The Norwegian Hospital Reform: Balancing Political Control and Enterprise Autonomy

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Abstract This essay focuses on the balance between governmental control and enterprise autonomy by examining the Norwegian hospital reform. We describe the enterprise model and give a description of the policy instruments that the government, as owner, has for exercising power and control vis-à-vis the health enterprises. How the trade-off between autonomy and control is experienced and practiced is analyzed from an instrumental, an institutional, and an environmental perspective. The database comprises a survey collected from health enterprise executives and illustrative cases. The trade-off can be characterized as ambiguous and unstable and we ask whether it is possible to achieve a strategy to more appropriately balance the goals of control and autonomy.

New public management (NPM) has many facets and embraces a number of different reform components. It prescribes centralization and control as well as decentralization and autonomy. There is thus a tension in NPM between the need for greater managerial flexibility and discretion and the need for a greater degree of political accountability and control (Christensen and Lægreid 2001a). On the one hand there seems to be a widespread belief that structural devolution can enhance performance and accountability, as well as political control. On the other hand, systematic evidence for some of the promised benefits is very patchy (Pollitt et al. 2001). In this essay we will examine one of the most comprehensive contemporary NPM-inspired reforms in Norway, the hospital reform.

In 2002, responsibility for the Norwegian hospitals was transferred from the counties to the central government. The ownership was thereby centralized to a single body—the state. The reform also set up new man-

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agement principles for the hospitals based on a decentralized enterprise model. One of the main challenges of the reform is to balance the autonomy of the health enterprises and the political control by the central government. On the one hand, the minister of health has full responsibility for conditions in the health sector and a new department of ownership has been established; on the other, the enterprises are given enhanced local autonomy with their own executive boards and general managers with powers of authority to set priorities and manage the regional and local health enterprises. The reform involves a strengthening of overall central government ownership responsibilities and control, simultaneously representing a decentralized system of management.

The focus of this essay is the balance between central governmental control and autonomy for the health enterprises. We examine how the trade-off between control and autonomy is practiced. We also attempt to determine whether it is possible to achieve a good balance between political governmental control and decentralized autonomy or whether the balance is difficult, ambiguous, and unstable due to different structural, cultural, and environmental conditions.

The hospital reform is still a novel one and is passing through a phase marked by interpretations and adjustments among the actors within the new structural framework. We therefore focus on the achievements or effects that eventually accrue from the process of the reform. We will discuss the transformation of the administrative apparatus both as a result of the structural features and as a more direct consequence of environmental factors and the historical-institutional context. We ask under what conditions the balance between political control and enterprise autonomy is influenced and altered.

First, we outline three perspectives on administrative reforms. Second, we place the reform into the Norwegian context and present a brief history of developments leading to the present reform. We describe the enterprise model and give a description of the policy instruments that the government, as owner, has for exercising power and control vis-à-vis the health enterprises. Third, we examine how the trade-off between autonomy and control is experienced and practiced so far—by using survey data collected among regional executive board members and illustrative cases. In the fourth section we discuss, based on the theoretical perspectives, why the trade-off can be characterized as ambiguous and unstable. Finally we conclude by asking whether it is possible to achieve a plus-sum game between political control and autonomy.

The empirical basis of the essay is official documents on the reform

and a mail survey conducted in 2003 of all administrative executives and executive teams and all members of the executive boards of all five regional and thirty-three local health enterprises. A total of 326 respondents answered the questionnaires and the response rate was 72 percent (Opedal and Stigen 2003). The case studies are based on public documents and press releases issued by the parliament (*Storting*), the Ministry of Health, and the health enterprises, together with information from their Web sites and media coverage in national and regional newspapers and the Norwegian Broadcasting Corporation (Neby 2003).

Theoretical Perspectives

New public management is a dominant reform paradigm focusing primarily on an instrumental concept of public administration. The reform idea is that the executive leadership can deliberately design and implement the reform measures based on market, management, and efficiency. It represents a holistic reform package that does not pay particular attention to contextual factors such as internal administrative traditions or external pressure from political actors. The NPM recipes have generally been presented as universal panaceas and the historical-institutional context of the different countries or policy areas has normally not been taken into consideration, nor are the different environmental constraints given particularly strong emphasis. NPM presents a global diagnosis and prescription rooted in a market economy and private sector management in which the special nature of the public sector is denied (Christensen and Lægreid 2001a; Olsen 2004; Pollitt and Bouckaert 2000).

Our argument is that culture and environment need to be integrated into the NPM approach to understand the hospital reform. A contextualization process that stresses the uniqueness of the national system in general and the health systems in particular must be taken into account. Thus, we use three different theoretical approaches to explain and support our arguments: an instrumental approach emphasizing the formal and hierarchical aspects of the reform, an institutional approach stressing the cultural features of the reform and the health sector, and an environmental approach discussing arguments connected to characteristics of political processes and policy types.

According to the instrumental view, public organizations change because some actors have a relatively strong influence on decisions and implementation, unambiguous intentions and goals, and clear means and insights into the possible consequences of various solutions, resulting in

effects that mostly fulfill the stated collective goals (March and Olsen 1983). The decision making is characterized by tight control of the actors involved and unambiguous organizational thinking concerning the structural changes made. From an instrumental perspective, specific goals provide clear criteria for selection among alternatives, and formalization structures the relationships among the set of roles and principles that govern behavior in the system. This makes behavior predictable and unambiguous through standardization and regulation (Scott 1981).

An active administrative policy encompasses elements of both political control and rational calculation (Dahl and Lindblom 1957). It assumes that the organizational form to be used is open to conscious choice, implementation, and control by central political-administrative actors; second, it assumes a tight coupling between goals and means, which are fulfilled through different organizational forms; third, it assumes that different organizational forms have different effects; and fourth, it assumes there are criteria that could be used to assess those effects (Christensen, Lægreid, and Wise 2002).

These assumptions are difficult to fulfill in practice. The leeway political leaders have in reform processes is influenced by historical-institutional contexts and environmental factors. We will therefore argue that reform processes are not characterized by a simple instrumental view of organizational decision making and change seen as administrative design: rather, they can be understood as a complex interplay of purposeful choice constrained by internal and external factors (Olsen 1992).

One set of constraints is represented by the historical-institutional context or cultural tradition, norms, and values that can have a 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 toward fundamental changes (Krasner 1988; Selznick 1957). 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).

Environmental characteristics are also potentially important for developing and implementing administrative reforms. The degree of ambiguity and stability in the relationship between political control and enterprise

autonomy can thus be discussed in an environmental approach, which examines the political processes that occur in the task environment. An environmental approach stresses that organizations exist in a dynamic and interdependent relationship with actors and groups in the environment. To understand the change and stability of the autonomy versus control relations, one has to take into account the characteristics of the environment (Olsen 1992). We pay special attention to the relationship to the parliament, to local pressure groups, to lobbyists, and to the role of media, which the owner (Ministry of Health) and the producers of health services (the health enterprises) have to handle and which affects the trade-off between autonomy and control.[1] Controversial issues, scandals, and unforeseen situations have on several occasions caused strong mobilization of political parties, media debate, and growth of local pressure groups. Negotiations and external pressure can potentially both enhance and hinder political and managerial control: leaders may intentionally build winning coalitions with external groups and actors, but external pressures may also result in socialization and aggravation of conflicts (Schattschneider 1960).

According to Theodore Lowi (1964, 1972), "policy determines politics." Public policies can be distinguished by their effect on society, whether costs and benefits are narrowly or broadly dispersed, and by the relationship among those involved in policy formation. The policy types create and identify winners and losers to various degrees. The level of conflict is especially high in redistribution policies involving efforts by the government to shift the allocation of wealth or rights among groups of the population. When a policy has redistributive effects, winners and losers are distinct, and the potential for conflicts and political intervention is high.

When hierarchically based instrumental reform processes run into problems, it is usually because of heterogeneity, either internal or external, due not only to technical managerial problems but also to problems of political management. Political and administrative leaders may have different opinions of how to implement the reform; there might be a misfit between the reform ideas and traditional norms and values in the hospitals, or there might be turbulence and disagreement among actors in the environment. This can modify policy capacity and rational calculation. Reform processes can be difficult to control and ambiguity in organizational thinking may increase.

1. Our focus on the political environment does not cover the whole theoretical universe of the notion. For instance, we have not paid particular attention to the institutionalized environments and how dominating international doctrines of good management and control may have affected the scope and character of political control vis-à-vis the health enterprises.

The Reform Context

Norway has been seen as a reluctant reformer (Olsen 1996). Until the early 1990s, major public domains such as the railways, telecommunications, the power supply, postal services, forestry, grain sales, and public broadcasting were organized as central agencies or government administrative enterprises. But since the mid-1990s greater structural devolution has become a major component in the Norwegian-style new public management. The Norwegian reform process consists of a combination of internal delegation of authority to agencies—with a more performance-assessment regime—and external structural devolution through the establishment of state-owned companies (Christensen and Lægreid 2001a, 2001b, 2002). As a result of the public reforms, more autonomous regulatory agencies have also been established. Following the examples of New Zealand (Boston et al. 1996), the single-purpose model has increasingly replaced the former integrated civil service model in which functions of the owner, regulator, controller, purchaser, and provider were all performed by the same organization.

The commercial parts of the government administrative enterprises mentioned above have all been corporatized, that is, established as various types of state-owned companies, whereas the regulatory parts have retained their agency form. The hospital reform is, together with road construction and air traffic control, the latest example of this development. The hospital reform is inspired by NPM, focusing on how to make the hospital efficient by introducing the business model and framework steering as a main political-democratic control device. The introduction of the enterprise model is thus part of a larger shift in the Norwegian public administration system. It can partly be seen as an ideological change toward neoliberalism and private sector models in Norwegian political parties in general, including the Labor Party. In contrast to the centralized planning state of the past, marked competition and management became the order of the day. The hospital reform was thus not only about hospital performance and health care but also about ideology and introducing the most popular organizational form in our time (Grønlie 2004).[2]

But the narrower health care context also has to be taken into consideration. Norway was pursuing other NPM-inspired health reforms parallel to the hospital reform. Within the hospital, the principle of unitary management was introduced in the mid-1990s. At the same time, quasi-markets

2. The reform may thus undoubtedly be seen in an institutionalized environments perspective. Cf. note 1.

and performance measurements models were introduced through the principle of free hospital choice for patients, the activity-based funding system based on the diagnosis-related groups (DRG) classification system, and a more comprehensive and transparent quality control system (Byrkjeflot 2004). In addition, the market for pharmacies was deregulated 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 health care.

This development in Norway reflects to some extent broader efforts throughout Europe to incorporate NPM principles into the governance of the health care system. This trend is most obvious for the United Kingdom, but can also be seen in other Scandinavian countries as well as in continental Europe (Byrkjeflot and Neby 2004; Ham 1997; Ranade 1998).

The NPM trajectory is, however, only part of the story. There are also specific components of the reform that must be understood in light of the Norwegian historical-institutional context. The NPM-inspired reform ideas are transformed and translated when they meet the domestic political-administrative tradition (Christensen and Lægreid 2001a) and the central government's takeover of the ownership of hospitals cannot easily be understood only as an NPM reform. Thus, a *health-state* perspective, focusing on the rise of regulatory state control in health care, and a *professional-state* perspective, focusing on the medical profession and how the professions cope with the new regulatory challenges and changes in the state-professional networks, have to be added to understand the full scale of the Norwegian hospital reform (Byrkjeflot 2004; Freeman 2000; Saltman 1997). The Norwegian case is not just a pure market and management model. It does not represent a privatization of the hospital sector and does not go very far in promoting market mechanisms. What we see is a decentralized company structure of managers and health enterprises with delegated responsibility constrained by professional stewardship and integrated into a system under rather tight executive control and instruction from a central government (Byrkjeflot and Grønlie 2004; Byrkjeflot and Neby 2003; Opedal and Rommetvedt 2005; Lægreid, Opedal, and Stigen 2005).

The Reform

Like the reform of other parts of public administration, the health reform is something of a hybrid, prescribing both centralization by transferring ownership from the regional level to the central government and decen-

tralization by changing hospitals' form of affiliation from that of a public administration body to a health enterprise. The reform has two faces—one that prescribes better governmental control and one that prescribes more autonomy to the sublevels of the enterprise.

The main intended goals of the reform were to enhance coordination and efficient utilization of resources and to ensure equity of access to health services for citizens in all parts of the country. The reform should improve the overall performance of the hospital system, search for greater efficiency, and enhance a more uniform quality of services. To enhance partly conflicting goals such as performance, quality, efficiency, equity, and economy through one reform is an overwhelming task.

The main instruments to fulfill those goals were stronger central government control and responsibility combined with clearer defined responsibilities for the regional health enterprises and increased operational flexibility. No changes were introduced in the system of funding, which is a combination of block grants and activity-based funding from the central government to the regional enterprises that allocate the resources to the local health enterprises.

In this essay we will pay special attention to the problem of balancing autonomy and authority and determine the degree to which the shifting nature of autonomy and control in the new governance model will improve or impair the performance of the hospital system. A primary challenge is how to balance local autonomy and central government control and how the trade-off between the centralization of policy and the decentralization of delivery responsibility affects the overall goals of the reform. Stronger central control might enhance the equity and economy goals and more local autonomy might improve performance and efficiency.

Centralization: From County to State Ownership

Like Sweden and Denmark, Norway has a history of a relatively decentralized and welfare-oriented health care system (Byrkjeflot and Neby 2003; Pedersen 2002). The takeover of responsibility for all Norwegian hospitals by the central government marked the end of thirty years of ownership by the nineteen counties and may signify a break with the common Nordic decentralized model of health care. The counties were assigned responsibility for institutional health services in connection with the introduction of the Hospital Act in 1970. Norway was divided into five health regions in 1974, and there was a voluntary regional cooperation

between the counties until 1999 when this cooperation was made mandatory (Opedal and Stigen 2002b).

The possibility of a takeover of responsibility for hospitals by the central government was discussed several times by the government—first in 1987, then in 1994, and once again in 1996. But only a minority in the parliament voted in favor of increased freedom and overall state control. In 2000, however, a political process started that resulted in the new Health Enterprise Act of June 6, 2001.

The Labor Party came into power in Norway in March 2000 with the Stoltenberg minority government. At its national congress in November 2000 the party decided to support the takeover of hospitals by the central government. The reform was then prepared and implemented at a rapid pace. Public hearings were held during the winter of 2001 and the necessary parliamentary majority was obtained in June with support from the Conservative Party and the right wing Populist Party. The novelty of the reform was the change of ownership combined with the new enterprise model for hospitals (Opedal and Stigen 2002a).

There were several arguments for state ownership (Hellandsvik 2001). First, the health sector is characterized by an increasing use of resources combined with continuous financial strain. The counties were owners, but in practice the central government had the financial responsibility (Hagen 1998). This resulted in unclear divisions of overall responsibility. The relationship between the state and the counties was often labeled the "old maid game." The hospitals were the largest budgetary component in the counties, making them a burden in times of economic hardship and resulting in unpredictable lobbying of the *Storting* for increased financing. Second, the development of professional specialization of medical health made it necessary to organize the flow of patients across county borders and create larger units of coordination with more formal responsibility than the former health regions held. Third, the variations between the counties in the medical services offered were too broad, and access to health services depended on place of residence. It was, in other words, difficult to attain the national goal of standardization in the hospital sector. Fourth, the counties executed their ownership in different ways. Some practiced management by objectives whereas others exercised more detailed control vis-à-vis the hospitals (Carlsen 1995; Opedal and Stigen 2002a). There were also large differences in the utilization of financial resources between the counties.

The aim of state ownership was thus to deal with what was seen as unclear divisions of responsibility, different and ineffective use of finan-

cial resources, and disparate access to health services in the population. The running of the hospitals was attacked for being overly influenced by regional politicians with a low level of competence, for lacking professional administrative leadership, and for being inefficient.

Decentralization: From Public Administrative Bodies to Health Enterprises

The hospitals also changed their organizational form from public administration entities to become parts of health enterprises. The new pattern of hospital organization envisages the Ministry of Health as the owner of the hospitals, with an ownership department in the ministry as the location of administrative responsibility. Under the ministry, five regional health enterprises with separate professional boards have been established, and in turn these have organized former hospitals and institutions into thirty-five local health enterprises under regional auspices. Today eighty-two hospitals and a number of smaller institutions are under local health enterprise auspices (fig. 1). The health enterprises are separate legal entities and thus not an integral part of the central government administration. Fundamental health laws and regulations, policy objectives, and frameworks are, however, determined by the central government and form the basis for the management of the enterprises.

The regional health enterprises are organized as hybrid companies subject to special legislation and they have no hospital service functions on their own. Their main function is to be regional administrative entities. They are tasked to maintain the roles of both purchaser and provider and, in contrast to the official Organisation for Economic Co-operation and Development (OECD) model, those roles are not divided but integrated, thereby representing a specific Norwegian solution (OECD 2003). Health services are delivered by the hospitals, which have been made into statutory companies organized into local health enterprises reporting to, and owned by, the regional health enterprises.

Centralized Decentralization

The managerial autonomy of the health enterprises is constrained by a number of steering devices from the ministry that illustrate the inbuilt ambiguity of the reform when it comes to balancing autonomy and control. The organization of the enterprises stipulates in several ways how the owner may exercise control. First, the central government appoints the

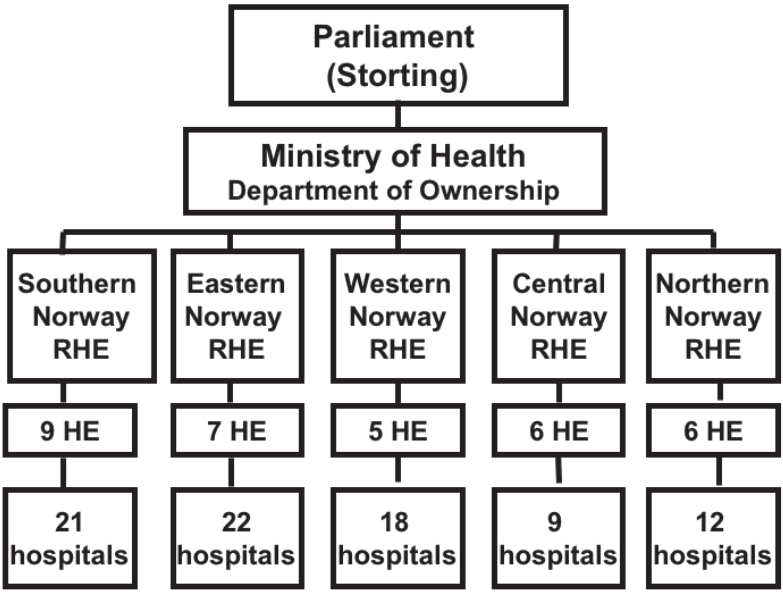

Figure 1 The Health Enterprise Model

Note: RHE = regional health enterprises; HE = health enterprises

regional board members. No politicians are members of the boards; the only group that has any formal representation is employees of the enterprises. There has been some debate on the composition of the boards—stressing that businesspeople have replaced political representation. Table 1 shows the actual background of the board members and that a majority of members have an occupational background from the public sector. To a large extent the majority is due to the representation of employees. If these members are excluded from the calculation, there is a greater balance between the number of members with occupational backgrounds from the public and private sectors. Second, the owner exercises control through the Health Enterprise Act, through the articles of association, through steering documents (contracts), and through decisions adopted by the enterprise meeting (Opedal 2004). In contrast to the laws regulating other public sector companies and enterprises, the hospital law specifies in more detail what tasks and issues must be approved by the ministry. The ministry has attempted to separate a formal steering dialogue (the *line dialogue*) from the more informal arenas of discussion (the *staff dialogue*) (Opedal and Stigen 2002a). Third, the state finances most of the

Table 1 Regional and Local Executive Board Members: Occupational Background in 2003

	All (%)	Excluding hospital employee representatives (%)
Public health sector	63	43
Other parts of public sector	20	32
Private sector	28	47
Interest organizations	7	6
Other	3	5
N = 100 %	205	123

hospital activities and the central government thus controls them by allocating funds to the 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 using quantitative indicators for monitoring results and measuring efficiency.

The intention is that the formal policy instruments of the central government should be strongly regulated. This is meant to safeguard the enterprises from detailed control on the part of the owner and help to give them genuine responsibility for their own actions. The principal idea of the reform is that the enterprise organization and the new management principles will reduce day-to-day management to the advantage of principal issues relating to priorities and hospital structure. Together with greater transparency, this is intended to allow for more steering in big issues and less steering in small issues. Of importance for the central government is obtaining greater control of management in relation to the structure of health services, for example by means of the distribution of functions.

At the same time, the managers of the enterprises are given greater responsibility and freedom within the framework and structure laid down. The empowerment of the managers implies discretion for managers and boards and only limited involvement of the politicians. The burden on the political leadership is thus intended to be reduced, and through a sharp division between politics and administration, political control may increase. The enterprises have their own responsibilities as employers and are responsible for the use of human capital. The enterprises are

also responsible for allocating the assigned funds subject to the proviso that they cannot go into voluntary liquidation. The purpose of organizing the hospitals as enterprises is thus to decentralize the management process, produce more efficient management, improve access to information, and delegate financial responsibility within health policy objectives and frameworks. Through structural devolution, the intention is to achieve less bureaucracy, an improved ability to manage change, and enhanced user information. At the same time, through its new roles the central government must secure overall coordination wherever this is necessary and appropriate. In official presentations of the reform it is emphasized that the reform does not involve privatization of the hospitals' operations: on the contrary, the reform means a tightening of current legislation. The Health Enterprise Act includes one provision that states hospital activities cannot be transferred to private owners without the permission of the *Storting* (Opedal and Rommetvedt 2005).

Last but not least, it should be underscored that the mainstay of control of the executive and central government by the legislature is the principle of ministerial responsibility. This principle implies that the minister is responsible to the *Storting* for everything that goes on within his or her ministry and in subordinate agencies and authorities. As such, the minister is accountable for how the administration performs its functions and tasks. This potentially implies strong vertical coordination and strong sector ministries, something that may well challenge the autonomy of the health enterprise.

In summary, the reform provides for decentralized management and delegation of financial responsibility at the same time that the minister of health, in theory, can instruct the regional health authorities and overturn board decisions in all cases (OECD 2003). Consequentially, the reform appears to represent a break with the stated goals of greater structural devolution and delegation under the modernization program for the public sector. A key challenge is how to balance the decentralization of the management process and the delivery responsibility with the centralization of control and policy issues. We see the content of the reform as consisting of potential inconsistencies, a tension between centralizing and decentralizing economic ideas. We think it is fair to say that the reform was based on a rather ambiguous organizational thinking. The relations between means and ends were not examined to a great extent (Herfindal 2004). Adding to this, the goals were partly inconsistent and the organizational models were rather broad, which allowed for a great variation in practice.

Political Control and Enterprise Autonomy—Some Experiences

The main actors and players after the hospital reform was put into practice are local stakeholders, media and lobby groups, managers and board members of local and regional health enterprises, the ministry of health, and the parliament. The Labor government was replaced by a center-right minority government in October 2001. The minister responsible for implementing the reform came from the Christian People's Party, which voted against the Health Enterprise Act.

Regional executives usually try to obtain as much autonomy as possible from the central ministerial level and the local enterprises try to enhance their autonomy from the regional authorities. The minister and his or her department try to control and instruct the regional health enterprises and overturn their decisions when necessary. The reform implies that politicians at local and regional levels are replaced by professional experts in the executive boards. This does not, however, mean that the politics fades away. It reappears in other arenas through media, protest movements, and lobbying when the health enterprises try to merge or close down hospitals. The popular protest is channeled to the central political level by activating members of parliament (MPs), who put pressure on the minority government and the minister of health, who have to instruct and control the health enterprises according to the signals from the parliament. The government might claim that its hands are tied when unpopular decisions have to be made and thus blame the executives in the health enterprises. The enterprises, however, might want to run to the government in such situations and one can easily end up in a "passing the buck" dynamics in which different actors have different incentives for a push and pull toward or away from autonomy when handling different issues. The challenge is that the political executives will try to delegate blame but not credit while the enterprise executives accept credit but not blame (Hood 2002).

How stable is the trade-off between political control and enterprise autonomy, and under what conditions does the balance change? The existing gray zone of authority between central political executives and regional health enterprises and also between local and regional health enterprises makes several trade-offs possible. Since the reform prescribes both centralization and decentralization, it is an open empirical question whether the politicians' control over hospitals will be weakened or strengthened in practice. One main argument for weakened political control is that structural devolution generally changes the instruments of control and

increases the distance between the political leadership and subordinate units (Egeberg 1989). But this specific reform stipulates a repertoire of steering tools from which the owner may exercise control.

Thus the balance between autonomy and political control is to a great extent affected by central players and their interests, and we will now describe and analyze such relations in more detail. First, we will describe the experiences of the health enterprise executives two years after the reform. How do they look upon the relationship between the Ministry of Health, the parliament, and the health enterprises? Second, we focus on selected cases in which a delegation of political authority could be said to have produced unsatisfactory results leading to trouble with the parliament, the media, and public opinion. These controversial cases are presented in the last part of this section.

The Broad Picture as Seen by Enterprise Executives

To assess the relationship between enterprise autonomy and political control, as seen by the executive managers and board members in regional and local health enterprises, we use different indicators such as contact pattern, perceived influence of different actors, and perceived autonomy and political control. Although the contact pattern shows how different actors orient themselves within the new corporate structure and toward the formalized steering dialogue, the perceived pattern of influence illustrates how the enterprise executives judge and experience the balance of power between the central government and the regional and local health enterprises. How the relationship between the central government and the health enterprises works out in practice is illustrated by means of different indicators showing how the executives perceive the degree of trust, autonomy, political control, and predictability in the relationship. The degree of clarity and stability between political control and health enterprise autonomy may be influenced by different challenges. To identify different challenges the hospital reform may be confronted with, enterprise executives have been asked to point out what challenges they see as most important.

The executives' contact pattern may provide a first impression of where they focus their attention (tables 2 and 3). The executives have the most frequent contact with other health enterprises, but they also have frequent contact with the media and employee organizations. The executives at the regional level (table 2) also have extensive contact with the ownership

Table 2 Frequencies of Contact by Board Members and Managerial Executives at the Regional Level and the Influence of Different Actors on Their Decisions in 2003

	Contacts at least once a month (%)	High or some influence (%)
Central government:		
Members of parliament	14	76
Political leadership of Ministry of Health	11	91
Ownership department of Ministry of Health	41	84
The Norwegian Directory of Health and Social Affairs	9	29
The Norwegian Board of Health	6	37
Health enterprises:		
Board members of other regional boards	57	
Other regional health enterprises		4
The board of the regional health enterprise		98
Board members of local health enterprises in the region	46	
Managerial executives of the regional enterprises	–	87
Managerial executives of local health enterprises	75	
Local health enterprises in the region		60
Hospital employee organizations	45	30
Regional user/patient committees	22	37
Other external actors:		
User/patient organizations	32	29
Local government	20	4
Media	52	5
Local pressure groups	18	2
Private health enterprises	24	4

Notes: The questions on contact were divided into five fixed categories: (1) weekly contact, (2) monthly contact, (3) contact only a few times, (4) no contact at all, and (5) uncertain/not of current interest. In the table, monthly and weekly contact were added together to identify the percentage share that most frequently has contact with different actors. The questions on perceived influence were divided into six categories: (1) high influence, (2) some influence, (3) average influence, (4) little influence, (5) very little influence, and (6) uncertain/not of current interest. In the table, some and high influence were added together to identify the most influential actors as the respondents perceive it. $N = 52–56$

department in the ministry. The executives in regional health enterprises have the least contact with politicians in parliament and the minister of health as well as with other central agencies. Seen from an institutional point of view, the relatively frequent contact with the former owners of the hospitals (local governments) is understandable, illustrating path dependency and cultural trajectories. Old contact patterns between local gov-

Table 3 Frequencies of Contact by Board Members and Managerial Executives at the Local Level and the Influence of Different Actors on Their Decisions in 2003

	Contacts at least once a month (%)	High or some influence (%)
Central government:		
Members of parliament	1	56
Political leadership of Ministry of Health	1	67
Ownership department of Ministry of Health	1	70
The Norwegian Directory of Health and Social Affairs	5	40
The Norwegian Board of Health	6	36
Health enterprises:		
Board members of the regional board	22	
The regional health enterprise in the region		96
Board members of other local health enterprises in the region	37	
Other local enterprises		4
The board of the health enterprise		88
Managerial executives of the regional enterprises	51	
Managerial executives of local health enterprises	–	92
Hospital employee organizations	63	25
Regional user/patient committees	15	11
Other external actors:		
User/patient organizations	19	10
Local government	16	4
Media	30	10
Local pressure groups	8	2
Private health enterprises	5	1

Note: The questions in table 3 were divided into the same categories as in table 2. $N = 226–261$

ernments and hospitals from the former integrated model as well as the traditional strong political control of hospitals by the parliament seem to persist in spite of the looser coupling both to local governments and to parliament enhanced by the new model.

Table 3 reveals that the local enterprises have very little contact with the central government at both the administrative and the political levels. This reinforces the instrumental model, which assumes that this kind of contact is channeled through the regional health enterprises.

To what extent does this pattern of contact indicate the influence of

these groups of actors on decisions made by the health enterprises? This is also shown in tables 2 and 3. The results are quite different from the pattern of contact. Even though the executives have only minor contact with political executives in the central government, compared to the health enterprises the influence of the parliament and the minister of health is considered substantial. The political leadership of the Ministry of Health and also the ownership department has high influence according to the executives in the health enterprises. This indicates that anticipation and autonomous adaptation might be important in understanding relations between the health enterprises and central government institutions. But for both the regional and the local health enterprises, their own boards and management are as important as central authorities for the outcome of decision making. Thus, in their own eyes they are important actors with substantial influence on decisions made by the health enterprises.

It is also worth noticing that the executive leaders at the local and regional level report that external actors such as the local government, the media, and local pressure groups have almost no influence regarding the decisions made by the regional health enterprises. These results may indicate that the enterprise executives have a strong loyalty toward their owner (Ministry of Health), but still control the outcome of the decision making within the frame-steering by the central authorities. Thus, the influence pattern reflects central components of the reform, as expected from an instrumental perspective. Also, the tendency for local level executives to see the regional executives as the most powerful and to see politicians at the central level as less influential than the regional executives confirms an instrumental perspective.

More specifically, how do the executives consider the relationship between the Ministry of Health and the health enterprises? Table 4 includes some assertions about this specific relationship in the new organizational model. Most noteworthy are the results of the assertions of enterprise autonomy and central control. On the one hand, a majority of the executives at the regional level agree with the assertion that they have considerable autonomy. On the other hand, a clear majority claim that the steering document from the Ministry of Health is too detailed. The results may indicate that the autonomy of the regional executives is high, but that the executives wish for even greater autonomy. Another challenge for the relationship concerns the policy signals from the Ministry of Health. Almost half of the executives agree with the assertion that the policy signals from parliament, the Ministry of Health, directorates, and central agencies very often are contradictory. The minister of health oper-

Table 4 How Board Members and the Managerial Executives of Health Enterprises Judge the Relationship between Different Actors in 2003

	Regional level (%)	Local level (%)	*N* (%)
A positive relationship of trust exists between the regional health enterprise and the Ministry of Health	66*	–	56
A positive relationship of trust exists between the regional health enterprise and local health enterprises in the region	61	60	315
The regional health enterprise has considerable autonomy	53*	–	57
The local health enterprises have considerable autonomy	57	35	317
The steering document from the Ministry of Health is too detailed	80*	–	45
The steering document from the regional health enterprises is too detailed		40**	256
The management of the Ministry of Health is difficult to predict	38*	–	55
The management of the regional health enterprises is difficult to predict	–	19**	258
The policy signals from parliament, the Ministry of Health, and central agencies are very often contradictory	53	43	298

Note: Values represent percentages that fully or partly agree. The question was divided into six categories: (1) fully agree, (2) partly agree, (3) both, (4) partly disagree, (5) fully disagree, and (6) uncertain/not of current interest. The percentage shares that fully or partly agree have been totaled to show the portion of the respondents that support each of the assertions.

*Only leaders for regional health enterprises

**Only leaders for local health enterprises

ates as an owner, a financier, and a regulator, and the minister himself pronounced that it is in practice difficult to balance the different roles at the same time.[3] It is also worth mentioning that the board members are divided on the question about the relationship between the enterprise and the ministry. Forty-seven percent of the regional executives say that there is full or part agreement between the Ministry of Health and the regional enterprises; the other half report disagreement or doubt (not shown in the table). The table also reveals that the local health enterprises assess their relations to the regional level as less problematic than the regional

3. Speech held by the former minister of health, Dagfinn Høybråten, at the health enterprise managers' annual meeting in 2002.

executives' assessment of their relations to the central government. This is in spite of a feeling of less autonomy than at the regional level. One explanation might be the tendency that in some cases the central government overrules the regional level in favor of local enterprises. Generally speaking, the trust relations between the different levels are, however, rather high.

We also asked the board members more generally about challenges that the hospital reform may be confronted with. The main challenges for the hospital reform, as the enterprise executives see it, are the combination of increased political demands for expansion in hospital activity and slim grants, lack of political support when it comes to the closure or merger of local health services, and insufficient coordination between the different roles of the state (table 5). The last problem is especially significant at the local level. As we have seen, the state has accumulated a wide range of different roles—as owner, purchaser, controller, auditor, and regulator. The roles of the state also include financing most of the activities in the hospitals. In practice, it is difficult to distinguish between the line dialogue and the staff dialogue as intended by the Ministry of Health.

An important challenge is lack of political support when it comes to controversial issues such as the closure or merger of health services, thus illustrating the external political pressure affecting the implementation of hospital policy. Protests from local government and local pressure groups do not seem to constitute a problem for the majority of the enterprise executives. When it comes to controversial issues, the main problem is the politicians and not the pressure groups. At the local level, though, four out of ten executives agree that local lobbying represents a problem.

As the enterprise executives see it, they themselves do not constitute a problem. Only a few of the executives agree with the assertion that as an attempt to avoid political conflict, the enterprise does not put controversial issues on the agenda. In accordance with an instrumental view, they do not agree with the assertion that the regional enterprise does not have sufficient authority to manage the local health enterprises. More challenging is the organizational culture of the local health enterprises, as expected from an institutional approach. Roughly 40 percent of the enterprise executives claim that the culture is a barrier to change and to modernization of the local health enterprises.

In summary, the new pattern of hospital organization envisages the Ministry of Health as the owner of the hospitals. The data show that the executives of the regional enterprises assign considerable influence to the Ministry of Health, and they also seem to be very loyal toward their

Table 5 Types of Challenges Hospital Reform May Be Confronted With, As Seen by Board Members and Managerial Executives in the Enterprises in 2003

	Regional level	Local level	*N*
Scarce grants and political demands for growth in hospital services are the biggest threat for the hospital reform	65	71	314
The coordination of the different roles of the state, as owner, regulator, controller, auditor and purchaser, is insufficient	59	69	304
The regional enterprise does not have enough authority to manage the local health enterprises in an effective way	16	22	311
The organizational culture of the local health enterprises is a barrier to change	47	40	315
There is a lack of political support when it comes to the closure or merger of local health services, i.e., maternity services	67	67	288
To avoid political conflict, the (regional) enterprise does not put controversial issues on the agenda	16	22	305
Protests from local government and local pressure groups make a barrier when it comes to implementation of closure or merger of health enterprises	22	40	304

Note: Values represent percentages that fully or partly agree. The questions in table 5 were divided into the same categories as in table 4.

owner. The central government is held to be more important than the local health enterprises and external actors such as the local government, media, and local pressure groups, but the regional enterprises also claim to be strongly autonomous. They seem to combine an autonomous role with a strong loyalty toward the Ministry of Health, something that is not surprising since the Ministry of Health appoints the members of the boards. Local health enterprises have very little contact with the central government and assess them as less influential compared to the regional enterprise. They also report less autonomy than the regional health enterprises and more pressure from lobby groups.

But the data also indicate that the trade-off between political control and the autonomous role of the regional enterprises might be unstable and

changeable. The organization of the enterprises and the ownership by the state do not seem to fully safeguard the enterprises from detailed control by the owner. The Ministry of Health stipulates a detailed steering document that keeps track of the annual financial transfers from the government to the health enterprises. In addition, insufficient coordination of the different roles of the state and lack of political support in controversial issues constitute challenges for the new organizational model.

In the next section we present a number of cases that serve to illustrate the tension between political control and enterprise autonomy and underline the importance of communication and cooperation between the central government and the enterprises.

Cases Illustrating the Trade-off between Enterprise Autonomy and Political Control

The first two cases focus primarily on the balance between autonomy and control in the relationship between the central and the regional levels and the last two relate to the relationship between the central and the regional levels as well as between the regional and the local levels.

The Dentosept Case

In 2002, a hospital infection affected a large number of patients in fourteen hospitals, the source of infection being a mouth swab. Between 140 and 180 patients were affected and twelve to fifteen succumbed to the infection (Neby 2003). This crisis caused a public outcry and it was high on the media agenda for several weeks. It soon became obvious that the case could not be handled through the formal channels of steering and control: there was a need for stronger hierarchical supervision and instruction as well as more informal and dynamic communication between the ministry and central authorities and the health enterprises. Because of the publicity and strong media pressure, the political leadership in the Ministry of Health felt a strong need to intervene and to make their handling of the case transparent both to the general public and to the *Storting*. The ministry established an ad hoc working group to handle the case and the minister delivered a special report on the case to the *Storting*. There was a clear tension between the autonomous role of the individual health enterprises on the one hand and the need of central political control and supervision on the other. The case illustrates the rift between the government as an owner and as a regulator. The regulatory role was underlined

at the expense of the role as owner. In crises such as this there is a need both to clarify the accountability of the ministry and the political leadership and to leave discretion for justified actions within the autonomous health enterprises.

National Coordination of Purchasing Systems

Another interesting case is the establishment of common purchasing systems for all of the health enterprises to obtain advantages of competence and economies of scale. In contrast to the main argument that managerial issues should be delegated to autonomous enterprises, this function was taken away from them and centralized to a specialized purchasing agency (ibid.). Owing to regional policy considerations the ministry wanted to establish this unit in Vadsø, a small town in the northernmost county. There was a strong local lobby behind this location, but the whole idea was very unpopular among the health enterprises, and they managed to reduce the size of the unit. The minister announced that it was up to the health enterprises to make a unified decision, but he also made it clear that the ministry would not hesitate to direct the decision if necessary. In this case the ministry put strong pressure on the health enterprises, favoring central control at the expense of enterprise autonomy.

Closure and Merger of Local Health Services

Several of the regional health enterprises have proposed closing down health services and concentrating health service facilities in central areas. This has resulted in local resistance and lobbying activity in an attempt to increase ministerial control over these enterprises. Several cases illustrate this dynamic. One is the initiative taken by the health enterprises to close down and centralize the maternity wards both in the rural districts and in Oslo. This resulted in a campaign across party lines by female members of parliament to prevent the closure of maternity services. The members of parliament in fact operated more or less as a lobby against the health enterprises (Christensen and Lægreid 2003a).

The reorganization and merging of maternity services is especially problematic in the north of Norway, with its large administrative areas and dispersed settlements. In this region, the local policy aspects and local and regional policy interests have been dominant in the reorganization debate. There has been a strong local lobby and the Ministry of Health has pointed out to the regional enterprise that it would be wise to include

local community actors in hearings and discussions about the reorganization of hospitals.

Similar processes are observed when the health enterprises try to close down local institutions. In 2002, the Mid-Norway Health Enterprise decided not to renew its contract with a local psychiatric institution. This resulted in criticism from the municipality where the institution was located and its MP asked the *Storting* how far the health enterprises could go in closing down the health services. When urged to intervene, the minister of health referred to the formal procedures for controlling the health enterprises, but stressed the need for good dialogue between all involved parties. He was reluctant to overrule the decision of the health enterprise as long as the needs of the patients were being met and he referred the case to the chief county medical officer to check whether this was the case.

Steering signals are also sent through informal channels. In a TV debate, the minister of health stated that in his opinion the regional health enterprises had undertaken actions in closures and mergers that were too radical compared to his intentions. This opinion has been emphasized and made more specific in enterprise meetings between the political leadership of the Ministry of Health and the regional health enterprises.

Following a cautious start, the minister seems to be more willing to intervene more directly in cases of merger or closure of emergency and maternity wards. In a few cases the minister has actually overruled decisions of the regional boards partly following pressure by the media as well as demonstrations and powerful protests from local lobby groups (Opedal 2004). In addition, the *Storting* seems to be more willing to instruct the ministry in the event of closures, mergers, and reorganization of local hospitals. This behavior illustrates that the owner is not a cohesive actor. The health enterprises are facing more than one principal. Because the regional councils no longer have an ownership role, members of parliament have received increased incentives to get involved in health policies, and some parliamentarians might work across party lines and thus subvert the NPM management structure on which the reform is based. Minority governments might be especially vulnerable to this possibility. One might ask whether the politicians left the roles fuzzy to give themselves leeway. A main challenge is how the government can manage to make or keep members of parliament happy when it comes to handling health care issues.

Controversial Lobbyism and Cheating on DRG

Lobbying can take many forms. One particularly crass example was when one of the regional health enterprises engaged a former health politician and member of parliament to lobby the government in a tussle over patients with another health enterprise (Christensen and Lægreid 2003b). When the minister of health became aware of this activity he immediately put a stop to it, saying it was unacceptable for enterprises to employ lobbyists to influence their own owner. The same regional health enterprise also made the controversial move of commissioning reports from two business colleges to argue against and oppose the owner, the ministry. But the most controversial case related to this regional health enterprise, headed by a former top civil servant in the Ministry of Health and Social Affairs, was the case of cheating on the DRG system (Christensen, Lægreid, and Stigen 2004). DRG is a system whereby medical doctors code each patient's disease according to a complicated typology of diagnoses. The more severe a diagnosis, the more the hospital is reimbursed, which obviously leads to many intricate strategies to obtain more money from the government. In this case, a subordinate doctor proposed to the health enterprise a new creative way of coding, something that the director and some single enterprises accepted. When this somewhat audacious method of cheating on the system was revealed, there was a strong criticism from both the audit office and the parliament. The minister mounted an investigation and the board of the regional health enterprise was instructed by the minister to react and report back. Some single local enterprise managers were dismissed and supplementary grants had to be paid back. The director of the regional health enterprise was also severely criticized and eventually he resigned from the position. The minister also replaced the members of the executive board of the regional health enterprise. This does not seem to be a unique case. Later investigations by the audit office revealed that creative coding seems to be a rather common practice at hospitals (ibid.).

These cases indicate first that it is difficult to limit central steering to formal arrangements such as the enterprise meeting once a year and the steering documents. Added to this there seems to be an ongoing dynamic informal steering dialogue. Second, the formal frames do provide the health enterprises with some autonomy as indicated by the cases of mergers and closures of local health services. Third, crises such as the Dentosept case necessitating immediate action clarify the balance between autonomy and control. Fourth, there are clear options for political control in spite of the formal autonomy of the health enterprises as illustrated by

the establishment of the unit for national coordination of purchasing. Fifth, there is an interesting dynamic balancing authority and autonomy in the relationship between the central and the regional levels and between the regional and the local levels. In some cases the authority at the regional level over the local health enterprises is overruled by the central level, as in the case of the closure or merger of local health services. In normal situations the local health enterprises can have a lot of autonomy, but when something goes wrong, as in the DRG case or the Dentosept case, the central level can intervene and strengthen its control. Finally, the cases illustrate that environmental factors such as media coverage affect the agenda setting and the trade-off between autonomy and control. Normally, cases that receive high public attention tend to strengthen the political control component, and not only in cases of principal importance (Neby 2003).

To sum up, these cases reveal that the trade-off between autonomy and control is not only about the relationship between executive politicians and regional health enterprises, but is also about the relations between regional health enterprises and the local health enterprises as well as a dynamic interaction between local political actors, members of parliament, and the minister of health. One intention of the reformers was to put politicians at arm's length by excluding the regional counties from the decision-making process and regional party politicians from the boards of hospitals. Although they have succeeded in doing this, political involvement is now tending to reappear in the form of local lobby groups and in an increased focus on health policy by members of parliament, thus challenging the balance between enterprise autonomy and central political control that the reform agents wanted to establish. In addition, more central control by the political executives is also looming because many of the cases shown decrease their legitimacy; however, their steering is moving away from the strategic frame steering and toward a stronger focus on individual cases.

Why Is There Ambiguity and an Unstable Balance between Enterprise Autonomy and Political Control?

Our survey data showed that the enterprise executives seem to combine an autonomous role with a strong sense of loyalty toward the Ministry of Health. At the same time they report detailed control from the owner, insufficient coordination of different roles of the state, and lack of political support in controversial issues. This ambiguity is further illustrated

in the case studies, which also revealed that the trade-off between the autonomous role of the enterprises and political control seems somewhat unstable and unpredictable. The relationship can therefore be characterized as dynamic—open to change and modification.

In this section we ask why the balance appears ambiguous and open to pressure based on the different perspectives on administrative reform. It can be argued that it is not a great surprise that the balance is unstable and ambiguous, considering the hybrid nature of the new model. This reform, like the other NPM-inspired reforms, has its roots both in the centralizing tendencies of contractualism and in the decentralizing tendencies of managerialism (Aucoin 1990; Hood 1991). As mentioned earlier, ambiguity may also be caused by the fact that the reform is still a novel one. More interesting than documenting ambiguity is to ask under what conditions is the balance threatened—is it possible to understand and predict when the balance may be upset? We argue that the balance is due to instrumental, cultural, and environmental conditions.

From an instrumental perspective, a central feature of the reform is the formal basis of the relationship between the owner and the health enterprises as specified in the Health Enterprise Act, the articles of association, the steering documents, and the general enterprise meeting. The question is whether these documents and formal arenas of communication define a clear division of responsibility between the owner and the enterprises. Have the new act and other formal arrangements clarified the former gray zone between the political executives and the health care institutions?

The Health Enterprise Act states that major and principal issues should always be presented to the owner for final decision. These are major issues concerning health policy in general, research and education, and other cases of high social importance. In the articles of association some specifications are made. One example is the major changes in the organization, dimensioning, and localization of the health services. But despite these specifications, we would argue that the amount of room for discretion and ambiguity is quite large. Neither in the preparatory legislative work nor in the articles of association is there a clear and unambiguous definition of what is defined as a major and principal issue (Opedal 2004). Even though the respondents claim that the formal division of responsibility between the owner and the enterprises is quite clear, it is possible to question which issues have to be presented to the owner. There is, as such, considerable leeway for different practices and interpretations. Correspondingly, many aspects of autonomy are not regulated in the formal framework of the reform. The trade-off between autonomy and control is therefore subject

to continuous interpretation and adjustment, depending upon the situation and the issues on the agenda.

To consider the hospital reform the result of a deliberate plan by politically elected leaders with comprehensive insight into the effect of the chosen organization model and power over the reform process would be to present an incomplete picture. Politicians do not live up to the ideal preconditions of an active administrative policy, but this does not mean that the idea of political choice and instrumental design has no explanatory power in this case. Through the power to intervene in individual cases and the use of indirect control mechanisms such as regulating the decision-making process, political leaders succeed in preserving a certain degree of latitude, albeit constrained by cultural features and environmental pressure.

From an institutional perspective it is important to focus on the compatibility between the reform content and the established traditions within this policy area. The change of ownership as well as the introduction of the enterprise model challenges the traditional way of organizing hospitals in Norway. We should expect some kind of cultural collusion between robustness and historic inefficiency when the reform encounters cultural constraints. This would particularly be the case in the ambiguous transition period of the initial years after the reform was launched and before it has settled into a new phase of equilibrium. The hospital reform is currently in its third year and it may well be argued that ambiguity between control and autonomy is also partly due to a cultural conflict between the former public administration regime and the new enterprise regime. The system has not yet developed a unique soul or identity, serving to create and maintain a gray zone between political control and autonomy.

We would argue that the health care sector is experiencing a process of new identity building that can explain why there is ambiguity between control and autonomy. The enterprises have, on the one hand, changed names, corporate images, and location (cultural artifacts). Through this process, one has tried to create a new identity for the organizations involved. It is stressed that the hospitals have become new entities with a new independent status, their own personnel and staffing arrangements, their own corporate image, and their own board of directors—one has tried to create a new corporate identity. On the other hand we witness tendencies of path dependency. We have interpreted our survey data as evidence of a clear loyalty toward the owner. This loyalty, however, may also be interpreted as evidence of a traditional culture in the sector. Traditionally, there has been a close relationship between the health institutions as public enti-

ties and the former owners of the hospitals—the counties (Carlsen 1995; Martinussen and Paulsen 2003). As a core part of the welfare state, health policy has gained much attention among central politicians, both at the ministerial level and in the *Storting*. One might thus argue that the culture so far favors political control more than autonomy (Lægreid, Opedal, and Stigen 2005). The actors in the health sector are accustomed to making appeals to the ministry and MPs when principal and difficult issues are put on the agenda. It is also worth mentioning that a significant number of administrative employees in the enterprises were previously employed in the county health administration (Opedal and Stigen 2003).

Likewise, it seems somewhat difficult for the politicians to accept that the reform for which they had voted actually states that the politicians are supposed to practice hands off to a greater degree than hitherto. The NPM ideas of decentralization set some limits for state ownership. Devolution and increased power to the executive boards place clear demands on how politicians should engage in an issue that has been transferred to the health enterprises. Devolution presupposes that the role of the politicians is more principal and long term and that there is a clear division of responsibility between politics and administration. Politicians are supposed to formulate goals and visions, while implementation is left to the administration (Boston et al. 1996). The hospital reform assumes that the MPs' role is restricted to principles of management and that they do not intervene and become embroiled in details, as was often the case under county ownership (Carlsen 1995; Odelsting 2000–2001).

The new and more strategic role for the politicians does, however, meet a strong traditional norm for political behavior—where solving concrete and immediate issues is central (Aberbach and Rockman 2000). On several occasions parliament has engaged in issues that formally were to be determined by the executive boards. The female lobby group in the maternity cases is one obvious example. This shows that parliament is quite uncertain about its new role. Intervention in single cases may be interpreted as an attempt to compensate for less control (Hood 1999), but with informal instruments that have no legitimate place in the new regime.

Seen from an environmental perspective, one has to take into account the characteristics of the task environment represented by parliament, local pressure groups, the media, and lobbyism to understand how the trade-off between autonomy and control occurs in practice and how it changes over time and between issues. Design and deliberate choice from the ministry as an owner is not only constrained by the historical-institutional context but also by contemporary pressure from actors in the task environment.

Parliament has devoted more attention to health policy since the ownership of the hospitals was transferred. In 2002, the first year of the reform, the number of questions in parliamentary question time covering hospitals and health enterprises doubled compared to the mean number during the six preceding years (Opedal and Rommetvedt 2005).

Increased political attention to health policies takes place in a period when parliament in general has become more important vis-à-vis the cabinet (Espeli 1999; Nordby 2000; Rommetvedt 1998, 2002, 2003). Over time parliament has become more active and unpredictable. The nature of the electoral system in Norway makes multiple parties and turbulent parliamentary conditions likely, and this has been the typical situation during recent decades. This situation often reduces the influence of the executive because the negotiations between the parties in the parliament become crucial. This is a kind of "super-parliamentarism" representing a situation when the *Storting* is considered too dominant over government exertion of executive power (Christensen 2003; Rommetvedt 2002: 69). State ownership combined with the present parliamentary situation (a minority government) can explain a greater political attention given to health policy. The reform has strengthened the role of the MPs due to the fact that there is no longer any formal regional political influence over health policies. In contrast to the previous divided responsibility between central government and the counties, the ministry now has control over and access to the entire range of policy instruments. The regional health enterprises are now regional owners and purchasers, and the local health enterprises are service suppliers. This has improved the conditions for vertical sector management and increased the power of central political actors, while the former owners of the hospitals, the counties, have been relegated to the sideline.

The parliamentary situation and a holistic responsibility placed on the central government are also prerequisites for an increased tendency of organized interest groups to direct their attention to and lobby of parliament (Christiansen and Rommetvedt 1999).

However, the attention of parliament, (local) pressure groups, and the media is not only dependent on structural and parliamentary conditions. We argue that it also depends on policy type. The empirical foundation is the observation that while some health issues seem to provoke only minor political engagement, others encounter much turbulence and political debate. For instance, very little public and political attention has been paid to the allocation of financial resources from the regional health enterprises to the local enterprises. There has also been very little discussion

about rules and guidelines for steering, control, and resource allocation. According to these issues, the regional health enterprises have substantial autonomy and the politicians seem quite comfortable with their position at arm's length from the enterprises. Other health policy issues have created considerable public attention and political controversy. Many questions raised in parliamentary question time have been concerned with economic retrenchment, closures and mergers of local health services, and especially the reorganization of maternity services (Opedal and Rommetvedt 2005). When these types of issues are placed on the agenda, politicians and pressure groups are on the alert and try to influence or reverse decisions, as some of the cases illustrate.

This phenomenon may be interpreted in terms of Lowi's typology of policy types and his idea that "policies determine politics"—that policy proposals structure politics (Lowi 1964, 1972). Lowi reversed the traditional concept in political science that politics determine policy outcomes and argued that different types of policy issues will constitute different policy arenas and processes, with different actors and degrees of conflict or cooperation (Roberts and Dean 1994). The potential of conflicts thus varies. When a policy has redistribution effects, winners and losers are especially significant and the potential for conflict is high.

In our cases, professionals, local interest groups, and politicians first and foremost protest against closure of local hospitals or certain medical services. The politicians, though, not only fight for their local hospital or service, but they also try to maximize political support or voters (Downs 1957; Schumpeter 1942). When the counties owned the hospitals, the regional politicians hesitated to put issues that implied redistribution on the agenda (Opedal and Stigen 2002b). They determined the limits of cooperation and thus prevented radical changes in the hospital structure.

State ownership leaves the regional health enterprises to decide on economic retrenchment and to undertake changes in geographical distribution of health services. Despite this, redistributive policies still harbor considerable potential for conflict, triggering tension between central politicians and regional owners and between decision makers and the surroundings encompassing pressure groups, media, and local politicians.

One implication of this dynamic is that autonomy varies by issue. The enterprises seem to have autonomy in some areas more than others. It is thus important to make a distinction between quality and safety of services, equity issues and location of services in which the intervention from the *Storting* and the central government seem to be rather frequent, and

other issues such as performance, efficiency, and allocation of financial resources in which there is more autonomy for the health enterprises.

Summing up, we have discussed three sets of factors that may explain ambiguity, instability, and dynamics between political control and enterprise autonomy in a reform that is in an introductory and implementation phase. The structural, cultural, and environmental aspects of the reform leave room for interpretation and adjustment and the trade-off between autonomy and control seems to be the result of a complex combination of deliberate choice, institutional constraints, and external pressure. In a process of interpretation, adjustment, and uncertainty there is leeway for political and institutional norms to challenge and influence the relationship between political control and autonomy. The tension becomes especially pronounced when redistributive policy is placed on the agenda.

Political Control and Enterprise Autonomy—Both Please?

The survey data and the cases studied revealed that there is a potential for ambiguity and conflict in the reform. The enterprises are loyal to the owner, but they also try to maximize autonomy. The politicians, however, experience loss of control when the enterprises live up to their autonomous role. The cases illustrate the conflict between a commercial logic, furthered by the regional health enterprises' enhancing efficiency and economy, and a political logic, furthered by local, regional, and central politicians, underlining the politically problematic and at times utterly unacceptable effects of such a policy. In many cases autonomy is challenged by political intervention in single issues and by other political efforts to enhance political control.

The data presented reveal that in practice it may become difficult to live up to the principles of devolution and the official formal governance model of frame-steering and performance management. The slogan "more steering in big issues and less steering in small issues" seems to be easier in theory than in practice. This is in line with experiences from other reforms (Christensen and Lægreid 2003b, 2004; Pollitt 2002). The ministry is supposed to set policy objectives, translate these into measurable targets, actively monitor and review agencies and companies annually as they strive to reach the targets, and ultimately reward successes and penalize repeated failures. In many cases, though, this model gives an imprecise picture of what is occurring in practice. There seems to be a zone of indifference in which the managers might operate with great autonomy

in the shadow of the politicians. However, this room for maneuverability is not stable. When something goes wrong and there is media pressure or lobbying, the ministry can intervene and withdraw some of the liberties of the agencies, formulate new rules, and reprimand the agencies for actions that really should have been discussed or clarified at target-setting time. The situation may imply that the minister ends up in a catch-22 situation. A minister who abstains from involvement may be criticized for being too passive, whereas a minister who does intervene may be accused for not complying with the rules of the game. The health reform has made the role of the health minister more complex, characterized by cross-pressure and conflicting expectations. This does not mean that the old system was perfect concerning central control and policy capacity, because the role of the counties was varied and ambiguous and the focus on efficiency was weak.

Our conclusion is that the assumption about a more refracted role of politicians and a more general strategic steering of the hospitals is not only a theoretical simplification. It is also unrealistic given the political-administrative constraints and the tradition of steering in this policy area (Lægreid, Opedal, and Stigen 2005). The government uses specific steering tools that supplement the strategic and general frame steering. Thus the balance between autonomy and control seems to tip in favor of control.

Going back to the question of how this trade-off between autonomy and control affects the fulfillments of the intended goals of the reform, we cannot give a firm conclusion partly due to the fact that it has not been in effect long enough to see the impacts. What we can say, however, is that it is very difficult to have positive effects along goals that are partly in conflict with each other, such as equity, efficiency, quality, and economy. By strengthening political control and weakening managerial autonomy, one might gain in equity and lose in efficiency.

One import question following this conclusion is whether it is possible to achieve a plus-sum game between control and autonomy. Stability in the trade-off between autonomy and control is probably an elusive goal and achieving a balance between the two has been a recurring problem in Norwegian administrative history (Grønlie 2001). An unstable balance is a basic systemic feature that cannot be solved once and for all. Instead, one must expect to live with partly conflicting values.

It therefore becomes a primary challenge to determine which factors affect the trade-off between central control and local autonomy. In this essay we have focused on some structural factors, cultural factors, and

environmental factors linked to the parliamentary system in Norway. But the type of policy issue and the political salience of the tasks and issues seem especially important. The cases clearly illustrate that we have to go beyond the legal status and formal powers of the agencies and the enterprises to understand how the balance between political control and autonomy works in practice (Christensen and Lægreid 2003a; Pollitt 2005).

One main lesson is that context matters. The effects of structural arrangements, culture, and the present parliamentary situation are dependent on the character of the policy issue that is on the agenda. If the issue has a redistributive character, it seems especially challenging for the balance between political control and autonomy. We are now facing the ambiguity of the implementation phase and the optimistic argument is that once the balance of autonomy and control is fixed up in the new system it might be a better policy instrument. The more pessimistic forecast is that the underlying policy theory of the reform is based on a naïve assumption that it is possible to get rid of the political processes by introducing management principles and organizational forms from the private business sector, implying that the reform is doomed to failure in its initial version.

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