The current issue and full text archive of this journal is available at
www.emeraldinsight.com/1477-7266.htm

The end of the decentralised model of healthcare governance?

Comparing developments in the Scandinavian hospital sectors

Haldor Byrkjeflot and Simon Neby

University of Bergen and the The Stein Rokkan Centre for Social Science Studies, Bergen, Norway

Abstract

Purpose – This paper aims to discuss recent contributions to comparative healthcare systems research, which emphasise decentralisation as a major characteristic of Scandinavian hospital systems. Whether the idea of such a "decentralised Scandinavian model" is appropriate and useful, how and why it was created, and what the alternative is, are central questions approached through a perspective gathered from historical institutionalism.

Design/methodology/approach – The paper employs an analysis of primary and secondary sources on the history of Scandinavian hospital systems, a classification based on historical developments, and an explanatory framework based on historical institutionalism.

Findings – The paper concludes that the idea of a decentralised Scandinavian model for hospital systems has had limited validity, constrained to the years 1970-2000. Historical trajectories and recent developments both indicate that the three systems are more different than commonly assumed, and that recently they seem to be moving in separate directions. The explanation for the developments is found in incremental dynamics, creating institutional change that to a large extent depends on national contexts.

Originality/value – The paper contributes to the current discussion and research relating to classification of health care systems, and aims at developing a more elaborate understanding of the role of the hospital sectors within the Scandinavian welfare states. It challenges the idea that a single model can capture the essence of such diverse systems, and proposes an alternative to such modelling, based on a historical-institutional approach.

Keywords Public sector reform, Hospitals, Health services, Scandinavia

Paper type Research paper

Introduction

The Scandinavian countries have recently, in different ways, engaged in reform schemes involving hospitals. Norway centralised control and ownership of all hospitals from the counties to the national government through a large-scale reform in January 2002. In Denmark, structural reform is under implementation (as of 2007), changing the layout of both healthcare and the public sector in general (Strukturkommissionen, 2004). The reform replaces counties with regions and centralises funding. In Sweden, a government commission recommends a state more involved in governance and less in making structural changes (Jonsson *et al.*, 2006, pp. 88-9) and merging counties into regions. There is broad political support for reform, and the current government aims to implement changes some time between 2010 and 2014.

Journal of Health Organization and Management
Vol. 22 No. 4, 2008
pp. 331-349
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777260810893944

The Scandinavian hospital sectors are usually described as variants of the National Health System in the UK, but are typically classified as decentralised compared with the centralised UK system (European Observatory, 2001a, b, 2006; Blank and Bureau, 2004; Vrangbæk and Christiansen, 2005; Haave, 2006; Grønlie, 2006). Funding and provision of health care has rested on local and regional governments, rather than on the central state. The claims are that the Scandinavian systems have become more similar over time, a convergence that is often explained through the observation that the countries historically have been inspired by each other – particularly that Sweden was a role model for the other two between 1945 and the 1970s (Grøndahl and Grønlie, 2004). Such comments and classifications influence our perception of particular events and developments, focusing on similar development patterns among systems that share characteristics. However, significant changes may also occur within the framework of a particular family of healthcare systems.

Our task is to account, first, for the various developments leading to the commonly applied notion of a Scandinavian decentralised model. We argue that this idea is inaccurate at present, as there have been signs of considerable divergence among the three systems during recent years. Second, we discuss why the model seems to be breaking up, and propose an explanation furthering the argument that developments over time are aggregated and combined, in turn causing changes that are unique to each country. These two aspects are assessed through a complimentary theoretical strategy (Roness, 1997, pp. 89-114) with both classificatory and explanatory ambitions. The classificatory task has been to identify dimensions of decentralisation and development dynamics, through a closer reading of primary and secondary sources on the history of the respective hospital systems. The idea is to map changes and make comparisons along the centralisation/decentralisation axis over time and across countries (Table I). Consequently, we have arrived at three distinct periods with differing characteristics:

(1) *The making of the decentralised model (before 1970)*. Political decentralisation characterised all three countries. In Sweden counties were the major public institutions; in Norway and Denmark, municipalities. The state and the counties incrementally became involved with hospitals, and funding gradually became a matter of public sector economy. Administratively, decentralisation marked all countries.

(2) *The heyday of the decentralised model (1970-early 2000s)*. Large and numerous reform initiatives indicate a more politicised sector and a consolidation of hospitals as a public responsibility. In spite of similarities, the timing and sequencing of reforms differed. Funding, political decision-making and administration were placed with the counties.

(3) *Challenging the decentralised model (after 2000)*. The three countries differ as new reforms are introduced – they no longer follow in one another's footsteps. Recent developments undermine the institutions that constituted decentralisation; Norway and Denmark are arguably becoming more centralised.

The explanatory argument is that the Scandinavian decentralised model was actually institutionalised differently in each country, and consequently that present challenges trigger differing responses. This current divergent development pattern may be

Table I.
Classification: degrees of political, economic and administrative decentralisation in Scandinavian hospital systems

	Decentralisation/ centralisation	Norway		Sweden		Denmark	
Before 1970	Political	Decentralised	Hospitals developed, governed locally	Decentralised	Counties central since 1862	Decentralised	Hospitals developed, governed locally
	Economic	Decentralised		Decentralised		Decentralised	
	Administrative	Decentralised		Decentralised		Decentralised	
1970-2000	Political	Decentralised	Counties central unit, regional coordination	Decentralised	Counties central unit, regional planning	Decentralised	Counties central unit, weak regionalism
	Economic	Centralised		Decentralised		Decentralised	
	Administrative	Decentralised		Decentralised		Decentralised	
After 2000	Political	Centralised	State hospital ownership, hospital enterprises	Decentralised	Counties central unit, regionalisation	Partly decentralised	Counties replaced with regions
	Economic	Centralised		Decentralised		Centralised	
	Administrative	Partly decentralised		Decentralised		Partly decentralised	

explained by employing aggregated long-, medium- and short-term perspectives (see Table II).

Classification: decentralisation and centralisation

Decentralisation is a multidimensional concept. Our analysis rests on three key dimensions:

(1) political decentralisation;

(2) administrative decentralisation; and

(3) economic decentralisation (Pollitt, 2005; Saltman *et al.*, 2007).

Political decentralisation policies devolve political authority or electoral capacities to sub-national actors, delegating power to autonomous public organisations and empowering them to make decisions based on legitimate political procedures. Administrative decentralisation transfers administration and delivery of services to sub-national organisational units. Operational institutions and service providers fall within this category. Economic decentralisation refers to policies designed to increase the fiscal autonomy of sub-national levels. Economic decentralisation is often rooted in fiscal federalism, which argues that where tax is collected locally, decentralised solutions will lead to increased welfare by allowing local authorities to adapt to local preferences and cost structures (Oates, 1999).

These dimensions are both empirically and analytically hard to separate; it is not always clear whether a change concerns one or the other. For instance, purchaser/provider models may refer to both economic and administrative decentralisation: whereas economic decentralisation lies with market simulations, the administrative dimension rests with the organisational roles that accompany such models. Moreover, different dimensions are likely to combine, producing effects that policymakers are not necessarily aiming at. In analytical terms, the three dimensions of decentralisation have been allowed to combine, intersect, diverge and converge in order to constitute different situations for each system. Also, it is not sufficient to focus on the domain of formal politics and reforms in order to understand processes of decentralisation and centralisation. It is necessary to take into account the established patterns of cooperation, competition and conflict within a given sector or organisation field (Pierre, 2001; Borum, 2005). Table I roughly outlines the combination of these variables for each country, along the suggested periodisation.

Explanation: historical institutionalism

Historical institutionalism is a research tradition concerned with how institutional frameworks constrain actors in the adoption and development of organisational solutions and ideas. Issues of long-term institutional development and institutional origins are central (Thelen and Steinmo, 1992; Guillén, 1994; Immergut, 1992). Originally, attention was directed towards critical junctures and path dependencies. An important assumption was that institutions build upon historical experiences, and that policy-making and institutional developments follow distinct patterns. At certain points in time, for example when a critical juncture occurs, a window opens for adopting system-transforming models. Gradually, more emphasis has been put on the role of ideas in change processes, particularly as such ideas are translated from one setting to the other (Campbell, 2004).

Table II.
Long-, mid- and short-term explanations for current mix between decentralised and centralised aspects of healthcare systems in Nordic countries

	Norway	Denmark	Sweden
Long-term explanation Since 1860s	Localism and voluntarism, centre-periphery conflicts, counties do not set their own tax rates	Localism, centre-periphery conflicts less important, counties collect taxes and set tax rates	Early county orientation, early conciliating mechanisms, counties collect taxes and set tax rates
Mid-term explanation 1970-2001	Layering of reforms 1990-2001 important; implementation of activity-based funding (ABF) and free choice undermine counties' legitimacy Drift towards centralisation	Layering of reforms; low emphasis on ABF, but free choice of hospitals. Counties keep legitimacy, develop conciliatory mechanisms Drift towards centralisation with intermediate democratic institution	Layering; experiments with market structures within counties. County institution less contested due to flexibility in reforms Drift towards decentralisation and centralisation
Short-term 2000-present	Enterprise reform 2002 continue tradition of layering and exacerbates drift towards a centralised model for healthcare governance	Structural reform means that counties are replaced and that there is a drift towards a modified centralised model	Emphasis on centralisation in current debate on healthcare reform, most likely outcome a modification of the Swedish decentralised model

There is interplay between such long-term institutional development patterns and the more intermediate dynamics of layering, drift, replacement, and translation (Thelen, 2004; Hacker, 2004; Streeck and Thelen, 2005; Béland, 2007, Czarniawska and Sevon, 1996). More precisely, layering refers to processes where new institutions are placed on top of the old; older institutions are not abandoned. New institutions may be introduced to avoid the more politically sensitive option of dismantling existing ones. Unintended effects are likely, however. Drift refers to failure in adapting existing institutions to address new problems. Often considered an apolitical process, drift may well be politically mediated: policy-makers may, for example, see that the legitimacy of counties is undermined by an increasingly interventionist state, but accept this development instead of intervening in favour of counties in order to improve the reputation and power. Replacement denotes the establishment of new institutions and the abolishment of old ones. Hence, a redistribution of tasks and roles occurs and changes the institutional outline of the system. Finally, there is translation: any idea, concept or program has to be translated and interpreted by the actors involved as it is set in motion in a new context. Ideological schemes, such as new public management, have to be adjusted to make a fit with local circumstances (Czarniawska and Sevon, 1996).

Our framework takes into account changes that follow an evolutionary and incremental pattern, as well as those that come as consequences of large-scale reform. Accordingly, our questions are interrelated: firstly, what were the particular developments and dynamics that served as foundations for the idea of a decentralised Scandinavian model of health care? And secondly, what are the conditions and mechanisms that create dynamics leading to divergent arrangements in the three countries, consequently challenging the decentralised model?

Before 1970: the making of the decentralised model

The three countries' hospital systems developed differently in the period before 1970, mainly through local initiatives of various kinds (see Table I). Although there are parallel trajectories, these do not appear to be similarly created or even products of similar dynamics. The historical development is one of incremental change and differing problem formulations; actors coexisted in cooperation and conflict with each other without particularly clear political mandates, administrative tasks or economic responsibilities – with the partial exception of Sweden.

The idea that decentralisation requires a centrally established decentralising policy cannot be sustained by an analysis of the Norwegian development in the late 1800s and early 1900s. Most hospitals were established and run by amalgamations of voluntary associations, firms, municipalities and counties. The state neither had the mandate nor the capacity to control these hospitals. Consequently they were rather autonomous actors embedded in a local habitat. Voluntary associations, such as the Norwegian Women's Public Health Organisation, were among the prime movers, albeit together with municipalities and counties (Hamran, 2007). The term "welfare localism" has been used to describe this system, and it has been argued that the changes that came in the 1970s were an interlude between localism and an extended role for the central state (Byrkjeflot and Grønlie, 2005; Grønlie, 2006). The main task of governments before the 1970s was to provide funding for the expanding hospital field, rather than influencing the layout of the system in any fundamental way. An important precondition for this

was the introduction in 1909 of a sickness insurance scheme that covered a portion of patient fees for hospitalisation. Significant growth in the number and sizes of hospitals occurred, showing how the insurance scheme led to an expansion without altering the institutional framing of the hospitals (Bjørnson and Haavet, 1994; Angell, 2007).

Norway's history connects to the unions with both Denmark and Sweden. The union with Denmark lasted until 1814, and the structures developed in Denmark were reflected in Norway: for example, the early development of a medical bureaucracy in Denmark; the Collegium Medicinum of 1740 led to the medical board Sundhedskollegiet of 1803 – with a Norwegian branch established in 1809. A medical bureaucracy was based on this heritage, particularly visible in the mid-1900s when the medical profession came to play an important role. Interestingly, Karl Evang, long-term Director of the powerful Medical Board in Norway, stated as late as in 1970 that the decentralised approach was a consequence of "the bitter experience that the state is not suited to actually run hospitals" (Nordby, 1989, p. 254). Notably, the local orientation of the hospital system was also visible in financial schemes – central state block grants, for instance, were not introduced for financing hospitals until the 1960s.

Sweden, by contrast, displays a larger degree of formally orchestrated political decentralisation. Healthcare provision has been a public responsibility more or less since the seventeenth century, when towns and cities started employing physicians. As the counties were established in 1862, acute care somatic hospitals were introduced as a county responsibility (Gustafsson, 1987). In 1864 the Swedish parliament introduced a standard for hospital boards that became a norm, implemented throughout the country in 1865 (Axelsson, 2000, p. 48). The counties' responsibility for providing general hospital care was extended and formalised through the 1928 Hospital Act – respectively 28 and 40 years prior to corresponding Danish and Norwegian legislation. Popular movements and voluntary organisations did mobilise, but to a less influential extent than in Norway (Ito, 1980, p. 48; Therborn, 1989). After the Second World War the first steps towards universal coverage were taken, through the 1946 National Health Insurance Act. The act was contested and was not implemented until 1955, due to a desire for consensus on funding issues (Immergut, 1992). Scandinavian healthcare has generally been described as hospital-centred, in Sweden more so than its neighbours (Ito, 1980, p. 56; Berg, 1980, p. 31; Erichsen, 1995, p. 105). This emphasis on hospitals followed from the early development of central planning in this area (Anderson, 1972). Regions were established in the 1960s, an administrative solution that was not seen in Norway until the mid-1970s.

In Denmark hospitals also emerged as local projects. In contrast to Norway, Denmark is a country of communities in close vicinity to each other. As in Norway, there was an impetus for each community to build and keep its own hospital, but this strategy was less legitimate and realistic, and the centre-periphery conflicts relating to hospital development were for this reason less bitter in Denmark (Borum, 2005; Vallgårda, 1992). In the early 1930s ideas about specialisation and centralisation gained momentum and challenged the established local hospital model. County politicians welcomed specialisation, whereas parts of the medical profession preferred patient-centred holistic models (Vallgårda, 1992, p. 391). Medical specialisation and welfare expansion continued at accelerated speed after the Second World War, leading to a further weakening of movements that favoured local hospitals and the

strengthening of counties as units for making plans for further consolidation of hospital development.

The Hospital Law of 1946 dealt mainly with financial issues (Frandsen, 1963). The established system had been a mixed affair of real estate taxation, fee-for-service, and even charities and donations. Health insurance schemes established by labour unions, farmer's cooperatives and other associations partly substituted fee-for-service payments (European Observatory on Health Care Systems, 2001a), but tax-based financing was predominant. From the 1930s onwards state contributions to the running expenses of hospitals increased, culminating in the 1960s with a share of 60 per cent of these costs (Haave, 2006, p. 221). These and other efforts to arrive at a more specialised and centralised hospital system did not challenge the prevailing institutional set-up, which similar efforts had done in Norway. Whereas Karl Evang talked on behalf of the state when he reported having had bitter experiences with his efforts to centralise hospitals, Johannes Frandsen, the Danish Health Director expressed his experience in a slightly more solemn and different way when he said that "it has been worked on a county basis – in order to preserve the decentralised order" (Frandsen, 1963, p. 72).

1970s-early 2000s: the heydays of the decentralised model

Entering the 1970s, all three countries reached a turning point as they engaged in local government reforms that directly concerned hospitals. In spite of significant variation, this period displays many of the characteristics of an ideal-typical Scandinavian decentralised model: public services, tax-based funding, and county governments were important (see Table I). After only a few years, however, the decentralised model started to become overburdened with political demands for expansion, equalisation and standardisation.

If politics means debate and contestation, the healthcare system in Norway was increasingly politicised between 1970 and 2002. Conflicts among professions, districts, administrators and politicians, and between local and central health authorities, were repeatedly aired in the media. Terms such as "rematch" and "scape-goating" were often deployed to describe the situation. In 1969, before introducing the 1970 Hospital Act, the Norwegian parliament had its first general debate concerning the hospital system, which marked the start of long-lasting political contest: in the 1980s health politics became a frequent issue in parliament as well as in election campaigns. Policy claims were that the period of institution-building was over; it was now time to develop a fair distribution of resources (Sosialdepartmentet, 1976). A stratum of professional health administrators emerged, although both politicians and administrators were amateurs in comparison to the physicians who were running hospital departments and clinical disciplines (Berg, 1997). As a result of the local government reforms, the county councils were democratically elected from 1975. With hospitals tied to the counties, limitations applied to state intervention, despite mandatory central approval of plans. Illustratively, in the scarcely populated county of Sogn og Fjordane, a glaring conflict between central and local politicians ended with a compromise in which both national and local aims were met: while the state wanted a central hospital but closure of several local hospitals, local politicians opted in favour of the existing structure. In the end, a new central hospital was added to the existing structure.

The 1970 Hospital Act established the state as the main provider of funding in Norway, and in the coming years the increasingly oil-rich country channelled rising revenues into the health sector. A given share of taxes was allocated to the counties, who could not set their own tax rates and thus depended on the state. The political responsibility for service provision was placed with the counties, however, creating an incongruity between government as provider of funds and the political leadership at the county level. This discrepancy contributed to the many conflicts around hospitals in Norway during the 1980s and the 1990s. The health regions were first set up in 1975; in 1999 they became mandatory instruments for planning, partly in response to coordination, equity and quality challenges (Hansen, 2001).

A range of experts and patient representatives started demanding transparency, quality control and free choice of providers. Waiting list guarantees were introduced in 1990 and patient choice in 1997; patient rights acts in 2001 and 2004. Norway started experiments with activity-based financing with a portion of funds allocated through the DRG system in 1991, which soon caught political interest. In 1997 a new national financing system was implemented, with a DRG share of 30 per cent, gradually increasing to 60 per cent (Torjesen and Byrkjeflot, 2007). The DRG share has since been subject to political negotiation at the national level, and has had an important centralising effect. Interestingly, instead of purchaser-provider models, as used in Sweden, there has been a focus on different kinds of accountability and organisational roles: hospitals used to be relatively autonomous, and now a movement towards external and organizational control of hospitals occurred.

In Sweden, the 1969 local government reform by 1974 drastically reduced the number of municipalities. Broad plans were presented and targets were set at the central level, but left for the counties to pursue. Apart from the local government reform and the "Seven Crown reform", which underlined universalism by reducing and standardising patient fees, most reforms in this period came with the 1980s. From then on, the trend of political decentralisation may have been further accentuated: the 1982 Health Care Act consolidated the planning, operation and financing of health care services at the county level, and cost containment became increasingly important as Sweden experienced an economic slump (Møller Pedersen, 2002). The decentralised orientation was not challenged by the 1988 establishment of planning regions for highly specialised care, which added tasks to the system already established in the 1960s, in order to improve counties' abilities to provide cost-efficient services through cooperation. Another indication of political responsibilities being delegated is the 1992 Ädel reform, which transferred long-term inpatient care and social services for the elderly and disabled from the counties to the municipalities. Subsequent changes in the following years actually transformed about 30 per cent of hospital beds into municipal nursing home beds (Andersson and Kalberg, 2000).

The Swedish county orientation differs from the Norwegian solution, as economic and administrative reforms were closely related. First, the Swedish counties' revenues came from local taxation and a variety of other sources, and not only from the central state. In 1970 the counties took over outpatient services and became reimbursed by the national insurance, in order to reduce patient fees and make healthcare more accessible (Anell and Claesson, 1995). There were few constraints on the counties' dispositions. Second, counties reimbursed hospitals; in 1998, about 62 per cent of county expenditures were spent on specialised healthcare and another 10 per cent on

psychiatry (European Observatory on Health Care Systems, 2001b, p. 72). Resource allocation principles varied significantly: in the 1990s, internal markets were introduced in several counties, including the purchaser/provider split, DRG-based reimbursements, and extended patient choice (European Observatory on Health Care Systems, 2005, p. 50). In some counties health districts became purchasing bodies; elsewhere, the purchasing body was the county itself. In counties where purchaser/provider models were not introduced, health districts were established with autonomous financing responsibilities and global budgets. Long waiting lists gradually became a national concern and additional funds were allocated to lessen the problem, but the actual problem was left for the counties to solve. In 1998, counties started taking over the economic responsibilities for medicine from the National Health Insurance.

Danish reform initiatives during the period 1970-2000 period were also oriented towards the regional political level. Although towns and counties had been responsible for hospitals since the eighteenth century, the counties did not formally gain this responsibility until 1970. Just as in Sweden and Norway, this was connected to a larger restructuring of local government. These reforms may in part be understood as a consolidation of a long tradition for decentralised healthcare, closely linked with local and regional governance and democracy (Vrangbæk and Christiansen, 2005). Healthcare in general became more politicised, although this did not imply more direct central governance (Jacobsen and Larsen, 2007). This means that there mainly was correspondence between economic, administrative and political responsibilities at the county level in the 1970s and 1980s. The "blame-games" taking place between central and local levels in Norway was less important in Denmark.

The 1970 local government reform replaced specific subsidies from the state with general block grants and county taxation (Vrangbæk and Christiansen, 2005, p. 35). Because the block grants were based on objective criteria, the county councils became responsible for both delivery and financing of hospital services. In 2002, however, the state block grants only accounted for about 17 per cent of the counties' healthcare expenditure (Møller Pedersen, 2005, p. 43). A system of "soft" contracts based on negotiations became important: in a hybrid solution, management by objectives was set into a scheme loosely resembling purchaser and provider roles – notably between the counties and the hospitals (Jespersen, 2001). In practice, the purchaser/provider model's reliance on transaction was replaced with negotiation – another indication that politics, economy and administration overlapped. Activity-based financing schemes were introduced only to a limited extent, although there were experiments with the DRG-based system – for cross-county, free-choice patients – following patient rights legislation and waiting list guarantees in the 1990s. At the central level, there were mainly regulatory, advisory and coordinative bodies and agencies (Vrangbæk and Christiansen, 2005) – all main responsibilities rested with the counties. Expenditure control has been an important aim for Denmark because the country has encountered several economic downturns, putting pressure on welfare expenditure (Møller Pedersen, 2005). Global budgeting has proved relatively effective in this respect.

Recent initiatives: challenging the decentralized model?

In spite of several similarities after the 1970s, the actual trajectories of change differ distinctively during this period. The three countries are currently diverging: Norway

and Denmark are becoming more centralised, whereas the Swedish counties still remain as strongholds of the decentralised model (see Table I).

Particularly, the 2002 Norwegian hospital reform signalled a major step away from the decentralised model. The state now owns the hospitals, through a system of regional and local health enterprises; the regional enterprises are geographically based on the regions established in 1975. These enterprises are led through a system of boards and executives, and in turn own the local enterprises – which more or less are comprised of actual hospitals. The idea has been to create administratively autonomous hospital organisations, aiming at incentives for hospitals to improve in terms of quality, efficiency, reputation and trust with the public. Equally important, the counties have been formally excluded from governing the sector, suggesting a "corporatisation" of Norwegian hospitals. The central government formally manages the regional health enterprises through what is called "the enterprise meeting" (in practice a handover of ministerial instructions), and through letters of instruction. Recently, these documents have increased substantially in size and scope. The drift towards political, administrative and economic centralisation observed in the previous period seems to continue (Byrkjeflot and Gulbrandsøy, 2006).

Health policy issues are hotly debated and national politicians intervene in relatively detailed matters – through parliamentary politics or ownership. Civil society still plays an active political role: as counties are excluded, civil movements channel local points of view towards central actors by means of the party system, lobbyism or the media. A consequence is that matters supposed to be handled autonomously by the enterprises often become tense national political issues. This also poses the risk that regional and local managers might be constrained from exercising the autonomous role prescribed for them in the reform documents. Politicians were reintroduced as board members of enterprises in 2006, but through appointment rather than election, accountable to the owner as other board members. Practically all financing comes from the central government, in spite of quasi-markets including patient choice and the DRG system. Just as before 2002, the DRG component of reimbursement is subject to top-level political negotiation.

Denmark has been implementing a swiftly introduced structural reform that aims at the regionalisation of healthcare and hospital services. Regions replace counties and municipalities are merged. Tasks are redistributed between the state, regions and municipalities; the regions' principal tasks concern healthcare. The most prominent argument for regionalisation is connected to the advantages of scale: larger regions mean larger numbers of inhabitants and patients per region, facilitating better coordination and higher quality (Indenrigs- og Sundhedsministeriet, 2004, p. 35). This also means that the economic arrangements change: the three principal sources of finance will be block grants (about 75 per cent), activity-based funding and various municipal reimbursements (expected to amount to about 12 per cent of regional expenses). These elements replace the tax income generated by counties, as earmarked taxes for healthcare will be redistributed to regions and municipalities by the state (Indenrigs- og Sundhedsministeriet, 2004, pp. 21-2) – which contributes to a significant economic centralisation. This creates a situation more like that in Norway, where regional enterprises cannot levy their own taxes and thus depend on state financing. As opposed to the regional Norwegian enterprises, however, the Danish regions are formal democratic institutions – although their capacity for autonomous political

action is uncertain. The reforms illustrate how political entrepreneurship and individual actors may, under certain circumstances, play a role in shaping and implementing large-scale changes (Bundgaard and Vrangbæk, 2007; Byrkjeflot, 2005).

Sweden has yet to implement resembling reforms. However, there is political will to engage in reform schemes aimed at the county/regional level (Socialstyrelsen, 2006), and recommendations stress a more standardised scheme for organising and operating the public sector. The idea is to avoid fragmentation and problematic definitions of roles and responsibilities. Similar to the overall ideas in Denmark, which are grounded in the economics and advantage of scale, suggestions include larger regions replacing counties. These regions are to be democratically governed, but a more active role is prescribed for the central level. There is a paradox to the Swedish reform scheme: whereas the regions are to be relatively autonomous in both economic and political terms, central initiative is to be more active and direct. Such an idea is not new to Sweden, however (Engel, 1968; Anderson, 1972). Although regions might replace counties, the main ambition, so far, has not been to introduce a new mode of centralised governance. Simply put, the idea is to improve the decentralised model – with more engagement from the central political level.

Explaining the break-up of the decentralised model

The characteristics shared by the three systems in the period from the early 1970s to the early 2000s indicate that those who have portrayed a particular Scandinavian decentralised model of healthcare governance were right in many respects. Most political, administrative and economic capacities during this period were indeed delegated to the county level in all three countries. Even so, this period displays considerable differences, for example in the mix of different decision-making capacities at the central and regional level and in the financial schemes (Bjorkman, 1985; Saltman *et al.*, 2007). The early 2000s also display reform plans and processes pointing in different directions: Norway is becoming a politically and economically centralised system, Denmark moves in the direction of economic centralisation, whereas Sweden currently stays with a county-oriented solution. In explaining this situation the interplay of different long-, mid- and short-term factors should be taken into account (see Table II).

Angell (2007) argues that long-term historical trajectories may explain differences between Norway and Sweden. County assemblies took part in governance of hospitals in the 1860s. Counties set their own taxes, and conciliating mechanisms – for example the "remiss" system and parliamentary committees dealing with diverse interests (Immergut, 1992) – were developed early on. These mechanisms were activated throughout the slow-moving reform processes that have characterised Swedish hospital systems in the post-war era, and a negotiated, consensus-oriented political culture developed. The general political institutional framework was stable, but nevertheless provided manoeuvrability for actors involved with hospitals. Saltman and Bergman (2005, p. 254) argue that "Core social values tied to national culture play an essential role both in defining the structure of existing health care institutions and the range of feasible policy options". Long-term factors such as values of equality, security and decentralisation became particularly visible during the 1990s, when new public management-style arrangements were encouraged. Even so, these arrangements were left to sub-central actors to pursue. With the introduction of the

purchaser/provider split, the traditional role of the Swedish counties could have been challenged, but was not; many of the counties easily adapted, others undertook no change whatsoever. Although quite a few counties introduced organisational models inspired by a neo-liberal philosophy, the overall institutional structures of the system remained.

Norway developed such mechanisms for cooperation and negotiation to a lesser extent, due to the tradition for centre-periphery conflicts and tension between different governmental bodies. In the 1990s, the tense relationship between central and local actors gave the Social Democratic government an opportunity to introduce financial reforms, free choice of hospitals, as well as the 2002 hospital reform. The government argued that because the problems in this sector were of such magnitude, there was no time to make plans for an integrated regional reform that also included other public sector functions. Although the 2002 reform formally removed counties from hospital governance, Norwegian counties still exist. County politicians continue to engage in healthcare matters, despite the lack of formal influence; there are even indications that county politicians now are more visible in the media than before (Johnson and Byrkjeflot, 2006). Although the health enterprises signalled a formal break with the past, they were indeed layered on top of the existing system, i.e. the counties, which continue to produce conflict and tension.

Rico and Leon (2005) also advance a political culture argument, i.e. that a strong liberal tradition in Danish society and politics was reflected in a model of devolution and strong local self-rule. The present establishment of the new regions also reflects this, for they differ distinctly from the Norwegian solution in that they are politically governed and replace the counties as the regional politico-administrative level. This replacement follows the Danish tradition for keeping decisions close to the population, but still has centralising effects. First, the financing of hospitals now mainly comes from the central government, with a smaller share of co-payments made by the municipalities. Second, the solution that was introduced relies on much larger organisational entities, both in the geographic and demographic sense. Local communities now have less influence over hospital matters.

For the Danish case, Jespersen (2001) has argued that the counties' heyday was actually limited to the 1970s, as economic restrictions and central initiatives have since then constrained the counties' possibilities for making autonomous priorities. Møller Pedersen (2006) points to similar constraints in an argument gathered from fiscal federalism, stating that it is necessary to place decision-making and fiscal responsibilities at the same level in order to avoid a blame-game situation. Both activity-based financing and free choice of provider could easily turn into a destabilising feature. The DRG system and free choice have an affinity to each other, since free choice of provider requires a diagnosis-based or fee-for-service reimbursement system. An unintended, potential side effect of patient choice is centralisation (Saltman *et al.*, 2007; Møller Pedersen, 2006).

The argument that the increasing lack of overlap between financial responsibilities and decision-making capacities causes centralisation also applies to Norway, but here the mismatch has a longer history and different consequences. Historically, the position of the Norwegian counties has been weaker than in Denmark, and support for the decentralised political model has declined as the counties became financially dependent on central government. The counties provided more than 72 per cent of

funds in 1996, but in 2001 the share was only 44 per cent (Hagen and Kaarbø, 2006). The DRG component that was introduced in 1997 and later increased did not fully cover marginal costs and contributed to a deficit. In Denmark and Sweden, the period 1970-2000 displayed a far higher degree of overlap between funding and other responsibilities, i.e. the counties raised about 80-85 per cent of the necessary funds themselves. The introduction of patient choice and activity based financial schemes has caused a drift towards centralisation in the Norwegian case, by undermining the power base and the legitimacy of counties. This situation led to the 2002 hospital reform. The new hospital enterprises relied on the health regions that had been set up for purposes of planning and coordination, and the counties were left to engage in other matters. As for Sweden, regionalisation has not produced a similar drift towards centralisation, perhaps because the development has been contained within a framework of existing institutional arrangements (Angell, 2007), and because of a more significant overlap between decision-making and financial responsibilities.

Discussing the decentralised model also involves relating to the issue of convergence among families of nation states, through processes of translation (Rico and Leon, 2005). Such translation mechanisms have indeed been identified in Scandinavia (Grøndahl and Grønlie, 2004), but if Sweden was once a major inspiration for Norway and Denmark, this is no longer the case. An important set of ideas that have been translated into all these countries since the 1980s is new public management (NPM), but clearly national institutional variations have influenced interpretations and the way in which such instruments were actually used. The current divergent patterns are partly caused by the timing of reforms and also the various emphases put on each kind of reform; for example, free choice of hospitals in Denmark was introduced early in Denmark, but without the same link to the use of DRG as a funding mechanism as well as an instrument for performance measurement as in Norway. Clearly, the mechanisms of layering and drift are activated, but in various ways, and we also have in Denmark an example of replacement as the counties were replaced with regions. The NPM reforms were translated and timed differently. Moreover, there is a connection between the problems each system faced and how NPM reforms were used, e.g. the harsh economic reality Sweden faced in the early 1990s in combination with the long tradition of county rule explains why there was a strong emphasis on NPM experiments in many counties at this time. Norway, again, provides a contrast, with a state that in the 1990s could continue to use oil revenues to fuel hospital expansion, but then in a manner that gradually exacerbated the counties' problems with balancing operational and financial responsibilities for hospitals.

Conclusion

As the three systems currently are on diverging pathways, the decentralised Scandinavian model of hospital governance seems to be evaporating. Although the three countries have faced differing economic challenges quite recently, and have to deal with geographical realities relating to population density and physical layout, these factors *per se* cannot explain the current developments patterns. Rather, long-term factors associated with tradition, culture, and history also have to be taken into account, along with intermediate explanatory factors as well as factors relating to recent reform events. It is particularly the intermediate factors and the concepts of layering, drift, replacement and translation that have been emphasised in this article.

These concepts help us bridge the past and the present by highlighting the evolutionary nature of institutions, and also allow us to estimate the impact of particular ideas and reform models that are translated into a given institutional trajectory.

Initially we asked what the particular conditions and mechanisms were that served as foundations for the development of a Scandinavian decentralised model, and how we could explain the fact that the model now seems to be breaking up. We have focused on three dimensions of decentralisation, i.e. economic, political and administrative. We found that Norway, Denmark and Sweden were decentralised in all these respects during the three latter decades of the twentieth century, and that there was a similar focus on the county level as a solution to governance problems in the hospital sector in all three countries during this period. The three systems have also each pursued their own development path, however, and the divergent aspects of their systems are now rediscovered, as the model seems to be breaking up. The Norwegian path has been towards centralisation – even in the period 1970-2000. The Norwegian counties failed because they did not provide an adequate solution to the centre-periphery problems in the hospital sector. It was particularly the changes in the financial system, along with the introduction of free choice of hospital, that undermined their legitimacy.

In Denmark, the county focus seems to represent a less decisive break with a tradition for decentralised healthcare, as towns and cities had been prime actors in a way that did not contradict the idea of county governance, at least not to the same extent as in Norway. The Swedish system was institutionalised at a much earlier point in time, and continues to exist within frameworks that can be traced back to the counties' first responsibilities for healthcare already in the 1860s.

What appear to have been similar choices in the period 1970-2000 are in fact products of differing institutional constellations in combination with different translations of NPM reforms. By institutional constellations we mean, for example, economic strength and legitimacy of the counties, impact of centre-periphery conflicts, mechanisms for conciliation developed to handle conflicts and distribute resources, and overlap of financial and decision-making responsibilities.

The particular combination of reforms in Norway that culminated with the 2002 enterprise reform is a good illustration of how a particular layering of reforms and institutions may exacerbate a long-term drift towards centralisation, and open the window for political entrepreneurs to introduce a large-scale restructuring of power relations in favour of the central state. The Danish structural reform was a similar display of a large-scale reform, but in this case counties were replaced with democratically governed regions. This different turn of events may be explained by less emphasis on activity-based funding in Denmark during the 1990s, and the more established position of the democratically elected counties. Historically, there was a strong overlap between financial and operational responsibilities, but this has been removed as a consequence of the structural reform. Lastly, Sweden displays a development where the overall institutional setting has been stable over a very long period of time, and where the historically established division of labour between central and local government have given the counties room for making their own translation of reform models. NPM reforms were thus introduced in the 1980s and 1990s to differing extent in the various counties, and the counties' collective status was

not threatened by problems in any single county. Among some counties there were also experiments with merging hospitals into regions. These processes of layering, drift and translation did not threaten the whole national institutional set-up in the hospital sector in Sweden in the same way as in Norway and Denmark.

The Nordic decentralised model of hospital governance had its heyday during the last three decades of the twentieth century. It now seems to be breaking up as the three countries follow different paths in their efforts to improve their systems for hospital governance. It remains to be seen whether this is only a period of transition, and whether we may, in the future, have the chance to discover a new Scandinavian model for hospital governance.

References

Anderson, O.W. (1972), *Health Care: Can There Be Equity?*, Wiley, New York, NY.

Andersson, G. and Kalberg, I. (2000), "Integrated care for the elderly: the background and effects of the reform of Swedish care of the elderly", *International Journal of Integrated Care*, Vol. 1 No. 1, pp. 1-10.

Anell, A. and Claesson, R. (1995), *Svenska sjukhus förr och nu – ekonomiska aspekter på struktur, politikk och framtida förutsättningar*, Tryckmedia, Halmstad.

Angell, S.I. (2007), "Two variants of decentralized health care: Norway and Sweden in comparison", Stein Rokkan Centre for Social Studies, Bergen, forthcoming.

Axelsson, R. (2000), "The organizational pendulum: healthcare management in Sweden 1865-1998", *Scandinavian Journal of Public Health*, Vol. 28, pp. 47-53.

Béland, D. (2007), "Ideas and institutional change in social security: conversion, layering, and policy drift", *Social Science Quarterly*, Vol. 88 No. 1, pp. 20-38.

Berg, O. (1980), "The modernisation of medical care in Sweden and Norway", in Arnold, J. and Elvander, N. (Eds), *The Shaping of the Swedish Health System*, Croom Helm, London.

Berg, O. (1997), "Meta-medicine: the rise and fall of the doctor as leader and manager", in Larsen, Ø. (Ed.), *The Shaping of a Profession: Physicians in Norway, Past and Present*, Science History Publications, Canton, MA.

Bjorkman, J.W. (1985), "Who governs the health sector? Comparative European and American experiences with representation, participation and decentralization", *Comparative Politics*, Vol. 17, pp. 399-420.

Bjørnson, Ø. and Haavet, E. (1994), *Langsomt ble landet et velferdssamfunn – Trygdenes historie*, Ad Notam Gyldendal, Oslo.

Blank, R. and Bureau, V. (2004), *Comparative Health Policy*, Palgrave, London.

Borum, F. (2005), "When implementation meets emergence – interpreting managerial reactions to the regionalization of Danish hospital services", paper presented at the Nordic Academy of Management Conference, Århus, 18-20 August.

Bundgaard, U. and Vrangbæk, K. (2007), "Reform by coincidence? Explaining the policy process of structural reform in Denmark", *Scandinavian Political Studies*, Vol. 30 No. 4, pp. 491-520.

Byrkjeflot, H. (2005), "The making of a health care state? Recent hospital reforms in Norway", Working Paper No. 15-2005, Rokkansenteret, Bergen.

Byrkjeflot, H. and Grønlie, T. (2005), "Det regionale helseforetaket – mellom velferdslokalisme og sentralstatlig styring", in Opedal, S. and Stigen, I. (Eds), *Helse-Norge i støpeskjeen – søkelys på sykehusreformen*, Fagbokforlaget, Bergen.

Byrkjeflot, H. and Gulbrandsøy, K. (2006), "Is there a change from government to governance in the Norwegian hospital sector?", paper to be presented at the 24th EGOS Colloquium 2008, Amsterdam, 10-12 July 2008.

Campbell, J.L. (2004), *Institutional Change and Globalization*, Princeton University Press, Princeton, NJ.

Czarniawska, B. and Sevon, G. (Eds) (1996), *Translating Organizational Change*, De Gruyter, Berlin.

Engel, A. (1968), *Perspectives in Health Planning*, Athlone Press, London.

Erichsen, V. (1995), "State traditions and medical professionalization in Scandinavia", in Johnson, T., Larkin, G. and Saks, M. (Eds), *Health Professions and the State in Europe*, Routledge, London.

European Observatory on Health Care Systems (2001a), *Health Care Systems in Transition: Denmark*, WHO Europe, Copenhagen.

European Observatory on Health Care Systems (2001b), *Health Care Systems in Transition: Sweden*, WHO Europe, Copenhagen.

European Observatory on Health Care Systems (2005), *Health Care Systems in Transition: Sweden*, WHO Europe, Copenhagen.

European Observatory on Health Care Systems (2006), *Health Systems in Transition: Norway*, WHO Europe, Copenhagen.

Frandsen, J. (1963), *Sundhedsvæsenet 1927-'60. Oplevelser og Erfaringer*, Nyt Nordisk Forlag, Copenhagen.

Grøndahl, Ø.N. and Grønlie, T. (2004), "From the Swedish ideal to EU direction: Scandinavian central-state administrative reform in the 1980s and 1990s, in a post-1945 perspective", in Heyen, E.V. (Ed.), *Administrative Reform in the Baltic Sea Region*, Yearbook of European Administrative History No. 16, Nomos, Baden Baden.

Grønlie, T. (2006), "Norwegian general hospitals, 1970-2002: county ownership – an interlude between welfare localism and state direction", *Medical History*, Vol. 50 No. 2.

Guillén, M. (1994), *Models of Management*, University of Chicago Press, Chicago, IL.

Gustafsson, R.Å. (1987), *Traditionernas ok – Den svenska hälso- och sjukvårdens organisering i historie-sociologisk perspektiv*, Esselte studium, Stockholm.

Haave, P. (2006), "The hospital sector: a four-country comparison of organizational and political development", in Christiansen, N.F., Petersen, K., Edling, N. and Haave, P. (Eds), *The Nordic Model of Welfare – A Historical Reappraisal*, Museum Tusculanum Press, Copenhagen.

Hacker, J.S. (2004), "Dismantling the health care state? Political institutions, public policies and the comparative politics of health care reform", *British Journal of Political Science*, Vol. 34, pp. 693-724.

Hagen, T. and Kaarbø, O. (2006), "The Norwegian hospital reform of 2002: central government takes over ownership of public hospitals", *Health Policy*, Vol. 76 No. 3, pp. 320-33.

Hamran, T. (2007), "Kvinneforeningene, institusjonsbyggingen og den nasjonale velferdspolitikken – Nord-Norge før 1940", *Historisk tidsskrift*, Vol. 86, pp. 411-30.

Hansen, F.H. (2001), *Sykehusstruktur i endring: de lange linjer og utviklingen siste tiår*, NIS SAMDATA Rapport 3/01, SINTEF Unimed, Trondheim, pp. 35-63.

Indenrigs- og Sundhedsministeriet (2004), *Aftale om strukturreform*, Indenrigs- og Sundhedsministeriet, København, June.

Immergut, E. (1992), *Health Politics: Interests and Institutions in Western Europe*, Cambridge University Press, Cambridge.

Ito, H. (1980), "Health insurance and medical services in Sweden and Denmark 1850-1950", in Heidenheimer, A.J. and Elvander, N. (Eds), *The Shaping of the Swedish Health System*, Croom Helm, London.

Jacobsen, K. and Larsen, K. (2007), *Ve og velfærd. Læger, sundhed og samfund gennem 200 år*, Lægeforeningens forlag, København.

Jespersen, P.K. (2001), "New Public Managementreformer i det danske sygehusfelt", *Nordisk Administrativt Tidsskrift*, Vol. 82 No. 1, pp. 22-41.

Johnson, H. and Byrkjeflot, H. (2006), "Media – public watchdog or hunting for news? How the interrelationship between media and hospitals in Norway was affected by recent reforms", paper presented at the 22nd EGOS Colloquium 2006, Bergen, 6-8 July.

Jonsson, P.M., Agardh, E. and Brommels, M. (2006), *Hälso- och Sjukvårdens strukturreformer. Lärdomar från Norge, Danmark, Finland och Storbritannien, Sveriges Offentlige Utredningar*, Ansvarskomitténs Skriftserie, February.

Møller Pedersen, K. (2002), "Reforming decentralized integrated health care systems: Theory and the case of the Norwegian reform", Working Paper 2002: 7, Health Economics Research Programme (HERO), University of Oslo, Oslo.

Møller Pedersen, K. (2005), "The Danish health care system: evolution – not revolution – in a decentralized system", *Health Economics*, Vol. 14, pp. 41-57.

Møller Pedersen, K. (2006), "Is there a theoretical rationale for the changes in the Scandinavian health care model?", draft paper, NHESG 2006 Meeting, Nordic Health Economists' Study Group, Copenhagen, 17-18 August.

Nordby, T. (1989), *Karl Evang: en biografi*, Aschehoug, Oslo.

Oates, W.E. (1999), "An essay on fiscal federalism", *Journal of Economic Literature*, Vol. 37 No. 3, pp. 1120-49.

Pierre, J. (2001), "Decentralisering, governance och institutionell förändring", in Rothstein, B. (Ed.), *Politikk som organisation: Förvaltningspolitikens grundproblem*, SNS Forlag, Stockholm.

Pollitt, C. (2005), "Decentralization: a central concept in contemporary public management", in Ferlie, E., Lynn, L. and Pollitt, C. (Eds), *The Oxford Handbook of Public Management*, Oxford University Press, Oxford.

Rico, A. and Leon, S. (2005), "Health care devolution in Europe. Trends and prospects", Working Paper 2005:1, Health Organization Research Norway (HORN), Oslo.

Roness, P.G. (1997), *Organisasjonsendringar. Teoriar og strategiar for studier av endringsprosessar*, Fagbokforlaget, Bergen.

Saltman, R.B. and Bergman, S. (2005), "Renovating the commons: Swedish health care reform in perspective", *Journal of Health Politics Policy and Law*, Vol. 30 Nos 1/2, pp. 253-76.

Saltman, R.B., Bankauskaite, V. and Vrangbæk, K. (2007), *Decentralization in Health Care: Strategies and Outcomes*, Open University Press/McGraw-Hill, Maidenhead/New York, NY.

Socialstyrelsen (2006), "Hälso- och Sjukvårdens strukturreformer. Lärdomar från Norge, Danmark, Finland och Storbritannien", Ansvarskomiteéns skriftserie februari 2006, Socialstyrelsen/Sveriges Offentlige Utredningar, Stockholm.

Sosialdepartmentet (1976), *De frivillige sosiale organisasjoner og myndighetene: Samarbeid og samordning*, Universitetsforlaget, Oslo.

Strukturkommissionen (2004), *Strukturkommissionens Betænkning nr. 1434*, Strukturkommissionen, Indenrigs- og Sundhedsministeriet, Copenhagen, January.

Streeck, W. and Thelen, K. (2005), "Introduction: institutional change in advanced political economies", in Streeck, W. and Thelen, K. (Eds), *Beyond Continuity: Institutional Change in Advanced Political Economies*, Oxford University Press, Oxford, pp. 1-39.

Thelen, K.A. (2004), *How Institutions Evolve: The Political Economy of Skills in Germany, Britain, the United States and Japan*, Cambridge University Press, Cambridge.

Thelen, K.A. and Steinmo, S. (1992), *Structuring Politics*, Cambridge University Press, New York, NY.

Therborn, G. (1989), "'Pillarization and popular movements', two variants of welfare state capitalism: the Netherlands and Sweden", in Castles, F.G. (Ed.), *The Comparative History of Public Policy*, Polity Press, Cambridge, pp. 192-241.

Torjesen, D. and Byrkjeflot, H. (2007), "When disease is being priced: the translation of the DRG system to the hospital sectors in Norway and Denmark", paper presented at the 2nd Nordic Workshop on Health Management and Organization, Gothenburg, 6-7 December.

Vallgårda, S. (1992), *Sygehuse og sygehuspolitik i Danmark. Et bidrag til det specialiserede sygehusvæsens historie 1930–1987*, Jurist- og Økonomforbundets Forlag, Oslo.

Vrangbæk, K. and Christiansen, T. (2005), "Health policy in Denmark: leaving the decentralized welfare path?", *Journal of Health Politics, Policy and Law*, Vol. 30 Nos 1/2, pp. 29-52.

Corresponding author
Haldor Byrkjeflot can be contacted at: haldor.byrkjeflot@rokkan.uib.no

To purchase reprints of this article please e-mail: **reprints@emeraldinsight.com**
Or visit our web site for further details: **www.emeraldinsight.com/reprints**