patient choice (which rely on informed patients, as well as doctors), quality and performance measurements (not just in medical terms), auditory activity and the subsequent implementation of measures, or political debate on issues central to specialized healthcare system. Removing the counties from hospital governance meant increasing the “size” of specialized healthcare discourse at the national level, certainly in terms of the relationship between parliament and government. This means that the concept of making information visible is essential to understanding the expanded healthcare sector – including services, politics, structure, finance and more. Furthermore, it can be assumed that this information (which can have different character depending on the subject matter) is basically *post factum*; it is provided after-the-fact.

Governance thus becomes a question of control more than of steering; a matter of reaction rather than pro-action. Thus, the contents of health policy – because of our knowledge of problems, challenges, poor management or medical malpractice – turn towards the things that we already know are not desirable, as much as to broad visionary political aims. Whether this really is something new remains an unanswered question in this paper, however. What is more, the finding that Norwegian specialized healthcare is connected with traditions for organization and practice that have significant roots (such as the creation of state-owned companies and ample engagement of central politics in detailed matters), indicates that the market, the hierarchic, and the network modes for governance all play out in some hybrid form. In addition to this, the mentioned importance of information and transparency accentuates parts of the specialized healthcare system that we perhaps would not focus on utilizing the traditional modes of governance. Problem is, however, that the increasing transparency drive is not necessarily classifiable as a rationale for governance – it all depends on how actors relate to information; to how information is conveyed, utilized and given values in its own.

What we do see after the implementation of the hospital reform, is that information provided through performance measurement, quality indicators, EBM, financial systems, civil society activity or audit plays a crucial role for the *control* of Norwegian specialized healthcare. And if control is a matter of exercising power, perhaps we should speak of some hybrid form of a “*post factum hierarchy*” where governance is an equal matter of politics, economy and medicine?

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