Health Care Reforms in Norway, Denmark and United Kingdom: Shifting Balances of Autonomy and Control

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Summary

This paper focuses on the balance between central governmental control, autonomy for health care institutions and (quasi)-market mechanisms by examining recent health care reforms in Norway, Denmark and United Kingdom. The reforms involve strengthening of overall central government control, simultaneously representing a decentralized system of management and business-like mechanisms to ensure patient choice. The theoretical basis of the study is theories explaining convergence and divergence patterns in health care reform policies. Even though New Public Management (NPM) is still a dominant reform paradigm in our time, culture and political dimensions need to be integrated into the NPM approach to understand health care reforms. A contextualization process that stresses the uniqueness of the national system in general and health systems in particular have to be taken into account. In the empirical section, recent health care reforms in the countries under study are described along three organizational trajectories, decentralization, marketization and centralization showing both convergent and divergent reform patterns.
1 Introduction¹

A central topic of health care reforms in many European countries is to find a proper balance between superior governmental control, autonomy for health care institutions and (quasi-)market mechanisms. The prescribed “state-plus-market” model is supposed to tackle a diversity and often contradictory set of targets, ranging from national need for macro-economic control and equity standards to local need for autonomy as a way to promote efficiency, quality of care and consumer choice.

How the trade-off between governmental control, autonomy and market turns out in practice will vary between countries reflecting the impact of global ideas like New Public Management (NPM) and national features like polity systems and dominating historical paths. Policy makers heavily inspired by NPM will probably promote health care reforms setting huge footprints on organizational trajectories like administrative decentralization and marketization. Leaning stronger to Weberian or Neo-Weberian reform elements, for instance reaffirming and modernizing the role of state as a main facilitator of health services, may imply health care reforms more inclined to preserve and strengthen national control and accountability.

To what extent national health care reforms diverge or converge towards a common and somewhat paradoxical state-plus-market model is an empirical question. This paper addresses recent health care reforms in Norway, Denmark and the United Kingdom (U.K.) As Beverigde-systems, all countries under study share a common basic health care model based on tax funding and predominantly public provision of health care services. However, while U.K. has a centralized National Health Services (NHS) model, Norway and Denmark have strongly supported a decentralized public health care model where the regional counties and local authorities play a significant role.

Recent health care reforms in the Nordic countries have put severe pressure on the decentralized Scandinavian health care model (Byrkjeflot and Neby 2005, Opedal and Stigen 2005). In Norway, the 2002 Hospital Reform involved transfer of the hospitals from the regional counties to the state. The ownership was thereby centralized to a single body, the state. In Denmark, the government decided in 2004 to abolish the 14 counties responsible for the hospitals and other health care services and replace them

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by five regions with their own elected representatives. The centralizing of ownership seems to move Norway and Denmark closer to the centralized British NHS-model, indicating a convergence among health care systems in this part of Europe. Combining political centralization with administrative decentralization, for instance the establishment of health enterprises in Norway and more self-governing NHS Foundation Trusts in U.K., the balance between governmental control, managerial autonomy and market mechanisms seems to undergo radical changes.

The aim of this paper is to compare recent health care reforms in Norway, Denmark and U.K. along three organizational trajectories, decentralization, marketization and centralization, as a way of describing the content of national reform packages. We ask how political and institutional structures enable or constrain countries in the process of adapting or rejection of global reform ideas and concepts.

The study deploys a qualitative approach through the method of structured comparison along the chosen organizational trajectories. Our comparison is based on a general distinction between methods of difference and similarity (Frendreis 1983; Lijphart 1971). We have chosen a mixed system research strategy that combines the two. In a mixed system strategy the cases will vary along both dependent and independent variables, thereby allowing for a variety of comparisons to be made. The countries under study differentiate in certain ways, but there are also important similarities.

First we outline the chosen organizational trajectories applied to describe recent health care reforms in the countries under study. Then we present theories explaining convergence and divergence patterns in health care reform policies. After a description of recent health care reforms in Norway, Denmark and U.K., we discuss to what extent the observed national reform policies in Norway, Denmark and U.K. converge or diverge, providing explanations for the observed patterns.

2 Decentralization, Marketization and Centralization

We have chosen a threefold scheme which is fairly “mainstream” in terms of classifying reforms, namely decentralization, marketization and centralization. The mixture between health care reforms along different organizational trajectories may differ from country to country due to the composition of national packages of reforms.

NPM prescribes centralization as well as decentralization and marketization. Vertical decentralization, greater horizontal role differentiation and management by
objectives and results have their roots both in centralizing theories of contractualism and in the decentralizing tendencies of managerialism (Aucoin 1990, Hood 1991), thus illustrating the hybrid nature of the NPM wave that prescribes both centralization, regulation and control and decentralization, autonomy and marketization (Christensen and Lægreid 2001, Lægreid, Opedal and Stigen 2005a, b). It is a widespread NPM belief that a proper and stable balance between decentralization, marketization and centralization is possible to achieve.

The NPM perspective has been criticised to overshadow reform policies that does not fit with the “tool basket” of NPM. To differentiate, a Neo-Weberian perspective has been introduced to intercept the broad range of reform proposals (Pollitt and Bouckhaert 2004: 99). This perspective underpins reaffirmation of the role of the state and representative democracy as main problem solving mechanism – even suitably modernized. Further, the idea of public services is important, but nevertheless, the perspective opens up for modernization through different devices for consultation with citizens’ views and greater orientation by public servants on the achievement of results.

Health care reforms along the decentralization trajectory can be reflecting both the NPM approach and Neo-Weberian ideas and concepts. The last decades, decentralization has become a popular management reform strategy in many European health care systems seeking to remedy the inadequacies of centralized national models (Saltman and Figueras 1997, Saltman et.al 2005). It has been customary to assess the outcome of decentralization in the light of health gain, equity, efficiency, quality of care and consumer choice. Given all the benefits it is little wonder that almost everyone in every country seems to be officially in favour of decentralization (Pollitt 2005).

Distinctions can be made between political decentralization, where the decentralized authority is transferred to elected political representatives, and administrative decentralization where authority is passed to an appointed administrative body. Authority, in the latter case, may be transferred by competitive means (e.g. contracting out) or by noncompetitive means. A third choice is between internal decentralization within an existing organization and external decentralization where authority is transferred to an independent external body.

While political decentralization fits with a Neo-Weberian perspective, the influence of NPM will affect decentralization in certain directions (Pollitt et.al 1998; Pollitt and Bouckhaert 2004). The Anglo-Saxon heartlands of NPM, including U.K. have preferred administrative decentralization by competitive means, often devolved to
autonomous bodies, while the Nordic countries have chosen political decentralization combined with more cautious forms of administrative decentralization.

Closely related to NPM inspired administrative and competitive decentralization, is transfer of government functions to non-governmental organizations which either is a voluntary agency or a private actor. The marketization trajectory implies higher degree of plurality of health care provision, more weight on competition and represents an opportunity for patients to make choices. A range of quasi-market measures have been linked to this first and foremost NPM trajectory, including demand-side reforms like free choice of hospital and extended patients rights. In addition, patients have been offered waiting time guarantees and formal channels of influence through the establishment of patient forums and commissions. On the supply-side, the health care delivery system has been the target of a range of reform proposals including contracting-out, activity based financing and rewards and sanctions based on performance management. To what extent market-style reforms are part of the modernization of health care sector seems to vary from country to country.

To counterbalance health care reforms along the trajectories of decentralization and marketization, different types of centralization reforms have been introduced by reform makers. Several commentators suggest that decentralization and centralization are not necessarily opposite processes but can develop in a parallel manner with certain functions being regulated at the central level while other functions of units remaining decentralized (Saltman and Figueras 1997, Christensen 2000).

In a NPM perspective, decentralization, marketization and central regulation and contracting seem to go in tandem. As a way for the state to guide the “invisible hand” of the market, the state is advised by NPM to make use of the “hidden hand”. Reforms through standard setting, monitoring, inspection, audit and application of rewards and sanctions have become more salient in the health care sector (Hood, Rothstein and Baldwin 2001, Altenstetter and Björkman 1997, Ham 2004). The rise of a Regulatory State (Majone 1994, 1997) involves a shift from direct command and control policy style to a more indirect and rule setting form of government. The state is kept at arm’s length from direct involvement, but has a well developed regulatory role. In contrast to the traditional welfare state model, which integrates regulatory, operating and policy-making functions, the regulatory state separates regulatory activities from operational ones, purchasers from providers, and the policy making role from operational role.
The reform track of central regulation and contracting is however only part of the story. For instance, the central governments’ take-over of the ownership of hospitals in Norway can not easily be understood as re-centralizing in accordance with NPM. It is an example lending support to the argument that health care reform, even where it embraces different forms of decentralization, also tends to increase the role of the state in others ways than through contracting and regulation. Thus, a Neo-Weberian perspective has to be added to understand the full scale of reform policies (Pollitt and Bouckaert 2004). Health care reforms, establishing new mechanisms of (direct) governmental command and control, may be seen as a part of the re-centralizing trajectory supplementing the NPM perspective of contracting and regulation.

To sum up, health care reforms can be placed along different trajectories adding up to complex package of health care reforms including decentralization, marketization and centralization. How recent health care reforms in the countries under study can be described along these organizational trajectories is the subject of the empirical section. In the next section, we ask to what extent it is theoretical plausible to expect convergent or divergent health care reform patterns in Norway, Denmark and U.K.

3 Theoretical Approach

The leeway or degree of manoeuvrability decision-makers have in reform processes is influenced by environmental factors, polity features and the historical-institutional contexts (Christensen and Lægreid 2001; Christensen, Lægreid and Wise 2002). These factors place constraints on and create opportunities for purposeful choice by decision-makers to launch reforms through organizational design. They can both further and hinder the introduction of different types of reforms.

Environmental characteristics are potentially important for the content of national reform packages (Olsen 1992). These would include factors such as economic crises and closeness to international concept entrepreneurs – both factors that seem important for NPM-like reform processes (Sahlin-Andersen 2001). An environmental perspective stresses that organizations exist in a dynamic and interdependent relationship with actors and groups in the environment (DiMaggio and Powell 1991). Global “prescriptions”, like NPM, may be seen as myths that create a deterministic pressure on different countries for changing their reform policies in certain directions.
Polity features of national political systems are connected to an instrumental-structural perspective. It underlines that public organizations change because some actors have a relatively strong influence on decisions, unambiguous intentions and goals, clear means and insights into the possible consequences of various solutions, resulting in effects that mostly fulfil the stated collective goals (March and Olsen 1983). The main features of the polity, the form of government and the formal structure of decision-making may all affect what kind of reforms nations adopt or reject.

One set of constraints is represented by the historical-institutional context or cultural tradition, norms and values that can have major impact on the instrumental features of an active administrative policy. An institutional perspective focuses on the cultural features of organizations; frequently on how culture serves to make them stable, integrated and robust towards fundamental changes (Selznick 1957, Krasner 1988). Reforms may have norms and values that are highly incompatible with the traditional cultural norms and values of the political administrative systems of specific countries, resulting in difficulty in making reform decisions or implementing reforms, or in the modification of reform elements (Brunsson and Olsen 1993). But cultural and institutional features of organizations may also have the potential to further instrumentally planned reforms (Veenswijk and Hakvoort 2002).

3.1 A Convergence Thesis

How far can it be said that Norway, Denmark and U.K. have been following the same reform route? It is frequently argued that over time there has been a tendency for convergence in the organization of medical care (Powell and Wessen 1999: 4). Moreover, similarities among health care systems of Western countries stem from the fact that they share a set of similar goals for their health care systems, face broadly similar economic and social problems, and have been exposed to ideological and “expert” policy prescriptions of worldwide currency. Reform is the catchword not only for OECD and the World Bank, but also for UNICEF and the World Health Organization (Byrkjeflot and Neby 2005; Saltman and Figueras 1997).

Norway, Denmark and U.K. face many common challenges in health care. The aging of the population, higher levels of chronic disease, the increased availability of new treatments and technologies, and rising public expectations have all exerted upward pressure on health care expenditures. The clash between, on the one hand the “good”
character of health care, and on the other the fiscal imperative of cost control has been a driving force behind much of the health care reforms all around in Europe.

A typical response to the pressures for health care reform has been to introduce components from NPM. According to OECD (1995) NPM represents a global paradigm change. It still creates pressure for similar reforms in many countries. NPM has been most elaborated in U.K. as one of the Anglo-Saxon countries. The Nordic countries have been more reluctant, adapting slowly to NPM by an incremental and pragmatic reform style. Over the last years, however, the pace of reform in Norway has quickened so that the label “reluctant” is less appropriate (Christensen and Lægreid 2001). Also Denmark has been eager to utilize the “tool basket” of NPM as a way to modernize Danish public sector (Ejersbo and Greve 2005: 77). In relation to the comprehensive structural health care reforms in both Scandinavian countries, the recent reforms may imply a move closer to the British NPM-inspired style of modernizing.

How NPM is adapted to the health care sector depends on polity features and dominant historical paths. As Beveridge systems, Norway, Denmark and U.K. share a basic state-centered model that distinguishes them from the continental Bismarckian social insurance-based model and more privatized health systems as in US. Although Britain is often termed a liberal welfare state, its public and tax-based NHS-model corresponds closely to Esping-Andersen’s social democratic regime. This is a regime “virtually synonymous with the Nordic countries” (Esping-Andersen 1999:78ff). We would expect that the long lasting stronghold of the “social democratic regime” in the health care sectors in all countries under study will block the most radical neo-liberal NPM ideas and concepts and give more leeway for modernization along Weberian or Neo-Weberian reform lines. Such a hybrid reform pattern may be strengthened by cross-national borrowing of reforms between Norway, Denmark and U.K. as neighbouring countries with close contact and collaboration.

3.2 A Divergence Thesis

The convergence thesis can be questioned in relation to different national environmental conditions, polity features and significant historical lines. An important distinguishing environmental factor is the economic situation in a country, both in general and in health care in particular. The economic crises that have hit the NHS organization several times in the 1980s and 1990s have been far more severe than the
ones in Norway and Denmark. Although Norway and Denmark experienced economic slowdown in the late 1980s, there was no major economic crises that solely could legitimate comprehensive health care reforms. Especially in Denmark, the lack of evidence for economic failure or breakdown in health care at the regional county level is striking (Vrangbæk and Christiansen 2005).

Another environmental factor that seems to distinguish Norway and Denmark is the perceived legitimacy of the regional county level. While the regional county level in Norway has been debated and questioned for years, there has been strong Danish support for the regional county level as a democratic management structure (Byrkjeflot and Neby 2005). Lack of trust can pave the way for radical reforms (Hood 1996).

Different polity features like state structure and nature of executive government may explain how different countries handle global pressures for reform in general as well in health care in particular. Such polity features seem to exercise significant influence on the speed and scope of national reforms. It is widely recognized that centralized, majoritarian Westminster systems as the one in U.K. enable more rapid and radical reforms than decentralized, multi-party systems with a strongly consensualist orientation as the ones in Norway and Denmark (Christensen and Lægreid 2001, Pollitt and Bouckhaert 2004, Pollitt 2006). While the systems in Norway and Denmark tend to result in negotiations and parliamentary turbulence, the Westminster system in U.K. has been related to a unitary form of government, a strong executive and tight party discipline in parliament.

In U.K. the process of changing the machinery of government has for long been remarkably easy. As one of the Anglo-Saxon countries that most aggressively have carried through the most vigorous, broad-scope reforms, it is reasonably to expect that U.K. is a frontrunner in health care reform policies comparing to Norway and Denmark. In Norway and Denmark, characterized by consensual political systems and coalition governments, the process of reform is likely to be less harsh and combative than in U.K. Reforms in highly decentralized countries are likely to be less broad in scope than in centralized states. As decentralized and consensual countries, it is reasonably to expect that Norway and Denmark find it more difficult to carry out sweeping, synoptic health care reforms than decision-makers in the more centralized U.K. model. Comprehensive structural reforms happen in Scandinavia too, but first and foremost as delayed responses to the NPM-movement, joining it after it has already peaked elsewhere (Christensen and Lægreid 2003).
The historical-institutional context, norms and values that characterize the politico-administrative systems, seems to underscore the differences between U.K. on the one side and Norway and Denmark on the other. We might suppose that U.K. is more comfortable with radical NPM reform, scoring high on individualism and is relatively accepting of uncertainty (Hofstede 2001; Pollitt and Bouckaert 2004). The Nordic countries have been characterized by a strong statist tradition, homogeneity in norms, equality, mutual trust between major stakeholders and public reforms through peaceful cooperation and incremental changes (Christensen and Lægreid 2001). These are all factors that would lead one to believe that NPM inspired health care reforms in Norway and Denmark will be adapted more slowly and reluctantly than in U.K. As members of the Nordic family, Norway and Denmark will probably give their modernization efforts a stronger Neo-Weberian fashion, emphasising more heavily public ownership and citizen-oriented participatory flavour than in U.K.

4 Health Care Reforms in Norway, Denmark and U.K.

What reform initiatives are to be included in the study? First of all, the present study is preoccupied with reform initiatives concerning decentralization, marketization and centralization most often defined as organizational or performance trajectories. The following description is based on governmental reform initiatives possible to identify in written material, e.g. official documents and secondary literature. Thus, the study does not cover practical consequences of the reform policies, for instance how they are implemented and what effects they bring about. Second, reform policies may encompass both state and county reform initiatives. More difficult is to assess initiatives taken by some counties and later on adapted by several counties resulting in a reform of the system as a whole, for instance the introduction of contracts in Denmark in the 1990s. As a guiding line, we have selected nationwide reform initiatives based on their relevance for the pointed out organizational trajectories. Third, “recent” health care reform initiatives means initiatives mainly taken the last decade with a particular focus on the 2002 Norwegian hospital reform (Department of Health and Care Services 2001), the 2004 decision on structural reform in Denmark (Agreement on a Structural Reform 2004) and the following up by the Blair government of the 1997 White Paper The New
Nevertheless, historical flashbacks are made as a way to point at dominating historical reform paths in each of the countries under study. At least, following the Norwegian hospital reform as a starting point for cross national comparison, secondary services are more focused than primary care. This limitation underline that the following description is not an exhaustive mapping of all kind of health care reforms in the countries under study.

4.1 The Decentralization Trajectory

Norway

Norway has followed a pathway with a history of relatively decentralized and welfare-oriented health care system (Byrkjeflot and Neby 2005, Hagen and Kaarbøe 2004). The years following the Second World War can be described as an ongoing reform process of political decentralization from central powers to local governments. The philosophy behind this has been that decentralization is an expression of applied democracy. It has brought decision-making closer to those who are affected and promotes popular participation in local political affairs. Underpinning political decentralization, the Local Authority Health Care Act was passed in 1984 and made local municipalities responsible for primary care. Consequently, and contrary to U.K. and Denmark (except for some public health related tasks like home nursing and home help in Denmark), the responsibility for primary and secondary care has in Norway been divided between different government tiers.

The counties in Norway were assigned responsibility for the institutional health services by the introduction of the 1970 Hospital Act. However, most hospitals were managed by county councils before this legal formalization. Since 1970, and until 2001, each of the Norwegian 19 counties was assumed the responsibility for the planning and operation of the local hospital sector, including both somatic and psychiatric institutions. The only exception was a few state owned highly specialized hospitals.

NPM principles like single purpose organizations and administrative decentralization had modest impact in the period of county ownership of the hospitals.

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2 This paper is essentially about the NHS in England. Prior to 1997, policies that applied in England set the model for the other three countries in the U.K. Since then there have been important changes following the devolution of power to the new political institutions created in 1999 (Woods 2004).
The counties in Norway were organized as multipurpose organizations, integrating different roles as owner, regulator, purchaser and provider, while the hospitals were left limited administrative discretion due to their status as integrated public entities. Principally, it was a model marked by political decentralization between the state and the counties and modest administrative decentralization between the counties and the hospitals. However, the state-initiated introduction of activity-based financing in 1997, was gradually combined with “soft”, noncompetitive contracts, leaving more leeway for the hospitals in using allocated resources (Hagen, Iversen and Magnussen 2001; Opedal and Stigen 2002). A few counties even tested purchaser-provider models and external decentralization through the introduction of health enterprise models.

The takeover by the state of responsibility for all Norwegian hospitals in 2002 led to a more pronounced shift in favor of NPM inspired policy change initiatives. Political centralization replaced the former decentralized democratic management model. The move on the decentralization trajectory is first and foremost marked by external administrative decentralization (Opedal and Stigen 2005). The take over by the state implied a change of organizational form for the hospitals from public administration entities to become separate legal entities as health enterprises. Under the Ministry of Health and Care Services five regional health enterprises with separate boards have been established, and in turn these have organized former hospitals and institutions into 33 local health enterprises under regional auspices. Today 82 hospitals and a number of smaller institutions are under local health enterprise auspices.

The regional health enterprises are tasked to maintain both the roles as purchaser and provider and in contrast to the official OECD model those roles are not divided but integrated representing a specific Norwegian solution (Byrkjeflot 2004). The health services are delivered by the hospitals that have been made into statutory companies organized into local health enterprises reporting to, and owned by, the regional health enterprises. In the period from 2002 to 2005 no active politicians were members of the boards. The election of a Red-Green majority cabinet (Labour Party, Agrar Party and Socialist Left Party) in 2005 led to a replacement of the professional board members by a majority of local and county politicians. To some extent, this policy change mark a turn around to a more politically decentralized model.
Denmark

Denmark has, as Norway, a long tradition of decentralized welfare administration (Vallgårda 1989, Vallgårda, Krasnik and Vrangbæk 2001). Since World War II, political parties on all sides have supported the idea that local public authorities should have a prominent role as welfare agents. The 1970 local government reform reduced the number of counties from 25 to 14 and responsibility for health care shifted from the state, towns, charities and counties to be a main responsibility of the counties. At the same time there was a change from direct state subsidies to general block grants and county-level taxation. In 1976 counties were given responsibility for psychiatric hospitals (previously under state control), and in 1977 the counties took over a number of private non-profit hospitals. That meant that the counties were given the whole responsibility of both health care provision and financing, including about 80 somatic and 13 psychiatric hospitals. Both decentralization and centralization marked the unification of health care tasks at the county level.

However, within the general decentralized framework there have been a number of health care reform initiatives affecting the scope of decentralization. More administrative responsibility has to some extent been delegated to managerial hospital levels as part of a contracting system between the state and the counties and between the counties and the hospitals (Bentzen 1999, Kragh Jespersen 2001, Vrangbæk and Christiansen 2005). Contrary to Norway, external decentralization between the counties and the hospitals has not been part of the reform strategy in Denmark. Hospitals have for decades been integrated as public bodies in the county governance structure.

As in Norway, global ideas of competition between providers via a purchaser-provider split have not been implemented in Danish health care sector. The principle of multipurpose organization has been far more pronounced than separating different roles through vertical or horizontal specialization. Both the state and the counties integrate different roles as ownership, purchaser and provider, while the hospitals have been left limited administrative discretion due to their status as integrated administrative entities. Principally, the Danish model has traditionally been marked by extensive political decentralization between the state and the counties and modest, noncompetitive administrative decentralization between the counties and the hospitals.

The establishment of five new regions from 2007 does not imply radical steps on the administrative decentralization trajectory in Denmark. The regions will inherit most of the counties health care responsibility including hospitals, general practitioners and
psychiatric treatment (Agreement on Structural Reform 2004). However, the agreement between the Conservative Party, Liberal Party and the Danish People’s Party does mean a transfer of the overall responsibility for any rehabilitation to the municipalities that does not take place during hospitalization. Before the reform, this responsibility was shared with the counties. In addition, the municipalities will take over the main responsibility for preventive treatment and promotion of health, integrating these tasks with other local tasks. In order to ensure correlation between the regions and the municipalities, they will have to enter into binding partnerships in health coordination committees.

While the distribution of tasks is somewhat changed between the regions and the municipalities, the structural reform does not indicate far reaching structural devolution in affiliation between the regions and the hospitals through the establishment of health enterprises, trusts or public owned companies. Denmark will still retain some political decentralization through the new regions with their own elected legislatives, combined with modest administrative decentralization between regions and hospital levels.

**United Kingdom**

Contrary to Norway and Denmark, United Kingdom has since World War II combined a political centralized model with shifting strategies for devolving more administrative power to actors within the NHS organization. Despite the longstanding existence of elected local authorities, U.K. has had highly centralized political institutions centred on its Parliament at Westminster. However, the Blair government elected in 1997 gained office with a commitment to embrace a constitutional change, and did so by devolving a range of political responsibilities to new political institutions in Scotland, Wales and Northern Ireland (Woods 2004).

The political decentralizing reform of the Blair government in 1999 is primarily an exception to the rule of administrative devolution within the NHS organization. Three milestones mark significant structural reforms of the NHS: the 1974 reorganization, the 1991 internal market, and finally the policies of the Labour government since 1997. According to Ham (2004), the NHS has moved from a hierarchical command and control system, introduced in 1948 with the establishment of NHS and renewed in 1974, through Margaret Thatchers’ internal market, to the Blair governments’ third way, emphasizing collaboration and partnership-working.
The 1974 reform was intended to unify health services by bringing under one authority all of the services administered by a large number of boards, committees, councils and local health authorities. A more hierarchical and integrated NHS with several administrative tiers was established consisting of regional health authorities (RHAs) with broad planning responsibilities and 90 area health authorities that were in turn, divided into districts administered by a district management team. A vertical accountability framework was combined with modest administrative decentralization downwards the NHS organization. In 1982 one administrative tier was removed by the Conservative government by merging functions of existing areas and districts into 192 District Health Authorities (DHAs) in England. Even if more administrative power was delegated to units of management, DHAs directly managed the hospitals in its area.

The 1991 internal market reform radically changed the NHS organization, making it more businesslike. At the heart of the NHS reform was the introduction of competitive contracts, a split between purchasers and providers and external devolution through the establishment of NHS Trusts and self-governing general practitioners (GPs), displaying a breakthrough of NPM doctrines (Robinson and Dixon 1999, Ham 1997, Bevan and Robinson 2005). The DHAs were transformed into purchasers of health care for their populations and were given the freedom to buy services from NHS or private-sector hospitals, while NHS hospitals secured the freedom to opt out of authority control and manage their own affairs as self-governing trusts. Trusts were expected to compete with each other for service contracts from purchasers. The reforms also included a number of measures designed to strengthen the power of NHS hospital managers over doctors (Secretary of State for Health 1989; Giaimo and Manow 1999).

The reform policies by the Thatcher government, anchored through the 1989 White paper, Working for Patients and the NHS and Community Care Act in 1991, represented a move away from vertically integrated forms of organization towards a more decentralized internal market. The degree of autonomy, however, was strictly limited. Both purchasers and providers were accountable to the regional offices, and these offices operated a strong performance management system. In addition, a smaller number of DHAs were strongly controlled in terms of planning and service priorities.

The path on which the new Labour government set out in the 1997 White paper The New NHS: modern, dependable was characterized by abandoning the rhetoric of competition and instead introducing a new organizing philosophy based on decentralization, collaboration and “partnership”. Through several reform initiatives, the
Labour government has taken new steps on the administrative decentralizing trajectory emphasising decentralization of power to new commissioning bodies and NHS Trusts.

Labour has retained the purchaser-provider split but created new purchasers, namely Primary Care Groups, which became about three hundred area-based Primary Care Trusts, organized around GPs, with the idea that this would lead to a more locally and primary-care-led NHS (Secretary of State for Health 1997; Bevan and Robinson 2005). Thus in England, up to 80 percent of the NHS budget is spent by Primary Care Trusts, commissioning services from other NHS Trusts and private providers. Assuming more responsibility to the new purchasers, the former 95 DHAs were in 2002 replaced with 28 Strategic Health Authorities (SHAs) responsible for strategic planning and performance measurement. In addition, the regional offices of the Department of Health were replaced by four Directorates of Health and Social Care, following up the initiative known as *Shifting the Balance of Power* (Department of Health 2001).

This initiative has since been reinforced through new initiatives by the Blair government. Changes to the organization of the Department of Health introduced in 2003 led to the reduction of the size of the Department of Health by one-third and to the abolition of the four regional directorates. The SHAs became, in effect, the regional tier of the NHS. The regional character of the SHAs has been underlined even more due to a reduction in the numbers of SHAs from 28 to 10 (Secretary of State for Health 2006).

The most radical step on the decentralizing trajectory is the establishment of NHS Foundation Trusts, set up under the powers in the *Health and Social Care Act 2003* (Smith 2004; Bevan and Robinson 2005). For acute hospitals, deemed eligible, there is an opportunity to become foundation trusts, which are outside direct-line management and control from central government and performance management by SHAs. Their autonomy is enhanced comprising freedom to retain any operational surpluses and revenues from land sales, to determine their own investment plans, and to raise capital funds, and the scope to offer additional performance-related rewards to staff. They are governed by a Board of Governors comprising of people elected from and by members of the public, patients and staff. In 2005, 31 NHS Foundation Trusts were in operation of a total of around 280 NHS Trusts (Department of Health 2005).

In terms of external decentralization, the creation of NHS Foundation Trusts marks a shift of decision-making power to the hospitals and the local communities they serve. Contrary to the Norwegian Health Enterprises and their vertical accountability line towards the Minster of Health, the NHS Foundation Trusts are located in a more
complex accountability framework including local communities, PCTs, semi-independent agencies and Parliament. The reform initiative underlines the ongoing process in U.K. of devolving administrative power downwards the NHS organization.

4.2 The Marketization Trajectory

Norway

Norway has been pushing quasi-markets and performance measurements models both prior to the 2002 hospital reform and afterwards. As a way to stimulate efficiency and hospital activity, the hospital funding system through activity-based financing in 1997 succeeded the era of global annual budgets introduced in 1980 (Hagen and Kaarbøe 2004). From July 1st 1997 a fraction of the block grant from the central government to the county councils was replaced by a matching grant depending upon the number of patients treated, the patients’ DRG (Diagnosis Related Groups Classification), and a national standardized cost per treatment. The activity based component has varied a lot since 1997, partly due to changing political majorities in parliament, from 30 percent in 1997 to 60 percent in 2003 and 2005.

Evolving a more transparent and patient-led hospital delivery system has been attempted through developing of national quality standards, performance measurement and extended patients’ rights (Christensen, Lægreid, Stigen 2004). Measurement of economic and activity indicators was in 2001 supplemented by the national quality indicators initiative (Ministry of Health and Care Services 2001). Each hospital is evaluated according to several quality standards including assessments done through national patient surveys conducted to sample data about patient experiences. To a modest degree, hospitals score on performance indicators have been used consciously by the state to reward or punish hospitals through funding, star rating systems or assigning selected hospitals more freedom from government interventions. But publicly available performance information constitutes an opportunity for patients to assess various hospitals achievements.

In addition, the 1999 Act on Patient’s Rights, implemented in January 2001 stated the opportunity of patients to choose hospital for elective treatment (Vrangbæk et. al. 2006). In 2004 the patients’ right to choose hospital was extended to include private
hospitals. At least, as a part of the 2002 Hospital Act, both regional and local health enterprises were instructed to establish patient commissions, formalizing a channel for the patient organizations to articulate their interests. Adding to these mostly NPM inspired reform initiatives, the market for pharmacies was de-regulated in the mid 1990s and a national system of general practitioners was put in place in 2001. Thus, the hospital reform partly dovetails with other ongoing reforms in the health care.

In Norway, the comprehensiveness of the NPM marketization trajectory is clearly restricted in terms of privatization. Private for-profit hospitals have been viewed with suspicion among a majority of the political parties. Norwegian law imposes tight restrictions on establishing private hospitals (Furuholmen and Magnussen 2000). Even though a certain growth in the number of private hospitals recent years, they still represent less than 3 percent of the total number of hospital beds (Samdata 2003). Both private hospitals and hospitals owned by voluntary organizations can enter contracts with the regional health enterprises, but the newly elected Red-Green government has signaled a more restrictive attitude towards contracting with commercial hospitals. For physician services outside of hospitals, including both specialized and general services, there is a contract-based market. Specialists are private, but they can enter into a contract with the regional health enterprises.

**Denmark**

Denmark has, as Norway, gradually introduced quasi-market instruments. The pace and number of change initiatives accelerated during the 1990s. Arguably, negotiated contracts, performance measurement and free choice of hospitals can be seen as key neo-liberal elements in the Danish style of NPM marketization (Vrangbæk 1999; Vallgård, Krasnik and Vrangbæk 2001; Vrangbæk and Christiansen 2005). The health care reform policies predominantly coincide with general reform principles embedded in the modernizing programs of shifting social democrat and bourgeois governments of the 1980s and 1990s, combining negotiated contracts, global budgeting and decentralizing of responsibility (Ejersbo and Greve 2005).

Contrary to Norway, government payments to hospitals have predominantly been via global budgets, but limited activity-based financing has been introduced in the 1990s based on Danish DRG classifications (Møller Pedersen 2002). From 2007, financing of the new regions will be a combination of central tax-based financing through activity-based payment (approx. 5 percent) and block grants (approx. 75
percent), and municipal tax-based financing (20 percent) through a combination of per capita and activity-based payment (Ministry for the Interior and Health 2005). Thus, the structural reform represents a break with the Danish tradition of having responsibility for ownership and financing at the same political level, but the activity based component in hospital funding will still be modest.

During the 1990s, most Danish counties introduced contracts for their hospitals. The contracts are “soft”, noncompetitive and not legally binding, but they are generally seen as important instruments for engaging in dialogue over targets and achievements (Kragh Jespersen 2001). Principally, the contracts between the counties and the hospitals are following ups of the annual negotiated agreement between central government and the Association of County Councils, establishing an integrated governance system between different tiers of government. As we have seen, the Danish hospitals are still integrated in the county governance structure, and the negotiated contracts can be seen as refinements of regular control instruments, allowing for some flexibility and arm’s length management (Vrangbæk and Christiansen 2005).

As part of the contract arrangement, performance measurements have been set higher on the public agenda, including an initiative on national quality indicators in 2000 and a system of accreditation in 2001. These measurements aim to allow for comparisons between hospitals (Vallgårda, Krasnik and Vrangbæk 2001). In 2000 and 2002, national patient surveys were conducted, supplementing information for patients about expected waiting times and score on quality indicators (Commission on Administrative Structure 2004). Such information constitutes an important condition for patient use of free choice of hospital, introduced as early as 1993 in Denmark (Vrangbæk 1999). The economic incentive to make use of free choice of hospitals has been increased as DRG rates are used instead of low flat rates.

Patient rights’ have also been strengthened through waiting time guarantees since the 1990s. In 2002, the liberal/conservative government issued a general waiting time guarantee of two month, unlike the Act of Patient’s Rights in Norway where the only obligation for hospitals is to set a time limit. Another difference between Norway and Denmark is the Norwegian establishment of regional and local commissions where the patient organizations are represented. Only a few Danish hospitals have established such boards (Commission on Administrative Structure 2004).

Parallel to Norway, private or voluntary hospitals play a minor role in Denmark. Private for-profit hospitals count for less than 1 percent of the total number of beds
(Vallgårda, Krasnik and Vrangbæk 2001). However, the growth in private voluntary health insurance and the inclusion of private for-profit hospitals in waiting time initiatives, give examples of new private involvement in health care sector in Denmark. But no essential political initiatives are taken in conjunction with the new structural reform to stimulate increasing plurality of provision in health care.

**United Kingdom**

Contrary to Norway and Denmark, U.K. has as one of the Anglo-Saxon heartlands of NPM, been perceived as a front-runner on the marketization trajectory. Even if Thatchers’ internal market was closely regulated, so a system of managed or regulated competition was developed, the internal market reform fitted well with the general perception of U.K. as a NPM marketizer - often portrayed in the Anglophone literature (Hood 1996, Kettl 2000, Pollitt and Bouckaert 2004).

Even though economic incentives and competition have been viewed with some suspicion in health care sector, U.K. has over decades introduced a broad range of market or quasi-market instruments. According to Tuohy (1999), Labour Party’s response to the policies of the internal market must be considered to be a move from a strong denunciation of the internal market when in opposition, when in government, adapting most of the model. As we have seen, the Blair government kept the split between purchasers and providers and the contracting arrangement.

However, there are certain reform differences. While the Thatcher government promoted competition between providers for contracts, the Blair government has de-emphasised competition on the supply-side and instead introduced demand-side reforms of more patient choice. Competition for short-term contractual relationships with purchasers is being replaced with longer-term service agreements emphasising collaboration between commissioners and providers instead of market-type competition.

The budget settlement of 2002 was, according to Bevan and Robinson (2004), the catalyst of a more market-style phase of new Labour government reform policies (cf. Secretary of State for Health 2002). The ambition of a more patient-led NHS was launched on the publication of *Delivering the NHS Plan* in April 2002 and made more specific in *The NHS Improvement Plan* (2004) and *Creating a Patient-led NHS – Delivering the NHS Improvement Plan* (2005) – all comprising initiatives to create greater plurality of health care provision, free choice of hospital and a system of payments by results.
The interest of the Blair government in creating NHS Foundation Trusts is closely linked to its wider policy to diversify the ownership of health care providers that deliver publicly funded health care, and in particular to give a more prominent role to private and other independent providers such as voluntary organizations. Compared to Norway and Denmark, private hospitals and clinics play a more significant role in U.K. comprising around 230 independent medical/surgical hospitals (mid-1998; Robinson and Dixon 1999: 65). Proposals in Delivering the NHS Plan include commitments to maximize the use of spare capacity in private hospitals, bring in overseas clinical teams to establish services for the NHS, and develop public-private partnerships to support the rapid development of diagnostic and treatment centres. Until 2005, 32 NHS Treatment centres have been established providing surgery and diagnostic tests for patients.

Free choice of hospital, public or private, is one of the Blair governments’ key initiatives to create a more patient-led NHS. According to the Delivering the NHS Plan: “…the Scandinavian system will be progressively introduced across the NHS in which patients are given information on alternative providers, and are able to switch to hospitals that have shorter waits” (Department of Health 2002: 5). From 2006, all patients requiring elective treatment have been offered the choice among four to five public or nationally procured private providers at the point of referral.

To support patient choice, more comparative information on waiting times and hospital performance is made available for patients (Department of Health 2003, 2005, U.K. Commission for Health Improvement 2003). The performance ratings are based on NPM inspired balance scorecards measuring performance against health care standards set by the Department of Health. Since 2001, NHS Trusts and PCTs have been awarded star ratings, ranging from three stars to the highest performing trusts to zero stars for the worst performing. In 2004, 590 trusts were awarded star ratings, where 146 got the highest performance ratings, while 35 trusts got zero stars (Department of Health 2005). An intervention mechanism is made available through NHS franchising as a way to introduce new management to poorly performing NHS organizations.

Parallel to government initiatives to widen the scope of patient choice, Patient Forums have been created in every trust to provide input into how services are run (Secretary of State for Health 2000). By the 1 December 2003, every NHS trust and PCT in England had set up forums made up of local volunteers. In addition, new patient advocacy and liaison services have been established in every trust as a part of more public and patient involvement in the NHS.
At the core of these new reform policies of the Blair government is “payment by results”, which aims to introduce a case-based payment system in which money follows the patient to promote provider efficiency by DRGs (Department of Health 2002). Taken the first steps in April 2004, hospitals will within the scheme of 2006-2008 be funded at a standard price (estimated national average costs) for cases defined by Healthcare Resource Groups. The new funding system is unlike the internal market where there were price competition and a funding mix involving global budgets with elements of cost-per-case payments.

Taken together, the policies set out by the Blair government include a long list of private sector and market-style instruments underpinning U.K. as a NPM frontrunner on the marketization trajectory even in the health care sector.

4.3 The Centralizing Trajectory

Norway

In Norway, the decentralization and marketization trajectories of health care have been counterbalanced by central government policy change initiatives marked by regionalization of the hospital sector, growing state activism towards the counties and at least, the 2002 hospital reform and the take over of hospitals by the state. In the long run, Norwegian hospitals have developed from being pure local welfare projects, via 30 years of county ownership, to state initiated regionalization and the recent state direction (Grønlie 2004, Opedal and Stigen 2005).

In 1974, Norway was divided into five health regions by the state, and there was a voluntary regional cooperation between the counties up to 1999 when this cooperation was deemed mandatory (Opedal and Stigen 2002). Authorizing of regional health plans by the Ministry of Health allowed the state more hands on control of priorities in the counties.

Growing state activism also found its’ expression by policy change initiatives introducing earmarked grants to county councils in the mid 1980s, waiting time guaranties in 1990 and action plans for heart, cancer and psychiatry in the second half of the 1990s (Hagen 1998, Magnussen et. al. 2006). Central government funding increased
gradually, more than 50 percent of the hospitals’ funding was provided by the central government.

To some extent, the take over of hospitals by the state can be seen as a formalizing of the expanded state responsibility for hospital matters. The 2002 hospital reform provides for decentralized management and delegation of financial responsibility at the same time as the Minister of Health and Care Services, in theory, can instruct the regional health enterprises and overturn board decisions in all cases (Lægreid, Opedal and Stigen 2005a, p. 1036). The managerial autonomy of the health enterprises are constrained by a number of steering devices from the ministry which illustrate the inbuilt ambiguity of the reform when it comes to balancing autonomy and control.

The organization of the health enterprises stipulates in several ways how the owner may exercise control. First, central government appoints the regional board members. Second, the owner exercises control through the Hospital Act, through the articles of association, steering documents (contracts), and through decisions adopted by the enterprise meeting (Opedal 2005). In contrast to the laws regulation of other public sector companies and enterprises, the 2002 Hospital Law specifies more in detail what tasks and issues that have to be approved by the ministry. Third, the state finances most of the hospital activities and the central government thus control by allocating funds to the regional health enterprises. Fourth there is also a formal performance management system, including a letter of allocation specifying tasks and objectives, a formalized steering dialogue and a performance monitoring system – with formal reports on finances and activities to the ministry. Through extensive use of contracts, political leaders are supposed to specify targets and objectives more clearly, and performance is to be controlled by use of quantitative indicators for monitoring results.

The NPM idea of administrative decentralization sets some limits for state ownership. However, regulatory means have been introduced through a more sophisticated performance management system. Indirect control by standard setting and monitoring has been emphasized since the 2002 hospital reform. But in addition, the state possesses – to some extent modernized – command and control policy instruments. This makes the role of state somewhat hybrid. NPM inspired use of contracts, regulation and monitoring has supplemented more traditional command and control instruments.
Denmark

As in Norway, the central government of Denmark has showed increased involvement in the health care sector. According to Vrangbæk and Martinsen (2005), the period of 1970-1991 represented a consolidation of the autonomy of the Danish counties, while the period of 1992 to 2004 was marked by growing state activism.

The annual budget agreements between the state and the Association of Counties have become increasing detailed. This is done by highlighting priority areas like cardiac surgery, cancer treatment and reduction in waiting times and through the establishment of more precise goals and performance indicators. Second, national–level politicians have showed a stronger tendency to interfere via legislation or by exerting pressure on the counties. Examples are the legislation on Free Choice of Hospitals, waiting time guaranties and extended patients’ rights, reducing the counties ability to make their own priorities. Third, the central government has made available earmarked grants to assist the counties in achieving some of the health care targets or to finance additional treatment provided that the hospitals’ activity level reaches certain predetermined levels. And finally, in line with the rise of a regulatory state, a semi-independent Centre for the Evaluation of Hospital Activity was established in 1998. Even if the centre was merged with the Danish Institute for Health Technology Assessment in 2001, it underlines the attention paid by the state towards management through standard setting, measurement and benchmarking.

The structural reform may speed up the pace on the centralizing trajectory in Denmark. First of all, the reform implies centralization of the ownership for hospitals from 14 counties to five regions. Second, the financing of the regions will be mostly central tax-based financing (80 percent), indicating more control at the central level. Finally, the Danish structural reform seems to underpin national standards and monitoring. According to the Agreement on a Structural Reform (p.37), “The regions will have uniform conditions for solutions of tasks within the health care sector”. And so on…“Central health care authorities will be responsible for ensuring systematic follow-up on quality, efficiency and IT application in the health care service based on common standards” (ibid.). In addition, a more pronounced and distinct role of the state finds its expression through the statement of “The National Board of Health will be responsible for providing strong national coordination and improved concentration of the most specialized treatment” (ibid.). Sanctions may be activated if the regions do not
follow the rule of the state. Economic disorder may lead to a situation where the regions being put under administration by the Ministry of the Interior and Health.

Thus, the new structural reform in Denmark may imply rather more state-directed regions. Combined with modest administrative decentralization between the new regions and the hospitals, the Danish structural reform seems to confirm the integrated feature of the Danish health care system as well as it represents a step away from the 30 years long period of a decentralized democratic management structure to a more centralized and state-led health care system.

**United Kingdom**

The centralizing trajectory in United Kingdom can be characterized as a move, at least in principle, from direct command and control, through state control and management of the internal market in the Thatcher era, to a profound belief in performance measurement and regulation after the election of the Blair government.

A strong dose of central control accompanied the internal market (Smee 1995, Ham 1997; Robinson and Dixon 1999). Restrictions on the competition between providers, known as managed market, and limited freedom for the NHS Trusts in financial affairs, stressed the importance of government interventions and responsibility. For example, the reform granted the health minister the power to appoint chief executives of health authorities and hospitals, thereby stripping local governments and professions their influence in this domain. The government also subsequently streamlined and further centralized the NHS’s administrative tiers.

According to Giaimo and Manow (1999), the NHS central executive found itself enmeshed in the day-to-day administrative decisions of health care service. Instead of using the internal market to devolve controversial battles over scarce resources away from ministers and Parliament to managers at lower levels, the administrative changes actually enhanced the control and interference of ministers and managers at the center. Thus, strong countervailing forces accompanied Thatcher’s internal market reform.

Alongside decentralization and reintroduction of market competition, the Blair government has made greater use of central regulation as a way to balance the decentralization and marketization trajectories. At the heart of this development stands a more limited role of the Department of Health centered on setting priorities and promulgating national standards and the establishment of several semi-independent agencies (Ham 2004).
In an early phase, the Blair government started the process of establishing national standards for the NHS through the establishment of National Institute for Clinical Excellence (NICE) in 1999, and it created an independent mechanism for inspecting providers in the form of Commission for Health Improvement (CHI). NHS organizations were required to implement systems of clinical governance to remedy failures in the quality of clinical care (Gray and Harrison 2004).

One of the changes heralded in the *Delivering the NHS Plan* (2002) was the establishment of a new Commission for Healthcare Audit and Inspection (known as Healthcare Commission) merging functions previously carried out by the CHI and the National Care Standards Commission. Other new regulators have supplemented the range of regulative bodies – examples are the National Patients Safety Agency and the National Clinical Assessment Authority. The Independent Regulator of NHS Foundation Trusts (known as Monitor) authorizes NHS Trusts and check that NHS Foundation Trusts treat patients according to the authorizing terms. In addition, the Commission for Social Care Inspection (CSCI), operational in 2004, has inherited some of the tasks carried out by National Care Standards Commission. Contrary to Norway and Denmark, there are a huge amount of semi-independent agencies in U.K. setting standards and make extensive use of performance indicators and star ratings to monitor progress towards numerous targets and standards.

Both *The NHS Plan* (2000) and *Delivering the NHS Plan* can be seen as attempts by the Blair government to move the NHS from a hierarchically managed to a more indirectly regulated health care system. But the previously established contracting system is still in work, suggesting that more direct hierarchical types of control are continued to be used alongside the build up of regulation mechanisms.

### 5 Converging and Diverging Health Care Reforms

The previous sections show that the well-established tax-based and state-centred Beveridge model in Norway, Denmark and U.K. still holds the line, representing a core principle for the formulation of reform policies by policy-makers along different organizational trajectories. The basic model has allowed for choosing reform strategies combining more state and more market pinpointing the close relationship between decentralization and re-centralizing driving forces (Christensen 2000, Saltman et. al.)
In all countries under study, the state-plus-market strategy seems to be more attractive than other, more radical neo-liberal alternatives.

Looking backward, what was seen as a predominantly political correct reform strategy of the 1990s (cf. Altenstetter and Björkman 1997, Ham 1997), scaling back the state and privatization cannot be seen as the guiding stars of recent reform policies in Norway, Denmark and U.K. As in the 1990s, minimizing the role of the state through privatization is looked upon with some suspicion. This has prepared the ground for a seemingly paradoxical reform strategy in all countries under study marching toward more decentralization, marketization and centralization simultaneously.

Within the common Beveridge model, recent reform policies reveal both convergent and divergent features. First of all, while the health care sector in the Scandinavian countries is often labelled as a decentralized NHS-model (Rice and Smith 2002, Hagen and Kaarbøe 2004), the centralizing of ownership seems to move Norway and Denmark closer to the centralized British NHS-model. Most evident is this in Norway, where the takeover-reform by the state of hospitals has changed the former decentralized NHS-model to a semi-centralized NHS-model. In U.K., the centralized model is still kept as a dominant feature of the British model, even if the prospective NHS Foundation Trust reform may affect the traditional public ownership model.

Secondly, Norway, Denmark and U.K. are all following a NPM-inspired decentralization trajectory leaving more autonomy and discretion power to managers of hospitals and other health care institutions. Predominantly, the recent reform policies on this trajectory seem to be echoing the NPM-inspired reform policies of the 1980s and 1990s, giving priority to vertical and horizontal role specialization and managerialism (Hood 1991). However, in U.K. collaboration between purchasers and providers and “joined up” arrangements, for instance the establishment of treatment centres, attracts growing attention (Pollitt and Talbot 2004). In Norway and Denmark the integrated model between purchasers and providers has been kept for a long time.

A third convergent theme is the de-emphasising of competition between providers in U.K. in favour of more emphasis on demand-side reforms like free choice of hospitals. Echoing the Scandinavian attempts of creating a more patient-led health care sector through extended patients’ rights, the Blair government has made decisions that direct U.K. out on the same marketization trajectory as Norway and Denmark. It is an example of cross-national borrowing of health care reforms which in the first place is inspired by NPM ideas of consumer orientation and freedom of choice.
However, the extent of convergence should not be exaggerated. It is not difficult to pinpoint national variations. First of all, the number and comprehensiveness of reform initiatives make a difference between the countries under study. In U.K., there has for decades been a continuous stream of health care reform initiatives surpassing the number of initiatives taken in Norway and Denmark. In Norway and Denmark, around 30 years mark the period between the comprehensive structural reforms of the 1970s and the structural reforms of the 2000s. In U.K., there has been an ongoing “revolution” measured in the number of structural reform proposals adding up to constitute broad reform packages promoted by different political regimes.

Second, there are country-specific differences regarding to what extent the health care reforms can be characterized as “big bang” reforms or incremental adjustments to dominating national reforms paths (Klein 1995, Ham 1997). Both the reforms devised by the Thatcher government in 1991 and by the Norwegian Labour government of Stoltenberg in 2002 must be characterized as state-led big bang reforms driven through in a short period of time and, at least formally, altering basic principles embedded in the former health care system. While the formative character of the Thatcher reform has had an influence on subsequent health care reforms in U.K., the Norwegian hospital reform is still passing through a phase marked by interpretations and adjustments making it difficult to estimate its prospective formative power (Lægreid, Stigen and Opedal 2005a).

In Denmark, the incremental reform strategy is more distinct where the decentralized nature of the health care sector has allowed for more “bottom up” reforms by the counties. Comparing the Norwegian hospital reform and the recent structural reform in Denmark, the Danish one is less radical and more adaptive toward the decentralized and integrated model of health care in Scandinavia. While Denmark to some extent still belongs to the Nordic decentralized health care model, Norway has undertaken a more radical shift compared to the previous county model.

Third, the impact of neo-liberal NPM ideas are more distinct and thoroughly in U.K. than in Norway and Denmark. Both in terms of administrative decentralization, marketization and central regulation, U.K. has entered the NPM train earlier and more rapidly introduced NPM inspired concepts as a way of reforming the NHS-organization. Regarding administrative decentralization the countries separate between modest decentralization in Denmark in terms of internal delegation, external devolution in the
form of health enterprises in Norway, and extensive external decentralization in England through the introduction of self-governing NHS Foundation Trusts.

In addition, U.K. has most aggressively introduced quasi-market mechanisms like star rating systems, payment by results and greater plurality of health care provision adding new layers to the business-like structure of health care sector composed of contracts and the purchaser-provider split. Both Norway and Denmark have been more cautious in introducing rewards and sanctions as parts of a performance management system. Economic incentives to improve performance have to some extent been introduced through activity-based financing, especially in Norway, but still incentives are unfolded to a modest degree in Norway and Denmark. To fulfil the NPM infusion of the British health care sector, the U.K. government has been more inclined than the governments in Norway and Denmark to make use of central regulation and semi-independent agencies as a way to control and improve performance.

6 Discussion

To explain why there are both convergent and divergent patterns, it is necessary to combine environmental features with instrumental features of national health care systems and the historical-institutional context (Christensen and Lægreid 2001). Our observations show how health care reforms in all countries under study are infused by global ideas and concepts, national polity features and certain health care sectoral configurations. Norway, Denmark and U.K. are exposed to the same international “wave” of regulation mechanisms, performance management systems and recipes to expand patient choice, all capable of sweeping over national and sectoral differences – not necessarily in a very deep manner, but certainly wide in its reach. The convergent reform policy patterns between in principle highly different countries underscore the still dominating role of the NPM movement. To some extent, global ideas run over customary distinctions made between neo-liberal Anglo-Saxon countries like the U.K. and the Nordic “social democratic” countries of Norway and Denmark.

Thus, explaining the peculiar mixture of “state and market” requires that we also look beyond the global pressure on countries to converge on the neo-liberal market path. Reaffirming the role of the state as the main facilitator of health care provision, does not necessarily fit well with the “tool box” of the NPM movement. More understanding seems to be given through notions describing Neo-Weberian inspired reform elements
supplementing NPM ideas and concepts. In our cases, it highlights the importance of sectoral institutions and past policies shaping current sectoral reform strategies. The Beverigde health care systems in Norway, Denmark and U.K. seem to represent an “ensemble of opportunities and constraints” that policy makers have to take seriously if their reform policies are to succeed. For instance, the employment of quasi-market forces in health care does not necessarily entail a rollback of the state. Indeed, in all countries under study the states have vigorously intervened in their health care systems, not only as a main actor leading reform processes, but also as a way to consolidate the role of the state in line with strong historical lines in health care. Arguably, the driving forces behind the convergent and hybrid character of health care reform policies are not solely global, sector-specific explanations need to be added.

However, as we have seen divergence reform patterns are also part of our observations. Even though there are important similarities, our three countries have not in all matters converged on a common health care reform path. Features of the existing national politico-administrative regime seem to exert a significant influence over the choice of health care reforms to be adopted. The state structure, the nature of central executive government and the prevailing administrative culture seem all to have effects on which reform ideas get taken up and how vigorously and widely these are adopted. The observations show that U.K. has been much more open to the performance-driven and market-favouring ideas of the NPM than Norway and Denmark. Undoubtedly, Britain’s political institutions – which centralize power in the cabinet, promote party discipline, and expand electoral majorities – allowed both Thatcher and Blair to initiate comprehensive health care reforms. The regimes of Norway and Denmark seem to blunt the sharper corners of the NPM, leading to a more cautious approach to NPM and a less rapid style of adopting reforms than prevailed in the U.K.

In addition, the more individualistic and risk-accepting culture in U.K. seems to allow the more vigorous use of devices like star-rating systems and payment by results. While such devices seem to be compatible with current dominant norms and ideas in U.K., they have so far been rejected in the more consensualist and collectivistic regimes of Norway and Denmark. This pattern fits well with the expectation that health care reform policies will be developed rather slowly, and modifies reluctantly because of a lack of compatibility in norms and values (Brunsson and Olsen 1993).

Thus far our theoretical expectations have been largely confirmed. What our chosen theories do not so well account for, however, are certain observable differences
in recent health care reform policies in Norway and Denmark. As we have seen, the Norwegian hospital reform represents a more evident break with the Scandinavian decentralized path in health care than the recent structural reform initiative in Denmark. They separate on structural reform even though Norway and Denmark share a lot of similarities in relation to global pressure for health care reform, national politico-administrative system and dominating historical paths in health care.

The driving forces behind the different choice of structural reforms in Norway and Denmark seem to underline the importance of environmental factors and how they interplay with the political climate and available policy solutions. In Norway, growing tensions between the regional county level and central authorities provoked a long range of interventions by the state, hollowing out the responsibility of the counties (Hagen and Kaarbøe 2005, Stigen 2005). The result was a Black Mans game over the responsibility for growing hospital deficits, waiting lists and geographical inequalities. The minority Labour government that came into power in March 2000 provided an opportunity for breaking the noisy decentralized path. Eager to modernize the public sector, the Labour government launched an ambitious modernization program. By claiming full and complete responsibility for all specialist health care the state hoped to block the blaming game between the central government and the counties.

In Denmark, the central government has as in Norway showed an increased involvement in health care services provided by the counties. But contrary to Norway, the interventions have not triggered a take-over reform of hospitals by central government. A less radical reform in Denmark seems to be due to the lack of evidence for failure and breakdown in health care services provided by the counties and a stronger position of the counties and the decentralized and integrated health care system (cf. Vrangbæk and Christiansen 2005). The underlying factors for prompting structural reform at all are linked to the shift to a conservative/liberal government in November 2002 and the importation of international ideas. Both the structural reform in Denmark and the hospital reform in Norway show how international and sectoral environmental factors constitute driving forces for health care reform.

Summing up, both the convergence thesis and the divergence thesis receive support comparing recent reform policies in Norway, Denmark and U.K. While the detail of reform is specific to individual countries, a number of common themes emerge. NPM still plays an important role as a dominating tool box inspiring reform policies in all the countries under study although with U.K. as a NPM frontrunner while Norway,
and especially Denmark, follow in a more reluctant manner. But it seems inappropriate to see national health care reform policies merely as NPM layers. Neo-Weberian reform elements infuse the national reform policies as well, making the health care reform policies of Norway, Denmark and U.K. to a more complex and hybrid mixture than the NPM reform prescriptions. Rather than portraying policy-makers in health care sector as laggards or faint-hearts, slow to climb aboard the NPM train, it makes more sense to see them as advocates of a peculiar mix of NPM and Neo-Weberian ideas and concepts composed to fit the basic features of the Beveridge model in health care.

The complex patterns of simultaneous convergence and divergence in health care policies point toward several opportunities for further research. International convergence theories have already received a good deal of academic attention, and this study is not the first that pinpoint the importance of national polity features and historical paths. Nevertheless, there is a shortage of works combining a meso-level analysis of health care as a task with macro-level analysis of national polity systems and administrative cultures. Our comparative study indicates a complex interplay between global ideas, national polity features and meso-level features like health care systems and path dependencies – all influencing the composition of national health care reform policies. They create contexts in which meso-level reforms have to be understood. So far, the theoretical maps of these complex interactions seem to be seriously incomplete.

Another question for further research is how the balance between central government control, managerial autonomy and quasi-market mechanisms work out in practice. U.K. has been more eager than Norway and Denmark to reform along the decentralization and marketization trajectories, but U.K. has also been more anxious to introduce central regulation mechanisms and control through performance management systems. Thus, the significance of central control mechanisms in U.K. makes it difficult to conclude that Britain has a highly more decentralized health care system than in Norway and Denmark. The presence of strongly countervailing forces in all countries under study indicate a wide spread search for an optimal and stable trade-off between central control, decentralization and marketization in health care systems.

However, the balance between control, autonomy and market is not only the result of different national reform policies. The balance is also affected by environmental factors and political and institutional norms and values. In Norway, the hospital reform has strengthened the involvement and influence of the Parliament in hospital matters even though the reform should promote delegation of authority,
discretion for managers and limited involvement of politicians (Opedal and Rommetvedt 2005). Also in Denmark, the Parliament has shown an increased interest in health care matters while in U.K. a steady stream of questions in Parliament represent a strong centralizing force (Christensen 2000, Ham 2004). Such centralizing forces driven by the logic of politics challenge the formal design of state-plus-market models in health care and make it even more intriguing to analyze the implications of health care reform policies for the roles of politicians, patients and professionals.

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