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Inger Marie Stigen

The structural anatomy of hospital government systems in Norway, Denmark and the United Kingdom

A comparison

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Preface

In this report the structural anatomy of the hospital government systems of Norway, Denmark and the United Kingdom is mapped and compared. The study is part of the project "Governing public health services: The interplay between patients, professionals and politicians in a comparative perspective", funded by the Research Council of Norway, as part of the program "Health care services". Head of research Hilmar Rommetvedt, International Research Institute of Stavanger (IRIS) has been project leader.

Inger Marie Stigen has written the report. Since June 2009 she has been employed as associate professor at the Oslo University College (OUC) and the report is finished as part of her research at OUC. The analytical framework of the report has been developed together with IRIS-researchers Ståle Opedal and Hilmar Rommetvedt (cf. Opedal, Rommetvedt and Stigen 2007 and Opedal and Rommetvedt, forthcoming 2010). They have also given valuable help and comments to earlier drafts. Thanks also to professor Tore Hansen, University of Oslo and NIBR for generous and helpful comments.

Oslo, April 2010

Trine Myrvold

Research director

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Summary

Inger Marie Stigen

The structural atonomy of hospital government systems in Norway, Denmark and the United Kingdom.
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In this report the structural anatomy of the hospital government systems of Norway, Denmark and the UK is analyzed. All three countries have implemented more or less comprehensive structural reforms in specialized health care during the last decades. The purpose is, first and foremost, to map and compare the formal structure of specialized health care in the three countries, but some possible implications for health care policy making are also outlined.

Descriptions are traditionally rather poorly valued in political science. Good descriptions are, however, necessary foundations for skilled research. In this report a simple, but coherent analytical design is used. We believe this design is a fruitful base for further studies with more specific analytical questions concerning specialized health care.

In chapter 2 the analytical framework is presented. This analytical framework highlights four basic dimensions. The first dimension deals with the allocation of *political-democratic authority and financial responsibility* between national, regional and local (municipal) governmental levels in specialized health care. The second dimension refers to *parliament-executive relations*. This concerns the power of the legislators relative to government in parliamentarian democracies. The third dimension that is included deals with *political-administrative relations*. Here a major distinction is made between integrated and separated systems. Three indicators are discussed: structural task and role specialization; form of affiliation and degree of

managerial autonomy; and accountability systems. The fourth dimension refers to structural arrangements for *patient/user involvement,* where a major distinction is made between obligatory and voluntary arrangements.

In chapter 3 the description is presented. It focuses on structures at the parliamentary level, at the ministerial and agency level and at the regional and local/hospital level. In chapter 4 the differences and similarities are discussed according to the analytical framework.

The description does first of all indicate variations in size and complexity of the three systems. The British specialized health care system is of course a lot more extensive and complex than the Nordic ones, partly because of country size. The description does, however, also show significant differences between Denmark and Norway. Both countries have implemented rather comprehensive reforms since the millennium change, but the reform in Denmark (in 2007) turned out less radical than the Norwegian one (in 2002). There are, however, elements that also make the Danish model quite novel and complex, particularly the financial system.

The mapping indicates how the three systems vary according to our analytical indicators. First; in Norway and the UK the political responsibility for specialized health care rests with the national parliament. The state also has the entire financial responsibility for specialized health care. Norway and the UK do, however, differ when it comes to parliament-executive relations. The Norwegian parliament is regarded as strong compared to the British parliament. In this respect, Norway and Denmark equals, but in Denmark, political responsibility for specialized health care rests with the popularly elected regions. Besides, in Denmark the financial responsibility is shared between the state and the municipalities. Thus, the responsibility of the Danish regions may be characterized as rather limited.

Second; task and role specialization and administrative autonomy are more extensive in the British and Norwegian specialized health care system than in Denmark. All three countries have a substantial number of health agencies subordinate to ministry, but especially the British system is characterized by extensive differentiation in organizational forms at the agency level. Besides, both the UK and Norway, contrary to Denmark, have made split-ups between ownerships-functions, commissioning, regulation and auditing, and service delivery functions. And of course, the enterprise/trust models in Norway and the UK indicate more extensive administrative autonomy for hospitals in these countries than in Denmark,

where all hospitals still are ordinary civil-service organizations. In particular the introduction of the foundation trust model in the UK has given more financial and administrative leeway for many hospitals.

Third; managerial accountability arrangements are more differentiated in specialized health care in the UK and Norway compared to Denmark. Boards of directors in Norwegian regional and local health enterprises and in British health care trusts are indicators of ex-ante accountability arrangements. Besides, there is substantial use of performance contracts, and various forms of reporting methods and auditing agencies, especially in the UK. Together this indicates more focus on "downward" as well as traditional "upward" accountability in British and Norwegian specialist health care than in Denmark.

"Downward" accountability is also aimed at through specific arrangements for patient involvement. In the UK and Norway structural arrangements for patient involvement is obligatory (patient commissions and local involvement networks). In Denmark patient involvement arrangements are voluntary.

In the last section I make some reflections on implications for health care policy-making.

Although the state (together with the municipalities) has the financial responsibility in Denmark and it thus has been argued that also the Danish system has become more centralized, the ownership structure indicates more influence and control to national politicians in the UK and Norway than in Denmark. It is however important to distinguish between government and opposition in the three countries. The "winner takes all" model which strengthen the executive vis-à-vis the parliament in the UK, indicates that the opposition in Parliament is less influential in the UK. Thus we assume less integration between parliament and the executive in the UK than in the Nordic Countries. In total, the Norwegian parliament is regarded as the most influential one.

In Norway, it is obvious that the hospital reform strengthened the national politicians' role vis-à-vis the politicians at the regional and local level, because ownership was transferred from the counties to the state. Following a debate on "democratic deficit" in hospital politics in general, and especially in locally or regionally related matters (particularly hospital structure), the new Red-Green government in 2005 decided that the composition of the regional and local enterprise boards was to be changed. When the hospital reform was implemented in 2002, no active

politicians were appointed members of the boards.
After 2006 former and active politicians constitute the majority of the board members. The local politicians on the boards are meant to increase the local and regional responsiveness of specialized health care, but they do *not* have political mandates from their constituencies. Their representation is gently spoken, quite ambiguous. The fact that the borders of the regional health enterprises and quite a number of the local health enterprises intersect the borders of the counties and/or municipalities as well as other state regions may further increase this ambiguity.

The introduction of the foundation trusts in the UK may also be interpreted as a means to strengthen the link to the local communities and make hospital policy more responsive to local needs and opinions. At least one member in each Board of Governors in the foundation trusts must represent Local Authorities in the area. In Denmark the regional politicians *are* responsible for specialized health care. Here it is more a question of if and how the municipal politicians may influence. One instrument is the financial one. Besides, the Health Coordination Committees with members both from the regional and local level is a formal channel for influence.

In the reform literature questions of balance between political control and the influence of health managers, bureaucrats and other professionals have gained far more attention than questions of differences in power between governmental levels. The mapping shows that the formal structures of the specialized health care systems in the countries under study may influence the trade off between political control and administrative autonomy differently. The specialized and segregated trust models in the UK and Norway may enhance managerial autonomy and role purification, but the "other side of the coin" may be less and poorer access to political leadership, poorer political coordination and control; probably even more in the UK than in Norway. The integrated and more "traditional bureaucratic" model in Denmark, on the other hand, indicates tighter political control and more easier access to political institutions and political leadership for bureaucrats and other professionals in health care.

Last, but not least, the mapping demonstrates how structural arrangements for patient involvement vary between the three countries. Both the UK and Norway have established formal and obligatory arenas for patient/user involvement, while Denmark seems to be "lagging behind". There are so far relatively few formal forums for user

responsiveness or downward accountability arrangements in Denmark. The difference may imply that patient groups are more integrated and have more contacts at the hospital level in the UK and Norway than in Denmark. Thus, patients and other interest groups in Danish health care probably act more in accordance with a citizen role than a user role.

1 Introduction

During the last decades Norway, Denmark and the United Kingdom have implemented more or less comprehensive reforms of their hospital government systems. In 2002 the responsibility for the Norwegian hospitals was transferred from 19 politically governed counties to the state and a decentralized enterprise model was established to run the hospitals. Denmark completed her reform in 2007. The 14 counties that were politically responsible for hospitals and other health care services were replaced by five politically governed regions. In the UK the NHS[1] trust structure based upon a centralized political ownership has been maintained for many years, but there has also been a trend towards more administrative delegation and introduction of new organizational forms which establish more immediate links to the local communities. The British system has been labelled a *centralized* NHS system, the Norwegian system has been labelled a *semi-centralized* NHS system and the Danish system has been labelled *semi-decentralized* (Hagen and Kaarbøe 2006, Opedal, Rommetvedt and Stigen 2007).

In this report the structural anatomy of the hospital government systems in Norway, Denmark and the UK[2] after the recent reforms, is analyzed in more detail. My purpose is, first and foremost, to map and compare the formal structure of the specialized health care in the three countries along different analytical dimensions, but in the last section I also discuss some possible implications for health care policy making. How may formal arrangements at different organizational levels shape access to the policy agenda, and thereby affect the way issues are presented, formulated and implemented in health care processes?

[1] National Health Service (NHS)

[2] I focus on the NHS in England. Scotland and Wales are not included in the analysis, since the NHS in Scotland, Wales and Northern Ireland, due to the devolution of power to the new Scottish parliament and Welsh and Northern Irish Assemblies in 1999, is organized and run separately from the NHS in England.

There are, needless to say, numerous comparative studies and typologies of health care systems and health care policy. Given this fact, my descriptive aim may, on the one hand, seem quite unambitious, on the other, a quite challenging one. It is unambitious if we accept parallel single country descriptions without clear analytical dimensions as comparisons, but it is a lot more challenging if the description is based on a set of analytical dimensions suitable for empirical operationalizations and hypothesis-testing. In this report I will use an analytical framework that we believe is theoretically and empirically fruitful for health system comparisons. Landman (2007) discusses four main objectives of comparative studies: contextual descriptions, classifications, hypothesis-testing and predictions. Contextual descriptions and classifications are less ambitious than theory testing and prediction, but as Landman (2007:21) states, "Predictions cannot be made without well-founded theories; theories cannot be made without proper classification; and classification cannot be made without a good description". Thus, a good description is a necessary foundation for skilled research.

It is often asked if there is a development in the direction of more convergence in the organization of medical care in Western countries (Powell and Wessen 1999, Blank and Bureau 2004, Opedal 2006). Similar goals, fairly the same economic and social problems, and exposition to New Public Management ideas, have been claimed to be important causes (Powell and Wessen 1999:5ff). Although there are many examples of convergence, there are also a significant number of countries that do not fit into usual typologies (Blank and Bureau 2004). To get a deeper understanding of the nuances in terms of structural differences and similarities, I claim that we need, not necessarily more comprehensive, but more consistent analytical frameworks.

Focusing on differences in welfare regimes and more basic characteristics of the governmental systems gives us a "wide structural panorama" for comparison. This panorama displays three countries that are unitary states in more or less centralized/ decentralized versions and with a Beveridge health care system in common (Blank and Burau 2004:23, Opedal 2006, Opedal, Rommetvedt and Stigen 2007). To be able to unpack the diversity and grasp the more subtle distinctions and nuances we have to go beyond such a panoramic view. We have to open multiple "organizational windows" as well as search for small "organizational peepholes", though without making the mapping too comprehensive and complex.

The perspective I try to apply more systematically is a perspective where I highlight some *basic political-administrative structural dimensions*. The assumption that organization matters is a simple, but nonetheless fundamental assumption for the analysis. By analyzing the way political-administrative systems are organized we gain an understanding of who is expected to do what and how, which interests and goals that are to be pursued, and which considerations and alternatives that should be treated as relevant. The structures set limits as to who can participate, and limit what is deemed acceptable, reasonable or valid perceptions of different situations, problems and solutions. Structural arrangements draw attention to certain concerns, while other concerns are downgraded or made invisible (Egeberg 2003:116ff, Christensen et. al. 2007). The structure is never neutral, it always represents a bias; be it participants, problems, solutions or decisions (Schattschneider 1975:30).

The data in this report has been collected from the government web sites of each country, from annual reports and from research publications dealing with specialized health care structures. The report is organized as follows: First I present my analytical framework, focusing on a government system typology with four main dimensions: One dimension deals with the allocation of *political-democratic authority and financial responsibility*. The second refers to *parliament-executive relations*, the third refers to *political-administrative relations* and the fourth deals with *patient/user involvement.* Second: the structural anatomy of the specialized health care policy structure of Norway, Denmark and the UK is described. The description focuses on structures at the parliamentary level, at the ministerial and agency level and at the regional and local/hospital level. In the third and last section I discuss the similarities and differences between the countries according to my analytical framework and make some reflections on implications for health care policy-making.

2 Analytical framework

To be able to grasp the structural complexity of the hospital government systems in Norway, Denmark and the UK, after the recent reforms, I base my analysis on four dimensions. Two of the dimensions refer to a typology on hospital government systems, developed and used by Opedal and Rommetvedt (cf. Opedal and Rommevedt 2010, forthcoming). This typology, which characterizes the hospital government systems and the changes caused by the recent reforms in the three countries, is illustrated in Figure 2.1.

The dimension on the horizontal axis refers to the allocation of political-democratic authority and responsibilities, and the dimension on the vertical axis deals with political-administrative relations. The figure indicates how the Norwegian hospital reform in 2002 involved both dimensions in the figure. Political-democratic authority was transferred from the county councils to the state level and political administrative relations changed from a traditional integrated model to a model of separation. In Denmark, regional political responsibility for hospitals continued after the comprehensive structural reform in 2007, but the new regional councils were given more limited authority than the former county councils had. At "the political-administrative relations" dimension, the Denmark hospital government system is still characterized as integrated. The UK is characterized by centralized political-democratic authority and more and more pronounced separation of political-administrative relations during the last decade (Opedal and Rommetvedt 2010, forthcoming).

Figure 2.1 *Hospital government systems and recent reforms in Denmark (DK), Norway (NO) and the United Kingdom (UK)*

		Political-democratic authority		
		National, Parliament	Sub-national, regional/county council	
			limited authority	wide-ranging authority
Political-admin-istrative relations	Integrated		NO DK$_{2007}$ ←	DK
	Separated	UK ↓ NO$_{2002}$ UK$_{2002}$ ↓ UK$_{2004}$		

Source: Opedal and Rommetvedt 2010, forthcoming.

My aim is to give a more comprehensive comparison of the three hospital government systems after the recent reforms. First, I include financial responsibility to the political-democratic authority dimension. Second, two more dimensions are introduced, based on Opedal, Rommetvedt and Stigen (2007) and Opedal, Rommetvedt and Vrangbæk (2008). One refers to parliament-executive relations or the strength of the parliament vis-à-vis the government. The other refers to arrangements for patient involvement in decision making processes related to hospital matters.

Below the dimensions are elaborated and discussed in more detail, and the main questions for the analysis are presented.

2.1 Allocation of political-democratic authority and financial responsibility: national versus sub-national arrangements

The political-democratic dimension refers to how *political* authority concerning specialized health care (i.e. hospital matters) is allocated between national, regional (intermediate) and local (municipal) governmental levels, i.e. *political centralization versus decentralization.*

Although the number of levels of government responsible for health care policy, including hospital care, does vary considerably among European countries, decentralization of authority to lower governmental levels seems to be a common strategy (Saltman, Bankauskaite and Vrangbæk 2007). The term decentralization must, however, be clearly defined, because it often "represents many things to different people" (Saltman and Bankauskaite 2006; Saltman, Bankauskaite and Vrangbæk 2007:1-2ff). In accordance with Saltman and Bankauskaite (2006) and Pollitt (2005:371ff), I distinguish between *two core* characteristics of decentralization: a) if authority is allocated to a regional or locally elected *political* body, run according to democratic rules, or b) if authority is delegated to *administrative* entities run according to managerial regulations prescribed by national government. The dimension on the horizontal axis in Figure 2.1 concerns *political* centralization and decentralization. This is, by definition, an allocation of authority to a national, regional or local *popularly elected body.* Besides, Opedal and Rommetvedt (2010, forthcoming) emphasize that allocated political authority to sub-national political authorities may be *more or less wide-ranging.* What should be considered limited versus more wide-ranging authority is, however, often not very obvious. This is indicated by the "dotted" line in Figure 2.1. The politically most decentralized hospital systems are those where popularly elected government at sub-national levels have wide-ranging authority, of which the right to impose taxes is the most wide-ranging one.

According to the discussion above, the first set of questions for the comparison is: Who is *politically* responsible for specialized health care services in the three countries under study? Are hospitals owned and governed by national or by regional and local elected bodies? And how wide-ranging is the authority of sub-national political authorities? An important indicator here is financial responsibility.

2.2 Parliament – executive relations

I include parliament-executive relations as my second analytical dimension. This concerns the power of the legislators relative to government in parliamentarian democracies, a relation that varies between countries.

The distinction between consensual and majoritarian democracies, made by Lijphart (1999) is considered (one of) the most powerful analytical distinctions in comparative studies of parliamentary democracies. A major difference between the two systems is that the power of the executive usually is more pronounced in majoritarian than in consensual democracies, while consensual democracies have stronger parliaments. A majoritarian (often also mentioned Westminister) system is characterized by single member constituencies and plurality voting, while consensual systems are characterized by multiple-member constituencies and proportional allocation of seats. By definition majoritarian systems lead to majority governments, usually dominated by one party. In consensual democracies, governments are often minority governments, either one-party or coalitions of parliamentary parties. They are considered less stable and more dependent on compromises in parliament. Thus, parliament gains a more influential role in such systems.

There are also other conditions that may influence parliament-executive relations. Rasch (2004:136) points to the distinction between "working" and "debating" parliaments. He especially emphasizes the feature of the committee system. A characteristic of "working" parliaments is, according to Rasch (2004:136), committees which broadly correspond to governments ministries, and "use their specialized knowledge to control and revise, rather than just rubber stamp decisions from the government".

Besides, Rommetvedt (2005:749) points to the political and administrative capacity of parliament. He discusses how "the acquisition of resources may enable parliaments and especially opposition parties to exert their potential power". The indicator Rommetvedt uses is number of staff in parliament relative to the number of MPs.

According to the discussion above, the second set of questions for my description is: How strong is parliament versus the executive in the three countries under study? Are the countries under study so-called consensual or majoritarian democracies, and how are the committee structure and the political and administrative capacity in parliament?

2.3 Political-administrative relations: integrated or separated?

The third dimension refers to political-administrative relations. Here a distinction is made between integrated and separated systems (Opedal and Rommetvedt 2010, forthcoming). An integrated system is characterized by limited vertical and horizontal structural specialization and tight political control over administrative functions. In a separated system the division between political and administrative functions is sharper, and the discretionary power of subordinate levels and managers are strengthened through vertical structural specialization and managerial devolution. While an integrated system is more in line with the traditional "old" way of organizing public administration, a separated system is more in line with "new public management" (Christensen and Lægreid (eds) 2001, 2007, Opedal and Rommetvedt 2010, forthcoming). A basic difference between an integrated and a separated model when it comes to political and administrative functions is that an integrated model "combines potentially tight control of the civil service with easy access for the bureaucrats to the political leadership, while the latter combines potentially weaker control of the civil service with poorer access of the bureaucrats to the political leadership" (Christensen and Lægreid (eds) 2001:97).

Political science literature on New Public Management reforms in Anglo-Saxon countries the last decades is vast. A common characteristic of the reforms is that they have resulted in substantial fragmentation of public administration, both along a vertical and a horizontal dimension (Christensen and Lægreid (eds.) 2001, 2007). Public administration has changed from integrated to more differentiated and complex structural systems. Terms like "agentification", "autonomization", "single purpose organizations", "siloization", "pillarization" and "fragmentation" are used to characterize this development.[3] More focus on accountability and accountability regimes is another typical characteristic (Pollitt and Bouckaert 2004, Christensen and Lægreid (eds) 2001, 2007*)*. In the following sections I will focus more in detail on three aspects of the political-administrative dimension: 1) structural task and role specialization (either vertically or horizontally), 2) form of affiliation and 3) accountability systems. Bearing in mind that the literature often is unclear

[3] Few do however define what they actually mean by the term "fragmentation". Where is the breaking point between specialization and fragmentation? Is it a structural and/or a procedural definition?

about what is meant by different concepts (Christensen and Lægreid 2006a:9), the aim of the discussion is to single out and clarify the variables in the comparative analysis.

2.3.1 Role and task specialization – vertically and horizontally

Specialized health care, like most other public policy areas, is characterized by a diversity of complex roles where attention has to be paid both to political considerations, professional considerations, considerations of user involvement, service quality and considerations of efficiency (Egeberg 2003, Christensen et. al. 2007:6ff). In the traditional welfare state model, different administrative roles and considerations generally have been bundled together in integrated organizational models. But, with the introduction of New Public Management ideas, one of the new administrative mantras became role-purification and more "unbundled government" (Pollit and Talbot (eds) 2004). The new administrative ideal has been streamlined and clear-cut administrative arrangements without risk of blurring more or less intersecting considerations and roles. The arguments have been founded on a fear for "foxes that shall keep the geese", especially in cases concerning audit and control.

The idea has been handled through greater vertical and horizontal structural specialization (Flinders 2004, Pollitt and Bouckaert 2004, Christensen and Lægreid (eds) 2001, 2007). While vertical specialization expresses how tasks and authority are allocated between organizations at different levels, horizontal specialization expresses how tasks and authorities are distributed among different organizations at the same hierarchical level (Christensen et. al 2007:24-25¸ Roness 2007:65). Thus, the question of separated or integrated systems is about two basic dimensions in organizational thinking - specialization and coordination (cf Gulick 1937; Egeberg 2003, Christensen et al 2007).

One indicator of task and role specialization is *separation of political and administrative or professional functions.* This concerns not only considerations of checks and balances between the political and administrative spheres, but also considerations of goal formulation and design versus implementation efficiency. Verhoest et al. (2007:328) describes the split/merger of policy design and implementation as a "topic of cyclical movements". The classical model was to "keep these two major components of the cycle in one hand since implementation should follow the logic of its design" (op.cit). NPM has, however, encouraged a split with goal formulation and design in one organization and implementation

in another. Politicians on an arm's length distance from administrative functions are expected to increase political control and administrative discretion and efficiency at the same time (Christensen and Lægreid 2001:97, Opedal 2006).

Another indicator of task and role specialization is *separation of administrative functions* among units *at different hierarchical levels or at the same level.* Responsibility for ownership functions, purchasing, service-delivery and regulation may be split, either between public agencies at the same governmental or hierarchical level, or between public agencies at different governmental or hierarchical levels.

Various types of central agencies/ directorates, state owned enterprises or state owned companies (SOCs) at arm's length from the ministries, often termed Arm's Length Bodies are indicators of task and role specialization along a vertical dimension. Where specialized health care is owned by the state (i.e. no political responsibility allocated to regional or local political bodies) the occurrence of *state field administration at regional and local level* is another indicator of vertical specialization. Indicators of *horizontal* specialization are the occurrence of separate, distinct entities for different administrative roles and functions at the *same* governmental or hierarchical level, for instance separation of ownership functions, development functions and financing of specialist health care in different ministerial departments. Following this line of argument, Hooghe and Marks' (2003) distinction between multi-functional and uni-functional governance at the regional level and between coterminous and non-coterminous administrative divisions of different state field administrations is interesting and relevant for our comparison (cf. also Hansen and Stigen 2007).

My next question for the description is accordingly: To what extent are different political and administrative roles and functions dispersed, between and at various governmental levels? And, following the conceptualization of Hooghe and Marks (2003): Is specialized health care politically or administratively bundled together with other policy areas, be it at national or sub-national levels? Besides, are the borders of health care administrations at regional levels coterminous with those of other regional authorities? A separated system is, compared to an integrated system, characterized by more extensive role and task specialization and dispersion, both vertically and horizontally.

2.3.2 Form of affiliation – degree of administrative autonomy

There is, as indicated above, a vast literature that describes how administrative authorities, due to NPM, have become more loosely coupled to the ministries and have gained more managerial autonomy. Agencification and autonomization are frequently used buzzwords. A weak point of the literature is, however, that it often lacks clear and operational definitions of the terms that are used (Christensen and Lægreid (eds) 2006, Roness 2007). Central agencies are, for example, described variously as central administrative bodies/directorates, as nondepartemental public bodies, as hybrids, as quangos or fringe bodies (Christensen and Lægreid (eds) 2006a:12). To be able to carry out a systematic and coherent comparison between countries we thus have to make clear which forms of affiliation we compare, and how the various forms are defined.

At the central governmental level, the agency form is not a new one, but it has become more differentiated during the last decades' diffusion of political and administrative belief in the benefits of managerial autonomy and arms' length positions from the political centres. I will, like Christensen and Lægreid (2006a) use Pollit and associates' (Pollitt and Talbot 2004) rather narrow definition of agencies as my point of departure. Christensen and Lægreid (2006a:12) define an agency as

> … a structurally disaggregated body, formally separated from the ministry, which carries out public tasks at a national level on permanent basis, is staffed by public servants, is financed mainly by the state budget and is subject to public legal procedures. Agencies have some autonomy from their respective ministry in policy decision making and over personnel, finance and managerial matters, but they are not totally independent because political executives normally have ultimate political responsibility for their activities.

Thus, the "agency" definition comprises *central administrative bodies outside the ministries that are part of the state as legal entities*. It may however cover a variety of forms, degrees and type of administrative autonomy as well as functions.[4] Regulatory agencies are for instance one subgroup of agencies

[4] In Norway for instance: ordinary civil service organizations (ordinære forvaltnings-organ), civil service organizations with extended authority (forvaltningsorgan med særskilte fullmakter) and government administrative enterprises (forvaltningsbedrifter) (Roness 2007:77)

that often have more autonomy than agencies with managerial tasks (Christensen and Lægreid 2006a:13).

The other main type of affiliation is represented by *non-departmental governmental bodies that are separate legal entities outside the state*. Various forms of state owned companies that are subject to specific law are typical examples of organizations with this type of affiliation.[5]

In my comparison of the specialized health care structure in Norway, Denmark and the UK I will distinguish between the two main organizational forms described above: administrative bodies outside the ministries that are part of the state as legal entities versus administrative bodies that are separate legal entities. I am, of course, well aware that this is a rude distinction, but my aim is first and foremost to indicate differentiation of organizational forms and sketch the autonomy of subordinate administrative health bodies. My question for the description is thus: what forms of affiliation between ministries and subordinate administrative bodies do occur in specialized health care in Norway, Denmark and the UK? Compared to an integrated system a separated system is characterized by more differentiated organizational forms and substantial autonomy for subordinate administrative bodies.

2.3.3 Variations in accountability arrangements

There is a close and dynamic relationship between the form of affiliation of subordinate administrative bodies, administrative autonomy, and the question of accountability arrangements. Due to the establishment of administrative bodies with more managerial autonomy a central question has been how to make agencies independent and at the same time accountable; upward to politicians and superior bureaucrats, but also downward to users or consumers (Christensen and Lægreid (eds.) 2006). Accountability is not easily defined. While some limit the term to the traditional meaning of answerability, others extend it and relate it to responsiveness. An implication of such an expansion is, amongst others, that attention is not only drawn to upward accountability arrangements, but also to downward accountability to users or interest groups. As a result of NPM reforms, there has also been a change of accountability modes, from ex-ante input- or process-oriented accountability modes, to

[5] In Norway for instance: government-owned companies (statsforetak), government limited companies (statsaksjeselskaper), hybrid companies established by special law (særlovsselskaper) and governmental foundations (statlige stiftelser) (Roness 2007:78).

more ex-post, result-oriented accountability (Christensen and Lægreid 2006a:28, Verschuere, Verhoest, Meyer and Peters 2006).

My question for the description is: How widespread are various accountability arrangements? In the comparison I will, inspired by Verschuere et. al (2006:277ff), distinguish between *ex ante*, *structural* arrangements and *ex-post instrumental arrangements*. According to Verschuere et al. there has been a renewed attention to board establishment and board representation as a structural accountability form. I will therefore map the existence of hospital boards and the composition of these, focusing especially on the presence of government representatives or representatives for local authoritites and user groups. Concerning ex-post instrumental arrangements I will focus on the application of performance contracts and other documents that specify the relationship between subordinate administrative bodies and political or administrative principals. A separated system is, compared to more integrated systems, characterized by several and more differentiated accountability arrangements; both structural and instrumental ones, ex-ante and ex-post.

2.4 Structural arrangements for patient involvement - voluntary or obligatory?

The World Health Organization and the Council of Europe have recommended involvement of patients, caregivers and citizens in health care and health policy (Forster and Gabe 2008:333). The fourth dimension in the analyses thus concerns arrangements for patient/user involvement.

Patient involvement may be dealt with both at an individual and at a collective level. Involvement at an individual level may be referred to as different forms of patient legislation, complaint procedures and the interests of individuals concerning their own (or their families') health and health care. Patient involvement at a collective level concerns structural arrangements for representation of broader health interests of particular groups or alliances (Forster and Gabe 2008:334, Opedal, Rommetvedt and Vrangbæk 2008, Vinblad and Ringard 2009:128). In this mapping I concentrate on *structural* arrangements for collective involvement, where patients have specific *user-rights*, guarded through patient commissions or other arrangements. Besides I distinguish between *obligatory and voluntary* arrangements for patient involvement (cf. Opedal, Rommetvedt and Vrangbæk 2008).The traditional collective mechanism, where patients

involve as citizens, through elections in the representative parliamentary system is not considered.

Thus, my fourth set of questions for the analysis is as follows: Which structural arrangements for patient involvement in specialized health care exist in the countries under study? Is formal representation of patient groups voluntary or obligatory?

3 The structural anatomy of specialized Health care in Norway, Denmark and the UK – An overview

3.1 Norway - state ownership and health enterprises

3.1.1 Basic model

In 2002 the responsibility for the Norwegian hospitals was transferred from the elected county-level governments to central state government. The ownership was thereby centralized to a single body – the state. The reform also set up new management principles for the hospitals based on a decentralized enterprise model, with 5 regional enterprises and a number of subordinate local enterprises. The takeover of responsibility for all Norwegian hospitals by central government marked the end of 30 years of ownership by the 19 regional counties and signified a break with the common Nordic decentralized model of health care (Byrkjeflot and Grønlie 2005, Lægreid, Opedal and Stigen 2005, Hagen and Kaarbøe 2006). The question of takeover of responsibility for hospitals by central government was raised several times by the government – first in 1987, then brought on the agenda in 1994 and evaluated once again in 1996, without success in Parliament. In the year 2000, however, a political process started that resulted in the new Health Enterprise Act of June 6, 2001. The reform was prepared and implemented at a very rapid pace (Herfindahl 2004). Several health care directorates and agencies were also reorganized in the same period, but these processes were initiated and implemented more or less independent of the hospital reform (Stigen 2005).

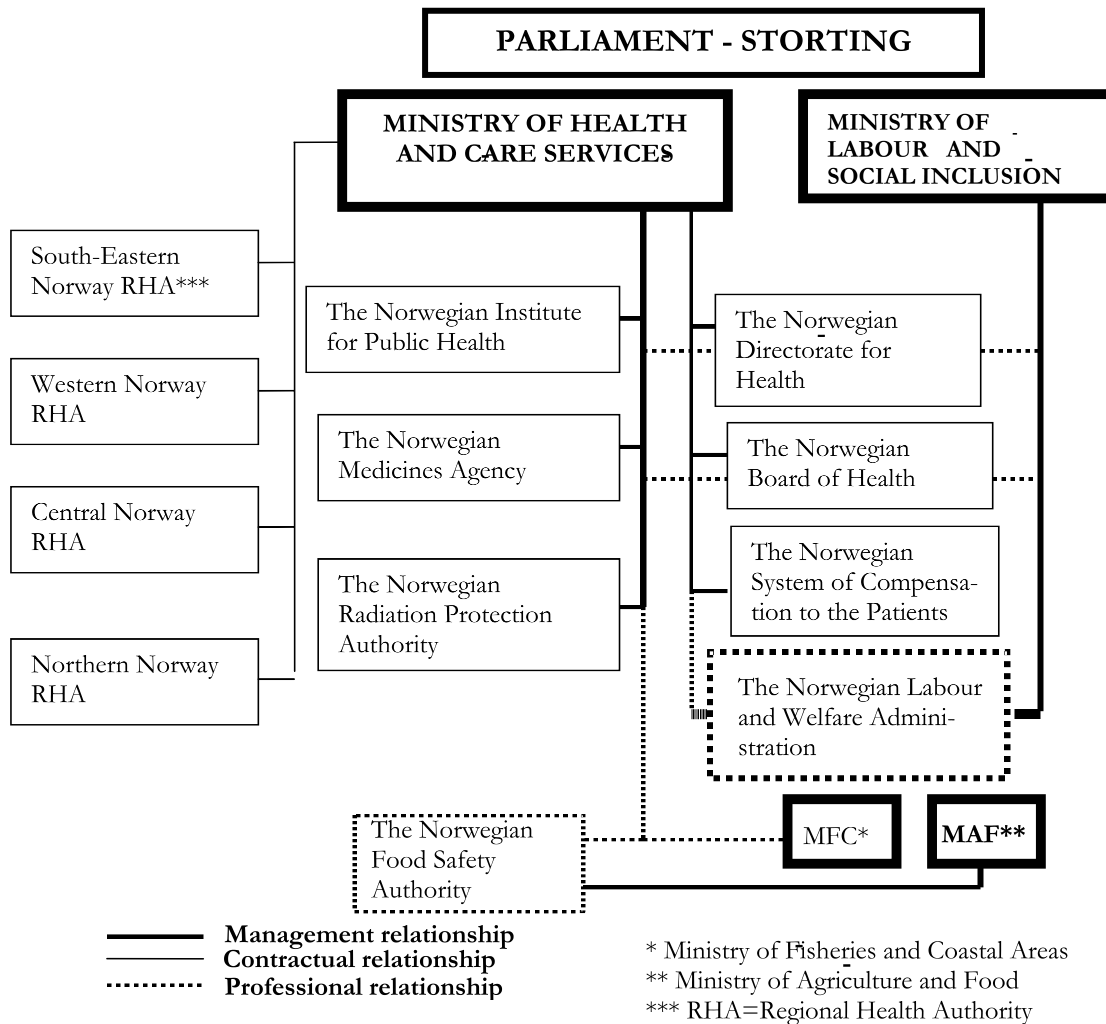
There were several arguments supporting state ownership and an enterprise model in the hospital sector. The principal idea of the reform is that the enterprise model and the new management principles will reduce day-to-day management by the politicians and allow "more steering in big issues and less steering in small issues". One wanted to come to grips with what was seen as unclear divisions of responsibility, ineffective use of financial 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 (Opedal and Stigen (eds) 2005, Hagen and Kaarbøe 2006). The unclear division of responsibility is illustrated by the fact that although the county councils were responsible for the running of the hospitals, the central government provided more than 70 % of the funding for these institutions (Hagen and Kaarbøe 2006:331). The financing system was not changed at the time of the reform, but in 2003 a commission assessed the system (NOU 2003:1). However, the Parliament did not approve the financial model suggested by the majority of the commission. The model that was adopted (proposed by the minority of the commission) was a continuation of the old model, with a combination of block grants and DRG-based financing[6] of somatic in-patient care (Hagen and Kaarbøe 2006:329f.)

Since the implementation of the reform in 2002 the number of enterprises is reduced, due to reorganizations both at the regional and the local level. There have also been some minor changes at the ministerial level. But the main principles of the system have been upheld, in spite of recurring political debate on the functioning of the model.

[6] DRG=Diagnosis Related Groups.

In figure 3.1.the specialized health care system in Norway is illustrated in more detail:

Figure 3.1 *The Norwegian Specialized Health Care Structure 2009.*



Source: Ministry of Health, and Stigen 2005, modified

3.1.2 Health in parliament: Structure and strength of the Norwegian Parliament (Stortinget).

In the Norwegian Parliament (Stortinget) health care matters are treated in the Standing Committee on Health and Care, one of the 13 standing committees in the Parliament. Social Affairs are treated in the Standing Committee on Labour and Social Affairs. The administrative capacity of the parliament has increased gradually during the last decades. From 1971 until 2009 staff has increased from 174 including people employed by the Storting and the parliamentary parties to approximately 612 in 2008, while the number of MPs has increased from 150 to 169 in the same period. From 2004 to 2008 the number of people employed by the Storting (i.e. party staff not included) has increased slightly from 392 to 421 (Source: Stortinget 2009).

The position of the Norwegian Parliament vis-à-vis the executive is considered strong. First; the principle of ministerial responsibility is fundamental to the parliament's control of the government and the executive. Second, the Norwegian electoral system has generated frequent minority governments the last decades[7]. Studies of Rommetvedt (2005) have indicated how the Norwegian Parliament strengthened her position vis-à-vis the executive during in these periods. He uses the term "parliamentarisation" about the development.

Rommetvedt points to the principle of parliamentarism, but, besides, he shows that the opposition did not use their potential power until the political and administrative capacity of the Storting was strengthened (Rommetvedt 2005:749). The standing committees in the Storting are influential (Rasch 2004:136).

3.1.3 Central government - Ministry and agencies/ALBs

The Ministry of Health and Care Services has the overall responsibility for government policy on health and care services. In Norway social care is the responsibility of the Ministry of Labour, but in the years previous to the hospital reform in 2002, health and social care were merged in a joint

[7]The Red-green coalition *majority* government representing the Labour Party, The Socialist Left Party and the Centre Party that came to power in 2005 and was re-elected in 2009 is one of three majority governments since 1965. In the same period there have been 15 minority governments.

ministry. In 2009 the Minister of Health and Care Services has three Secretaries of State and one Political adviser.

The Ministry of Health and Care Services consists of seven departments in 2009. The department of Specialist Health Services and the department of Hospital ownership are the two departments with main responsibility for specialized health care.[8] The Department of Specialist Health Services has the main responsibility for health care development. This task includes the letter of commission and the annual transfer of funds to the regional health authorities. The state ownership of the regional health authorities is administered by the Department of Hospital Ownership. A central task is to prepare and follow up the regional health authorities through the regular enterprise meetings. The enterprise meetings, as required by the Health Enterprise Act[9], are held twice a year and the letter of commission is sent to the regional enterprises in January each year. Two separate departments, one for specialized health care and one for ownership, were established in order to make a clear division between the commissioning ("purchase") role and the ownership role towards the regional health enterprises.

Norway has a 150 year long tradition with agencies/directorates subordinate to the ministries, but over time there has been a recurring debate between the political executive and professionals groups on the structural form of the agencies. There have been periods when the directorates/agencies have been integrated in the ministries and other periods when the doctrine has been autonomous directorates/agencies outside the ministry. Since 1950 the dominating doctrine has been directorates/agencies outside the ministry. The last decades' NPM-ideas have also resulted in a process of structural devolution with more differentiated agency models (Christensen and Lægreid 2003, Roness 2007).

Health care is one of the sectors where the discussion on integration/disaggregation between ministry and directorates/ agencies has been especially enduring, and there have been numerous "ebbs and flows" of the organization of the health directorates. The most recent major reorganization was implemented in 2002, when the Directorate for

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[8] The other five departments are: Department of Public Health, Department of Municipal Health Services, Department of Health Legislation, Department of Administration and Department of Budget and Financial Affairs (http://www.regjeringen.no/en/dep/hod/About-the-Ministry.html?id=426)

[9] Lov om helseforetak m.m. (Health Enterprise Law). Lov- 2001-06-15-93

Social Affairs and Health was established. This directorate is a merger of all together 12 professional health agencies, indicating that horizontal structural specialization, in spite of NPM, has not been that predominant in Norwegian central administration (Stigen 2005). In 2008 the Directorate for Social Affairs and Health was split and social cases were transferred to directorates subordinate to the Ministry of Labour and Social Inclusion.[10] At present there are approximately 20 independent agencies, boards and institutions subordinate to the Ministry of Health and Care Services.[11]

3.1.4 The regional and local/hospital level

At the regional level the four (until 2007 five) state owned regional health authorities (RHA) are responsible for specialist health care services. These four regional enterprises (South-Eastern Norway Regional Health Authority, Western Norway Regional Health Authority, Central Norway Regional Health Authority and Northern Norway Regional Health Authority), are responsible for providing specialist health care services, either through hospitals owned by the regional health care authorities or through contracts with private service producers. In 2009, there are 31 local health enterprises under regional auspices, and each local health enterprise normally consists of several geographically dispersed hospitals. Both the regional and local enterprises have boards.

In Norway there has been an increase in regional single-purpose state regions with various regional divisions (Hansen and Stigen 2007). The establishment of health regions is an example of this development. And - using the terms of Hooghe and Marks (2003) - the political-administrative responsibility for the hospitals was not only transferred from the counties to the state in 2002, it was also transferred from a multi-purpose to a uni-purpose governmental system at the regional level. Besides the health regions are only coterminous with two other regional administrations, and

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[10] Now Ministry of Labour.

[11] The most important agencies in specialist health care are: The Norwegian Directorate for Health *(Helsedirektoratet)* which implements national health policies and serves as an advisory body to central authorities, municipalities, regional health authorities and voluntary organizations; the Norwegian Institute for Public Health *(Folkehelseinstituttet)* which monitors the health of the population and works to improve general health by focusing on health promotion and the prevention of disease; and the Norwegian Board of Health (*Helsetilsynet*) which has the overall responsibility for the supervision of health and social services in Norway.

a significant number of the local health enterprises intersect county boundaries.

The regional and local health enterprises are subject to special legislation through the Health Enterprise Law. They are separate legal entities and thus not an integral part of the central government administration. 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 have no hospital service functions of their own. Their main responsibility is ownership, planning, organizational matters and distribution of health care services in their region. Thus, they are expected to maintain both the role as owner and commissioner. The owner role is, however, organizationally split from the "purchaser" role in separate owner's departments in all four regional enterprises. The actual health services are delivered by the hospitals organized as local hospital enterprises. Enterprise meetings and commissioning letters are important steering devices for the regional health authorities in their relation to the local health enterprises; equal to the management system at national-regional level.

The managerial autonomy of the regional and local health enterprises is, as indicated above, constrained by a number of steering devices laid down, either through the Health Enterprise Act or through additional statutes. First, central government appoints the regional board members, while the boards of the local health enterprises are appointed by the regional enterprises. Until 2006 no active politicians could be members of the boards; the only group that had any formal representation was employees. Board members were supposed to be "professionals", not politicians. In 2005 the new Red-Green Government changed the statutes. After 2005 active local/county politicians may become board members, and they make up over 50 % of the members. They are proposed by the municipal or county councils, but appointed by the Ministry of Health and Care or the regional health authorities respectively. It is, however, stressed that the politicians in the boards do not have a local or regional political mandate. Second, the state exercises control through the commission documents that specify tasks and objectives and through decisions adopted by the enterprise meetings. In contrast to the laws regulating other public sector companies and trusts, the Hospital Enterprise Law specifies a lot more in detail what tasks and issues that have to be approved by the ministry (Opedal 2005, 2006). Third, there is also a performance monitoring system

– with formal reports on finances and activities to the ministry. Last, but not least, the state finances the hospital activities.

3.1.5 Formal patient involvement

Due to the Health Enterprise Act from 2002 both regional and local health enterprises *have to* establish patient commissions. Patient involvement is also stressed in the composition of the boards, although the patient organizations do not have any formal board representation. Opedal, Rommetvedt and Vrangbæk (2008) interpret the arrangements for patient involvement in the Norwegian specialized health care both as a NPM inspired method to strengthen the power of the consumers (patients), and as method in line with the corporatist traditions of Norway, where affected organized interests are integrated into public policy-making.

3.2 Denmark – regional political ownership without taxation power

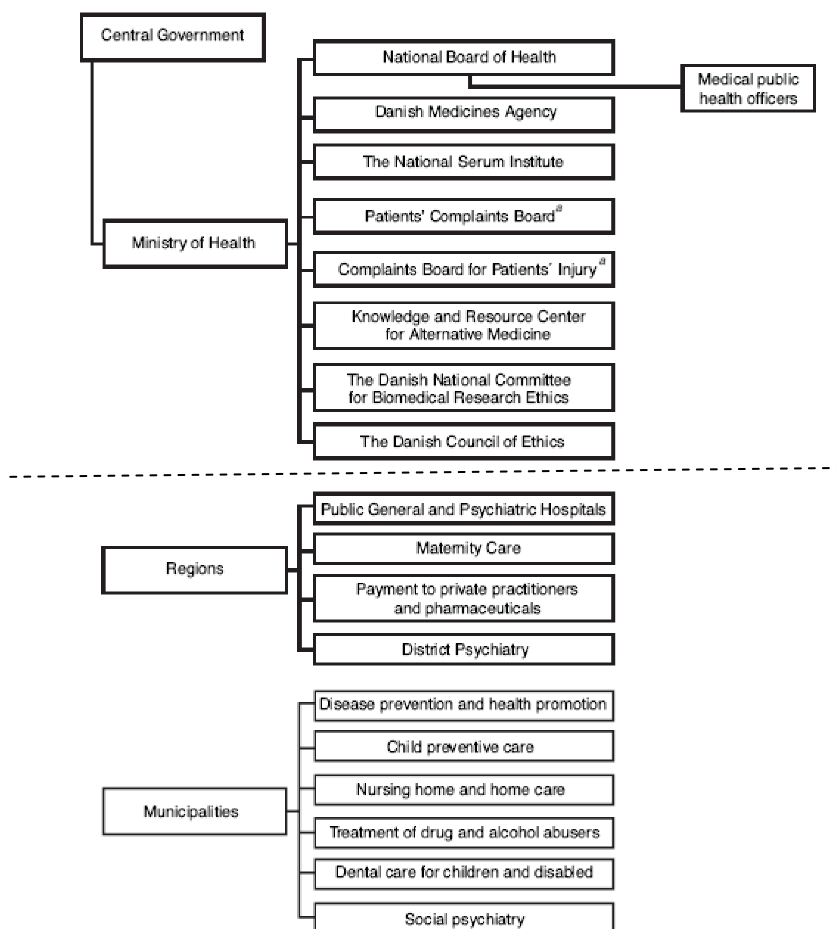
3.2.1 Basic model

As in Norway, there has been a long tradition of decentralization in the health sector in Denmark. Since the beginning of the 18th century, health care has been the responsibility of towns and counties (Strandberg Larsen et. al 2007:26). During the last decade however, there has been signs of increasing centralization in the health sector as well as in other policy areas (Vrangbæk and Christiansen 2005, Vrangbæk 2009). The great administrative reform (The Structural Reform) implemented in 2007 can be seen as part of this ongoing trend (Martinsen and Vrangbæk 2008:174, Vrangbæk 2009:61f). The result of the reform was that 14 counties were replaced by 5 regions, and 271 municipalities were reduced to 98. Andersen (2008:15) characterizes the reform as a “centralized decentralization”. He argues that “central government is clearly gaining a more influential position in relation to the field of economy while leaving the more mundane obligations of administration and service delivery to the lower tier of government.”

Specialized health care is now the dominant responsibility of the popularly elected regional authorities. In

Figure 3.2 the specialized health care system in Denmark is illustrated. The figure also indicates the distribution of tasks between the regional and the municipal level. The regions are responsible for public general and psychiatric hospitals, maternity care, payment to private practitioners and pharmaceuticals and district psychiatry. Disease prevention and health promotion, child preventive care, nursing home and home care, treatment of alcohol and drug abusers, dental care for children and disabled and social psychiatry are municipal tasks. The state is responsible for financing, systematic follow-up on quality, efficiency, monitoring, IT-usage and organizational issues (Commission on Administrative Structure 2004, Strandberg Larsen et al. 2007, Andersen and Jensen 2009, Vrangbæk 2009).Thus the supervisory and regulatory roles of state bodies, especially the National Board of Health, have been strengthened (Andersen and Jensen 2009:3).

Figure 3.2 *The specialized health care structure in Denmark 2009.*



Source: Strandberg Larsen et. al. 2007:2. Slightly modified.

The 2007- reform lead to substantial changes in financing of health care. In contrast to the former counties, the regions do not have taxation power. After 2007 specialized health care is solely financed through earmarked proportional taxation at the national level. Besides, the state and the municipalities share the responsibility for funding. The state contributes with 80 % of the total expenditures in the regions (75 % is a governmental grant based on various objective criteria and 5 % is activity-conditioned) and the municipalities contribute with 20 % (10 % is fixed based on an amount per inhabitant and 10 % is activity dependent based on citizens actual use). The intention is to create greater transparency

within the sector (Strandberg Larsen et. al. 2007:XVI-XVII, Andersen and Jensen 2009:4).

The financial framework agreements between the state and the regions negotiated on an annual basis are important means for financial coordination and prioritization (Ministry of Finance 2009).[12] The size of the municipal grant is similarly yearly laid down through negotiations between the regions and the municipalities.[13]

Another important keystone in the Danish (specialized) health services after the 2007-reform are health agreements between the regions and the municipalities. The purpose is to further cooperation between the regions and the municipalities. Health agreements are worked out at least once during each election period, and supervised and approved by the National Board of health. Six topics are mandatory: 1) procedures for signing out weak and elderly patients, 2) procedures for admission to hospitals, 3) rehabilitation, 4) Auxiliary means, 5) Health promotion and prevention and 6) Efforts concerning people with mental illnesses. The first generation of agreements were submitted and approved in 2008 (Andersen and Jensen 2009: 5-6).

3.2.2 Health in parliament: Structure and strength of the Danish Parliament (Folketinget)

In the Danish Folketing health care is treated in the health committee (Sundhedsudvalget) which consists of 17 members and 12 substitutes. There are all together 25 standing committees in the Danish Folketing, usually with 17 members in each committee. Besides there are substitutes that participate in the work of the committees, but they do not vote. Concerning parliamentary administrative resources, there was a major expansion in the early 1980s and from 1995, but the number of people employed by the Danish Folketing was very modest almost to the end of the 20th century (Damgaard 1992). In 1998 there were 359 people full time employed by the Folketing (number of man-labour years). In 2004 the number had risen to 389 full time employed people, and in 2009 the number is slightly higher, 394 persons, not included people employed by

[12] Ministry of Finance, Denmark 2009: http://uk.fm.dk/Portfolio/Local%20Government.aspx

[13] Cf. for instance: http://www.rm.dk/om+regionen/%c3%b8konomi

the political parties in the Folketing (Data from Folketing administration 2009).[14] The number of Danish MP is 179.

As in Norway, negative parliamentarism and a proportional electoral system often give minority governments. The Danish Folketing, like the Norwegian Storting, is regarded as strong. As in Norway, the parliament also has assumed increased importance vis-à-vis the government the last decades, especially what concerns the opposition parties (Damgaard 1992, 2003, Damgaard and Jensen 2006, Christiansen and Togeby 2006).

3.2.3 Central government - Ministry and agencies/ALBs

Until autumn 2007 specialized health care in Denmark was part of the responsibility of the Ministry of the Interior and Health.[15] Then the ministry was separated, and the Ministry of Health and Prevention was established.

The Ministry of Health and Prevention (2009) is divided into five centres, where Centre of hospital policy has the main responsibility for tasks concerning hospitals.[16] Compared to Norway the Danish health ministry is less organizationally specialized with less role-differentiation, but as in Norway the principle of ministerial responsibility implies that every minister is personally responsible for all activities in his or her ministry and subordinate institutions. It is, however, necessary to mention that Denmark, in contrast to most other Western democracies, does not have politically appointed civil servants, apart from media advisors and a very limited number of politically appointed advisors. This implies that Danish ministers receive most of their political advice from career civil servants. Although there has been a debate whether Denmark should introduce a system of junior ministers or politically appointed advisers, it has not yet been introduced (NOU 2000:11 p.120, Christiansen and Togeby 2006:9-10). Christiansen and Togeby (2006:10) argue that "if there has been any actual change in the relationship between ministers and their departments,

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[14] http://www.ft.dk/~/media/Aarsberetning_adm_pdf/Hovedtal%20for%20Folketinget%202004%2009.ashx

[15] In 2001 the Ministry of Health and the Ministry of Interior were integrated.

[16] The others centers are: Center for health and psychiatry, Center for judicial health, Center for health economy and a secretariat (Center for administration). Source: Ministeriet for Sundhed og forebyggelse (Ministry of Health and Prevention) 2009. http://www.sum.dk/Om%20ministeriet.aspx

it has been in terms of a shift towards greater political responsiveness among the bureaucrats, rather than the opposite."

Concerning subordinate directorates, agencies and ALBs, Beck Jørgensen and Hansen (1995:549) describe two opponent institutional trends within Danish central government. The first trend, which they label agentification, was dominant in the 1960s and 1970s. In this wave sub-departmental units (directorates/ agencies) were established and/or existing sub-departmental units were made more autonomous. The second trend, which they label de-agentification, was dominant in the 1980s and 1990s. Then sub-departmental units were integrated in the ministries and/or made less autonomous. However, there has also been a revitalization of the agentification trend in the 1990s where sub-departmental units are made more autonomous. A number of directorates have been transformed into state-owned companies and companies with state share holdings, but another interesting trend is the growing diffusion of "contract agencies" during the last decades (Beck Jørgensen and Hansen 1995:555, Greve 2003, Binderkrantz and Grønnegaard Christensen 2009). Reorganizations of the Danish public sector may be characterized as incremental, with no grand policy design (Greve 2003:277). An example of this is contracts which now are spread to almost all agencies with wide range of tasks, but in a piecemeal and pragmatic manner (Binderkrantz and Grønnegaard Christensen 2009:76). Greve (2006:161) states that NPM reforms "have taken a firm hold" also in Denmark, but with more emphasis on modernization than marketization.

Compared to the Norwegian agency structure, the Ministry of Health and Prevention has fewer subordinate agencies, which indicates a more integrated directorate/agency structure in Denmark. The National Board of Health (*Sundhedsstyrelsen)* is the most important subordinate agency.[17]

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[17] Other subordinate agencies are: Danish Medicines Agency (*Lægemiddelstyrelsen*), The National Serum Institute *(Statens Serum institut)*, Kennedy Centre *(Kennedy Centeret)*, Patients Complaints Board (*Patientskadenævnet*), The Patients' Injury Appeals Board *(Patientskadeankenævnet*), Knowledge and Resource Centre for Alternative Medicine *(Videns- og Forskningscenter for Alternativ Behandling),* The Danish National Committee for Biomedical Research Ethics (*Den Centrale Videnskabsetiske Komitè*), The Danish Council for Ethics *(Det Etiske Råd)* and The Danish Fitness and Nutrition Council *(Motions- og Ernæringsrådet)*. Source: Ministeriet for Sundhed og forebyggelse (Ministry of Health and Prevention) 2009.
http://www.sum.dk/Om%20ministeriet/Organisationsdiagram%20for%20ministeromraadet.aspx)

3.2.4 The regional and local/hospital level

Hospital services are the main duties of the Danish politically governed regions. This includes hospitals, psychiatry, general practitioners, specialists and health insurance. Besides hospital service, the regions are responsible for the establishment of transport companies, regional development plans, regional growth forums, the operation of a number of institutions for groups with special needs, and the coordination of the operation and development of a large range of basic education program. The regions also have responsibility for coordination of environmental issues and for soil pollution and raw materials, mapping and planning.[18] It is interesting to notice that the former Minister of Interior Affairs and Health, Lars Løkke Rasmussen (now prime minister), did not want regions with a broad portfolio of responsibilities; he favored that the regions should have only one responsibility, healthcare (Bundgaard and Vrangbæk 2007:509). That said it first has to be stated that the different policy areas are financed separately. The regions are not allowed to prioritize between and across the different policy areas. Second, health care costs amount to over 90 % of the budgets in the regions.[19] This indicates how important and predominant specialized health care and hospital matters are in the regions portfolio.

The five regions (The Capital Region, Region Sealand, The Region of Southern Denmark, Central Denmark Region and The North Denmark Region) are governed by regional councils, which each consist of 41 politicians, popularly elected every fourth year. [20] Concerning health it is important to notice that every region must have a Health Coordination Committee, with members both from the municipalities and the regions. The main task of the Health Coordination Committee is to prepare the health contract between the region and the municipalities. These committees do not have decision power; it is the political authorities in the regions and the municipalities that make the final decisions. The members of the Health Coordination Committees are appointed by the Regional

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[18] Danske regioner 2009 (http://www.regioner.dk/Om%20Regionerne/Regionernes%20opgaver.aspx)
[19] Danske regioner 2009 (http://www.regioner.dk/Om%20Regionerne/%C3%98konomi/Regionernes%20-oeonomi/Budget%20og%20regnskab/Regnskab/~/media/Filer/Økonomi/Fakta%20om%20regionernes%20regnskaber%20i%202008.ashx)
[20] The first Regional Councils after the Structural Reform were elected autumn 2005.

Council, the Municipalities in the region and general practitioners in the region.

Although the Danish municipalities do *not* have any *ownership* responsibility for specialized health care, they are quite important vis-à-vis the regions in hospital matters. It follows from their financial responsibility and the functions of the Health Coordination Committees where representatives of the municipalities participate. The political organization of the municipalities may therefore be of importance. It may for instance make a difference if a municipality has a political health committee or not. There is no formal instruction what concerns establishment of political health committees[21], and Danish municipalities vary regarding the use of health committees. It is reasonable to assume that a special municipal political health committee will secure more organized and stable political attention to the management of hospital matters in the regions in general and to the work of the Health Coordination Committees in particular.

The hospital structure in Denmark may be characterized as moderately specialized. One indicator is the number of hospitals. In 2009 there are about 33 superior administrative hospitals units, and about 74 hospital units ("sygehusmatrikler") in Denmark.[22] In the aftermath of the Structural Reform and the establishment of the regions, the future hospital structure has been on the agenda in all the regions. The ambition is, amongst others, to reduce the number of hospital units (sygehusmatrikler) by approximately 30 %, to 58 in 2020, and develop a further specialized hospital sector (Ministry of Health and Promotion 2008:49). In the obligatory guidelines for hospital planning, which are laid down by the National Board of Health, it is made an important distinction between *main* and *special* hospital functions. All of the regions developed proposals for new hospital plans in 2007-2008, the plans have been evaluated by an expert panel established by the government, and the regions are now in the midst of a further planning and implementing process. The recommendations of the expert panel and the economic incentives for

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[21] Cf. Lov om kommunernes styrelse (the Local Government Act). https://www.retsinformation.dk/Forms/R0710.aspx?id=10330

[22] Source: Danish regions (http://www.regioner.dk/Om%20Regionerne/Pr-ae-sentation%20af%20regionerne.aspx) and Ministry of Health and Prevention 2008:49 (http://regioner.dk/Aktuelt/Nyheder/~/media/Filer/Sundhed/Ekspertpanelets_screening_nov_2008.ashx)

restructuring developed by the government have, however, been met with protests both in the regions and in parliament (Andersen and Jensen 2009:5).

3.2.5 Patient involvement

According to the Commission on Administrative Structure only a few Danish hospitals had established commissions for patient involvement in 2004 (Commission on Administrative Structure 2004). The European Observatory health system review also indicates that structural arrangements for user involvement so far have been relatively scarce in Denmark, both at the regional and at the hospital level. According to Strandberg-Larsen et al. (2007:36) patient involvement takes place in three ways in Denmark: 1) through organized patient groups, nationally, regionally or locally; 2) through patient councilors, and 3) indirectly, through feedback from national surveys. A screening of the web pages of the regions indicates that The Central Denmark Region, The North Denmark Region and The Region of Southern Denmark have established user boards rather recently, and in the Capital Region the regional council has decided on a user, patient and relative policy. The reason that few Danish regions and hospitals so far have set up patient commissions is probably that, contrary to Norway, it is voluntary to establish patient commissions in Denmark (Opedal, Rommetvedt and Vrangbæk 2008).

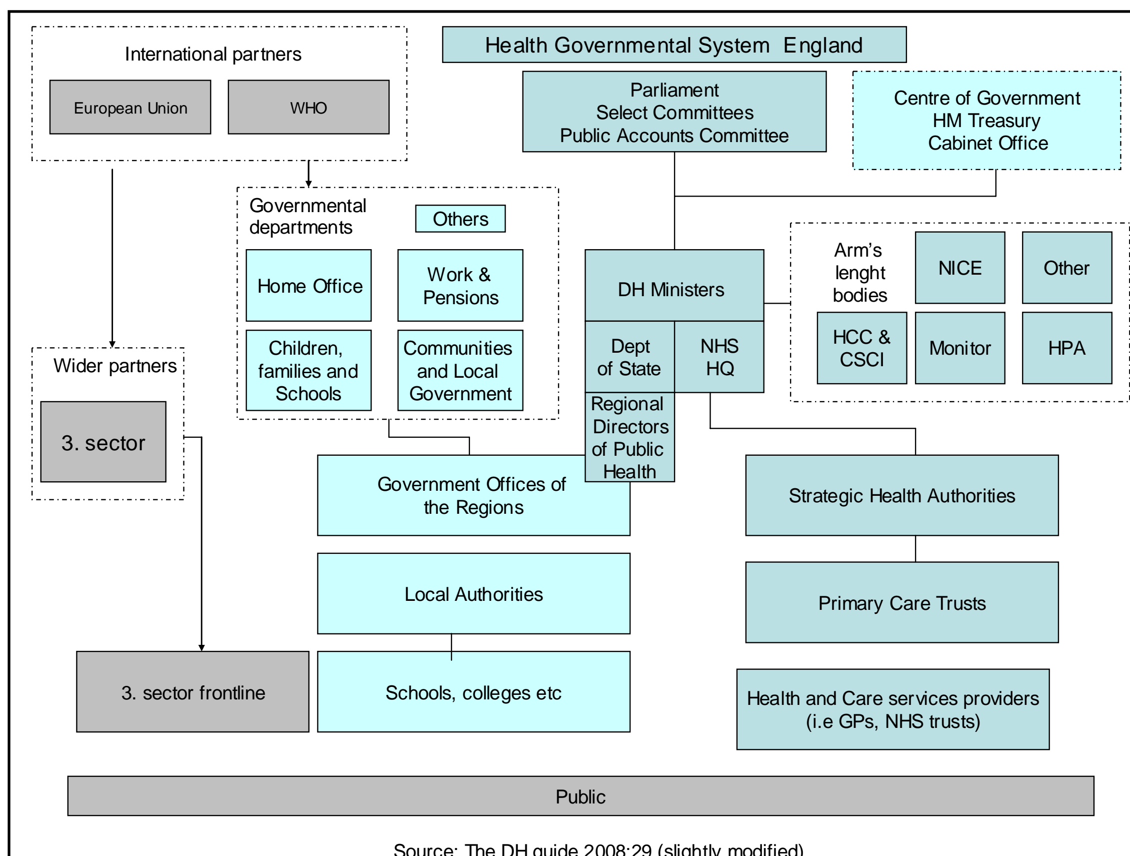
3.3 The UK – state owned trusts the cornerstones of NHS

Basic model: The British National Health Service (NHS) was founded in 1948. By this foundation hospital, general practioners, opticians, dentists and other services were brought together in an integrated health-care system. Since the seventies there have been substantial changes in the system, culminating in 2000 with Labour's 10 year modernization program of investment and reform, the so called NHS Plan. The NHS-reorganization in 1974, Margareth Thatcher's introduction of the internal market in 1991 and Tony Blair's introduction of the "third way" in 1997 are other important milestones in the NHS history (Opedal 2006, Opedal and Rommetvedt 2010, forthcoming). But although there were substantial changes during the Blair period, the NHS-trusts that were established in 1991, owned and controlled by the Department of Health, are the cornerstones of the health care system in the UK. Together with the

Primary Care Trusts, established in 2001, and the Strategic Health Authorities at the regional level, founded in 2002 by a merger of the numerous former District Health Authorities, they are the main institutions responsible for the patient services in the UK.

Figure 3.3 illustrates the health governmental system of the UK. The Department of Health makes a distinction between three basic delivery chains in health care: 1) the NHS, 2) social care, especially through local government, and 3) other private and third sector partners, particularly on public health. This constitutes a complex network of organizations, including central and local government, the NHS and agencies and bodies from the private and third sectors, that need to work together (DH guide 2008:30).

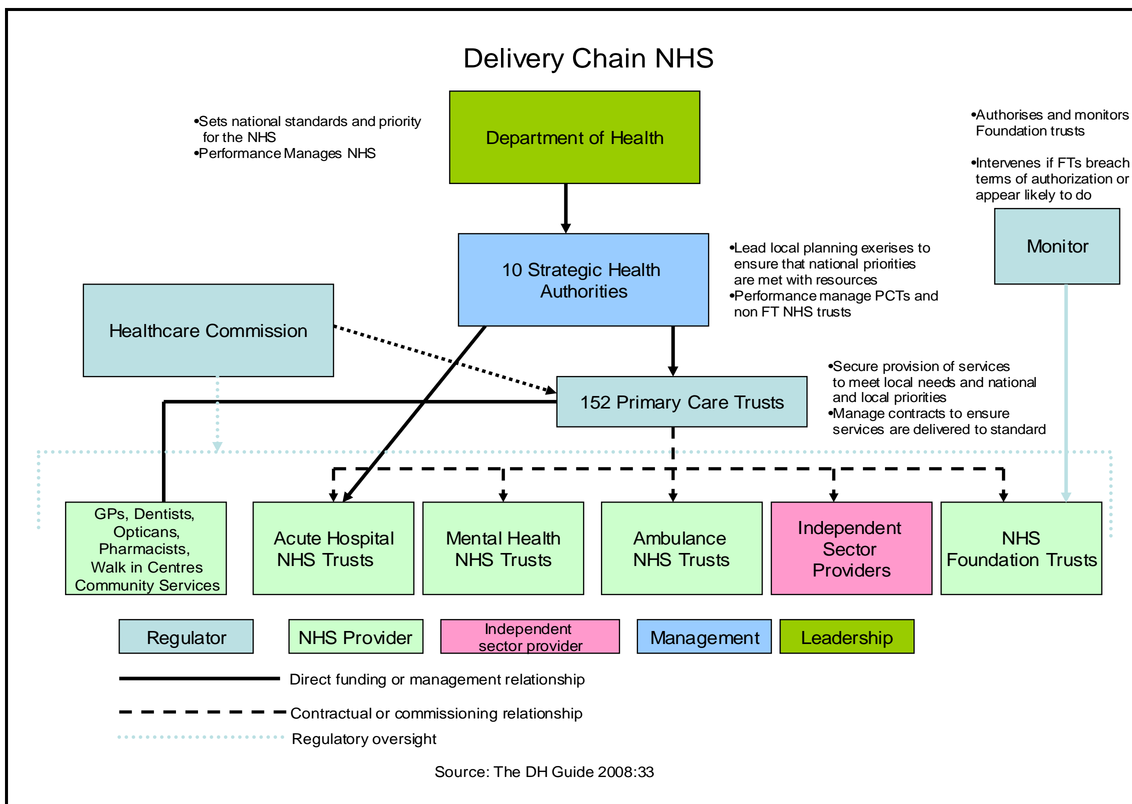
Figure 3.3 *The health governmental system of the UK.*



Source: The DH guide 2008:29 (slightly modified)

In Figure 3.4 the NHS system is further illustrated. In particular, it is worth noticing that the relationship between the different authorities may either be a direct funding or management relationship, a contractual or commissioning relationship, or one of regulatory oversight.

Figure 3.4 *The UK. The NHS system further illustrated*



The NHS is funded through general taxation, which is allocated through different funding streams: 1) "Primary Care Trusts direct or unified allocations", 2) "Central budgets" distributed to strategic health

authorities, NHS trusts, Primary Care Trusts and other NHS bodies for special centrally specified purposes, 3) " Non-discretionary funding" allocated to the Primary Care Trusts to reimburse ophthalmic and pharmaceutical services, and 4) "Primary Care Trusts allocations for NHS dental care". The Primary Care Trusts control over 80 percent of the NHS revenue budget mostly allocated to the PCT's as direct or unified allocations. The Primary Care Trusts use nearly 60 % of these allocations to commission hospital services. The direct or unified allocations are distributed to each PCT in accordance with a weighted capitation formula (for more information cf. Talbot-Smith and Pollock 2006:79 ff, and Department of Health 2009).[23]

3.3.1 Health in parliament: Structure and strength of the United Kingdom Parliament.

The committees in the British Parliament are made up of around 10 to 50 members of parliament (MPs) or Lords. There are four types of committees: Select Committees, Joint Committees, General Committees and Grand Committees. Regarding health policy and policy-administration relations the Select Committees are the most important ones. *Select Committees* work in both the House of Commons and the House of Lords, and they may on their own initiative examine the work of government departments, agencies and regulators. The most important of the Select Committees are the Commons Select Committees, one for each department.[24] There are altogether 19 departmental Select Committees, including a Health Committee, consisting of a minimum of 11 members in 2009.[25]

The number of staff in the British Parliament has increased substantially over the years. From 2001 until 2007 the number of full time House staff increased from 1486 to 1606, (Rush 2005:129, Opedal and Rommetvedt 2010, forthcoming), serving 645 members of Parliament.

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[23] Department of Health 2009: http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_076547)

[24] We use the term" department", not ministry about the English ministries, because "department" is the term that is used at the web-pages and in official documents.

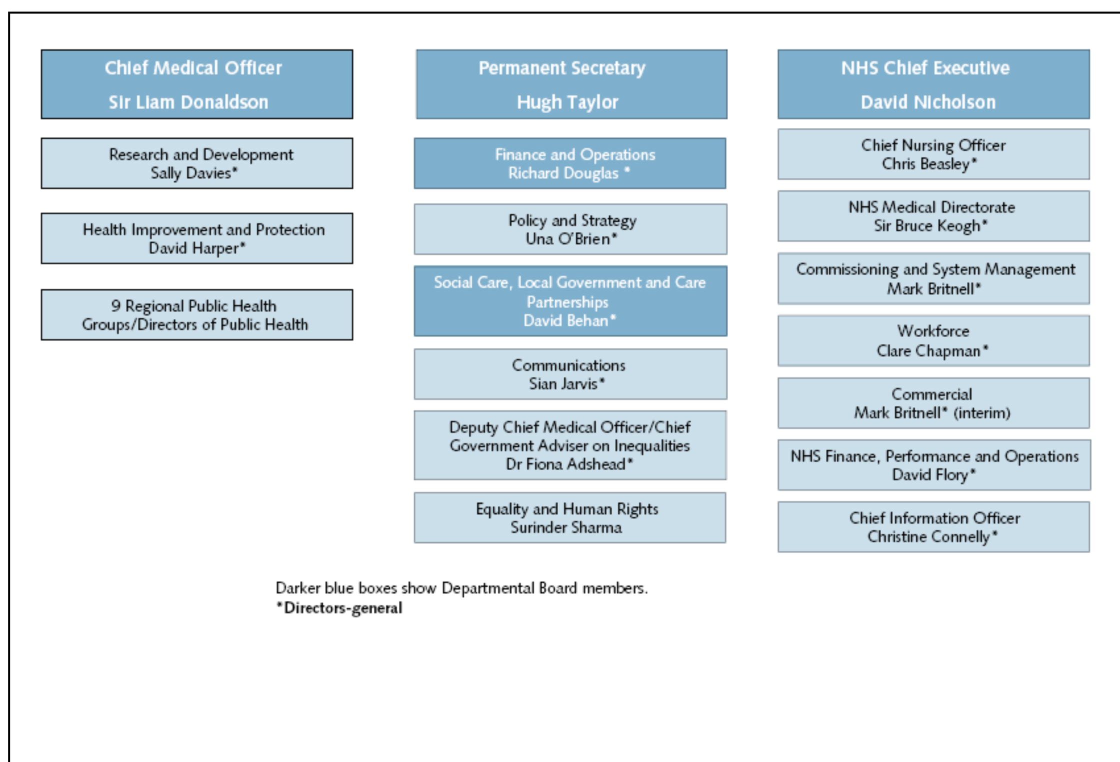
[25] Source: http://www.parliament.uk/parliamentary_committees/parliamentary_committees16.cfm (http://www.parliament.uk/documents/upload/p02.pdf) http://www.parliament.uk/parliamentary_committees/health_committee.cfm

A basic difference between the UK and the two Nordic countries under study is the parliamentary system. Contrary to the Nordic proportional, consensualist system, the English system is a simple majority system, i.e. a "first past the post" (winner takes all) method of electing members of government. This system gives more leeway for the executive, especially in periods with relatively large parliamentary majorities, for instance in New Labour's government periods (Dixon 2006:23). Lijphart's (1999:132f) index of executive-legislators relations shows that the dominance of the executive in the UK is evident. The parliament is less influential than in Norway and Denmark.

3.3.2 Central Government: Ministry and agencies/ALBs

The Department of Health is led by the Secretary of state for Health, Minister of State for Health Services and Minister of State for Public Health and three parliamentary undersecretaries. From 1968 until 1988 the ministry was merged with the Ministry of Social Security and formed the Department of Health and Social Services (DHSS). Due to reorganizations and delegation of power to different subordinate agencies and bodies the size of the department has decreased over the last years (DH Guide 2008:6). However, compared to the Norwegian and Danish health ministries, the Department of Health is of course huge. In Figure 3.5 below the organizational structure of the Department of Health is presented:

Figure 3.5 *The organizational structure of Department of Health. Source:*



Source: Department of Health. Departmental report 2009. [26]

The Department of Health is led by the Permanent Secretary, the Chief Medical Officer and the NHS Chief Executive. We notice that there is a commissioning and system management unit in the department, indicating a distinction between purchasers and providers. Further, a unit for Social care indicates that social care matters, unlike in Norway and Denmark, are integrated in the Department of health. In Norway and Denmark there are separate ministries for social affairs, respectively the Ministry of Labour and Social Inclusion and the Ministry of Interior and social affairs.

As a result of the UK Next Step Program, which created more than 140 new semi-autonomous agencies (Christensen and Lægreid 2006a:22), the

[26](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_100819.pdf)

agency level in the UK now consists of a huge number of so called arm's length bodies (ALB). The great number of "fringe bodies", extra-governmental organizations, non-majoritarian institutions and quasi-autonomous governmental organizations are often referred to as "distributed public governance" (Flinders 2004:884). This has made the structure of British administration increasingly complex and difficult to follow.

As indicated above, the ALBs may be categorized in many ways (see for instance DH Guide 2008, Flinders 2004, and Flinders and Buller 2006), and it is often far from obvious what is meant by the term. In this analysis I will base my description upon the official classifications presented at the web-site of the Department of Health.[27] Here one distinguishes between a) the degree of accountability vis-à-vis the Department of Health (Some may also be accountable directly to the Parliament), and b) type of function.

Concerning accountability there are three types of ALBs: Special Health Authorities (SHA), Executive Agencies and non-departmental public bodies (NDPB). Executive agencies are all accountable to the Department of Health. Special Health Authorities have a more autonomous position, but they are all subject to ministerial direction. Non-departmental public bodies are, as the name indicates, not part of government departments, and can thus not be instructed from the DH. The ALBs normally have boards.

The ALBs may further be categorized by function. Here the Department of Health distinguishes between 1) regulatory ALBs; 2) standard ALB, i.e. ALBs that focus primarily on establishing national standards and best practices; 3) public welfare ALBs that focus primarily on safety and the protection of public and patients; and 4) central services to the NHS ALBs. These are, according to the DH web pages, established to provide cost-effective services and focused expertise across the health and social care system.

Besides there are numerous DH advisory bodies, which are working groups and forums advising the department on topics across health and social care. They do not, according to the DH, come under the same

[27] Department of health 2009. (http://www.dh.gov.uk/en/Aboutus/OrganisationsthatworkwithDH/Armslengthbodies/index.htm)

categories as the arm's length bodies described above. Appendix 1 gives an overview of the current executive agencies, special health authorities and non-departmental public bodies in health care.

3.3.3 The Regional and local/hospital level

At the regional and local/hospital level various authorities and trusts are the cornerstones of NHS. Appendix 2 gives an overview of the authorities and trust structure.

The 10 *NHS Strategic Health Authorities* (until 2006 28)[28] are headed by SHA Chief Executives and are directly accountable to the NHS Chief Executive in the Department of Health. They are the key links between the NHS trusts and the Department of Health. The Strategic Health Authorities play a strategic role by overseeing planning and activity in their area. They monitor the performance of the NHS trusts and the PCTs, and ensure that national priorities are integrated into local health service plans (NHS 2009). [29] It is important to notice that there is a distinction between the 10 Strategic Health Authorities that are part of the NHS delivery chain and the DH regional directors of public health in the 9 Government Offices for the regions.

Though it has to be emphasized that the regional leadership for the NHS services is provided by the NHS Strategic Health Authorities, it is interesting to notice that the borders of the NHS Strategic Health Authorities are coterminous with the Government Offices for the regions,

[28] 10 NHS Strategic Health Authorities:

- East Midlands Strategic Health Authority
- East Of England Strategic Health Authority
- London Strategic Health Authority
- North East Strategic Health Authority
- North West Strategic Health Authority
- South Central Strategic Health Authority
- South East Coast Strategic Health Authority
- South West Strategic Health Authority
- West Midlands Strategic Health Authority
- Yorkshire and The Humber Strategic Health Authority

[29] NHS 2009.
(http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx)

apart from in the South East Region where there are two Strategic Health Authorities: South Central and South East Coast (DH Guide 2008: 55).[30]

As mentioned in section 3.3.1 most of the NHS funding is allocated to the 152 *Primary Care Trusts (PST)*, which have a pivotal role in the NHS system, especially what concerns the purchaser-provider split.[31] The PCTs main duty is to secure provision of services in accordance with local needs and to manage contracts with the various providers. Commissioning of services from NHS trusts and private providers are thus a central task for the PCTs. They are also responsible for the formulation of Local Delivery Plans (LDPs) which describe NHS and joint NHS and social care priorities in their area. In addition to the commissioning and planning activities the PCTs manage the primary care in their region. This implies that they have the managing responsibility for the general practitioners, Dentists, Opticians, Pharmacists, NHS Walk-in Centres, and NHS Direct. [32]

The main functions of the other NHS trusts are to *provide* services to the patients (ie. acute hospital services, ambulance services, mental health services and other special services) and plan the services for their institutions. Thus they have a close relationship to the PCTs as commissioning bodies, through service level agreements (SLAs). These are contracts that specify an agreed type, cost and volume of service together with the quality of service parameters that are agreed with the PCTs or specified in national standards. The SLAs also specify how service may be monitored by the PCTs (NHS-boards guide 2003: 45-46). The NHS trusts are accountable to the Strategic Health Authority in the region and thus the Chief Executive of the NHS.

At the hospital level the *acute trusts* are the central institutions. In 2004 a new organizational form was introduced, the so-called *foundation trusts.*[33] These are new types or NHS hospitals run by local managers, staff and

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[30] http://www.gos.gov.uk/national gives further information about the Government Offices for the English Regions.

[31] NHS 2009 (http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx#primary)

[32] NHS Walk-in-Centres are centres staffed by nurses that offer patients treatments without an appointment. NHS Direct is a service providing 24 hour access to health information and clinical advice, via telephone, the NHS Direct Webside or the NHS interactive digital TV service. Source: DH guide Glossary 2009

[33] Department of Health 2009. http://www.dh.gov.uk/en/Healthcare/Secondarycare/NHSfoundationtrust/index.htm

members of the public. The foundation trusts are fully part of the NHS, (i.e. regulated through authorization, monitoring and inspections by central agencies), but they have more operational and financial freedom than the other NHS trusts. They have freedom to retain any operational surpluses and revenues from land sales, to determine their own investment plans, to raise capital funds, and to offer additional performance-related rewards to staff (Opedal 2006, DH 2009)[34].

The aim of the establishment of foundation trust was to decentralise the control and management of health services. Central state accountability is thus replaced by accountability to the communities. This means that the foundation trusts are not accountable to the Secretary of State for health through the Strategic Health Authority (as other NHS trusts) but instead to a local body of elected governors that have an absolute majority of representatives elected by local people, carers and staff that are members of their local foundation trusts (NHS Foundation Trusts Information Guide 2005, DH 2009).[35]

3.3.4 Patient involvement

In 2003 the Commission for Patient and Public Involvement (CPPIH) and the first Patient and Public Involvement Forums (Patients Forums) were established. There were set up patient forums for every NHS trusts and PCTs. The forums did have a range of functions including monitoring and reviewing of health service. In 2007 the Patients forums and Patient and Public Involvement were abolished and instead Local Involvement Networks (LINks) were established.[36] A major difference between the Patients forums and the LINks are that the LINks cover an area while the Patents Forums were tied to a specific organization (DH A stronger local

[34] http://www.dh.gov.uk/en/Healthcare/Secondarycare/NHSfoundationtrust/DH_4131784

[35] http://www.dh.gov.uk/en/Healthcare/Secondarycare/NHSfoundationtrust/DH_4062806

[36] DH 2009 (http://www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/DH_076366) (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_077488.pdf)

voice 2006:7). The local authorities of the area contract organizations, which set up and run the links. Thus, these organizations are the hosts, not the trusts or local authorities. The aim of the reform was, amongst other things, to give a stronger focus on the involvement of the public in commissioning services and on regulation, and to provide more flexibility in user involvement (Ibid:13). The LINks function in near cooperation with the Overview and Scrutiny Committees (OSCs) that scrutinizes the organizations that provide local health and social care.

4 Comparison and discussion of implications

In this last section I first sum up the descriptions. Then I discuss the similarities and differences between the countries according to my analytical framework. In a short concluding remark I make some reflections on implications for health care policy-making.

Figure 4.1 presents a summing up of the previous description of the structure of specialized health care systems in Norway, Denmark and Norway.

Figure 4.1 *The structure of specialized health care system of Norway, Denmark and the UK*

	Norway	**Denmark**	**The UK**
National level			
Parliament:	Stortinget	Folketinget	United Kingdom Parliament
Separate health committee:	Yes. Standing Committee on Health and Care Services	Yes. Standing committee on Health	Yes. Select committee for health
Numbers of MPs and staff in parliament (2008/09) Party staff not included	MPs: 169 Staff: approx 420	MPs: 179 Staff: approx 390	MPs: 645 Staff: approx 1600
Ministry:	Ministry of Health and Care Services	Ministry of Health and Prevention	Department of Health
Social care included	No	No	Yes
Number of departments	7	5 (centres)	16

To be continued on next page

Departments with main responsibility of specialized health care	- dep. for specialist health care services - dep. for hospital ownership	Centre of hospital policy	- NHS Finance, performance and operations - Commissioning and System management
Central agencies /ALB's - number and other regulatory bodies	Approx 14	Approx 10	A pprox 20 executive agencies, special health authorities and Non-departmental Public Bodies + "numerous" advisory regulatory bodies
Regional level:			
Regional political responsibility	None	5 Regional councils and Health Coordination Committees	None
Regional administrative responsibility	4 Regional Health Authorities (enterprise model)	5 regions	10 NHS Strategic Health Authorities
Boarders coterminous with other regional political/administrative units	No	Yes	Yes
Local/hospital level:			
Local political responsibility	No	Yes (Local authorities in financing, and Health Coordination Committees)	Only in Foundation Trusts[37]
Hospitals: organizational form	Enterprises	Ordinary civil service	Acute trusts or foundation trusts
Board of directors	Yes	No	Yes
Patient commissions/ patient involvement networks	Yes, obligatory in enterprises	A few, voluntary	Yes, obligatory in area
Borders coterminous with other local political/ administrative units	Varies	Yes	Yes
Financial responsibility	State	State and municipalities	State

[37] At least one member in Board of Governors in Foundation trust must represent Local Authorities in the area http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4029990.pdf

The description of the various systems does first of all indicate variations in size and complexity of the three systems. Not surprisingly the British specialized health care system is a lot more extensive and complex than the Nordic ones, of course partly because of country size. The description does, however, also show significant differences between Denmark and Norway. Both countries have implemented rather comprehensive reforms since the millennium change, but the reform in Denmark (in 2007) turned out less radical. The Norwegian hospital reform (in 2002) resulted in a specialized health care system that apparently is more complex and differentiated than the Danish one. The financial system in Denmark is, however, more complex than the Norwegian one (cf. section 3.2.1).

Second, the systematic mapping indicates how the three systems vary according to our analytical indicators; political responsibility/ownership, financial responsibility, parliament vs. executive relations, task and role specialization, administrative autonomy, variations in accountability arrangements and characteristics of structural user arrangements. In Figure 4.2 the different systems are categorized according to our analytical indicators.

Figure 4.2 *Countries, by analytical indicators.*

Analytical indicators	**Norway**	**Denmark**	**The UK**
Political responsibility (ownership)	State	Regions	State
Financial responsibility	State	State and municipalities	State
Parliament vs. Executive	Strong parliament	Strong parliament	Weak parliament
Task and role specialization (vertically and horizontally)	Moderate to high	Low to moderate	High

To be continued on next page

Administrative autonomy	High	Low	High
Variations in accountability arrangements	Moderate	Low	Extensive
Structural arrangements for patient involvement	Yes, obligatory	A few, voluntary	Yes, obligatory

The categorization in Figure 4.2 supports and strengthens the picture of differentiation and complexity. In public administration literature and especially in the reform literature "complexity" and "fragmentation" often seems to be used synonymously. It may be argued that the term fragmentation indicates not only incoherent (or split up) administrative structures but also "poor" processes and policy coordination. This is however an empirical statement that our data does not cover. My mapping does only indicate the degree of "differentiation" or "complexity" of the various systems, not system performance.

First; in Norway and the UK the political responsibility for specialized health care rests with the national Parliament. The state also has the entire financial responsibility for specialized health care. Norway and the UK do, however, differ when it comes to parliament-executive relations. The Norwegian parliament is regarded as strong compared to the British parliament. In this respect, Norway and Denmark equals, but in Denmark, political responsibility for specialized health care rests with the popularly elected regions. Besides, in Denmark the financial responsibility is shared between the state and the municipalities. Thus, the responsibility of the Danish regions may be characterized as rather limited.

Second; task and role specialization and administrative autonomy are more extensive in the British and Norwegian specialized health care system than in Denmark. All three countries have a substantial number of health agencies subordinate to ministry, but especially the British system is characterized by more differentiation in organizational forms at the agency level. Besides, both the UK and Norway, contrary to Denmark, have made split-ups between ownerships-functions, commissioning, regulation and auditing and service delivery functions. And of course, especially the enterprise/trust models in Norway and the UK indicate more extensive administrative autonomy for hospitals in these countries than in Denmark,

where all hospitals still are ordinary civil-service organizations. The introduction of the foundation trust model in the UK has in particular given more financial and administrative leeway for many hospitals.

Thus it is, third, quite logical that managerial accountability arrangements are more differentiated in specialized health care in the UK and Norway compared to Denmark. Boards of directors in Norwegian regional and local health enterprises and in British health care trusts are indicators of ex-ante accountability arrangements. Besides, there is substantial use of performance contracts, and various forms of reporting methods and auditing agencies, especially in the UK. Together this indicates more focus on "downward" as well as traditional "upward" accountability in British and Norwegian specialist health care than in Denmark.

"Downward" accountability is also aimed at through specific arrangements for patient involvement. In the UK and Norway structural arrangements for patient involvement is obligatory (patient commissions and local involvement networks). In Denmark patient involvement arrangements are voluntary.

In Figure 4.3 the three countries are placed according to our analytical dimensions, based on the categorizations in Figure 4.2.

Figure 4.3 *Hospital government systems in Norway, Denmark and the UK. – by analytical dimensions.*

Political-democratic authority and financial responsibility	National parliament	Norway The UK Denmark (financing)
	Regional councils	Denmark
	Municipalities	Denmark (financing)
Parliament-executive relations	Strong parliament	Norway Denmark
	Strong executive	The UK
Political-administrative relations	Integrated	Denmark
	Separated	Norway The UK
Structural arrangements for patient involvement	Yes, obligatory	Norway The UK
	No, voluntary	Denmark

Concerning political-democratic authority and financial responsibility Norway and the UK fit into the "national parliament cell". In Denmark the politically governed regions are politically responsible for specialized health care, but the financial responsibility does not correspond with the political and administrative authority. Thus the authority of the regions is not as wide-ranging as the political-administrative responsibility and distribution of tasks may indicate. Concerning dimension two - parliament-executive relations - Norway and Denmark obviously fit into

"the strong parliament cell", while the UK fits into in the "strong executive cell". Dimension three – political-administrative relations – is represented by three indicators: task and role specialization, administrative autonomy and variations in accountability arrangements. Figure 4.2 indicates that the Danish specialized health care system turns out as integrated, while the Norwegian and the UK systems turn out as separated on political-administrative relations in Figure 4.3. A decisive factor is the enterprise/trusts models in Norway and the UK compared to the Danish ordinary civil-service model. At the fourth and last dimension – structural arrangements for patient involvement – Norway and the UK also differ from Denmark – due to the mandatory elements in the Norwegian and British systems.

Last, but not least, what are the possible implications for health care policy making of the picture outlined? How may the differences in structure affect the possibilities of various groups, be it politicians, professionals, users or other interest groups, to come to grips with and influence hospital matters in the three countries under study?

First; how may the different systems affect the possibilities of national versus local politicians to influence and control health care policy? In all three countries, ministerial responsibility is a fundamental principle regulating the relationship between the parliament and the executives, but the executive is regarded strongest in the UK. In Norway and the UK the hospitals are owned by the state, while in Denmark specialized health policy is a political responsibility of the regions. Although the state (together with the municipalities) has the financial responsibility in Denmark and it thus has been argued that also the Danish system has become more centralized, the ownership structure indicates more influence and control to national politicians in the UK and Norway than in Denmark. It is however important to distinguish between government and opposition in the three countries. The "winner takes all" model which strengthen the executive vis-à-vis the parliament in the UK, indicates that the opposition in Parliament is less influential in the UK. Thus we assume less integration between parliament and the executive in the UK than in the Nordic Countries. In total, the Norwegian parliament is regarded as the most influential one.

In Norway, it is obvious that the hospital reform strengthened the national politicians' role vis-à-vis the politicians at the regional and local level, because ownership was transferred from the counties to the state. Local or regional politicians do no longer have any formal responsibility in

specialized health care. Following a debate on "democratic deficit" in hospital politics in general, and especially in locally or regionally related matters (particularly hospital structure), the new Red-Green government in 2005 decided that the composition of the regional and local enterprise boards was to be changed. When the hospital reform was implemented in 2002, no active politicians were appointed members of the boards. The intention was to establish so called "professional boards", and no other groups than employees were given a formal mandate of group representation. In 2006 the statutes were changed, and now, as described, former and active politicians constitute the majority of the board members. A number of politicians are proposed by counties and municipalities, but selected and appointed by the ministry (what concerns boards of regional health enterprises) and the regional health enterprises (what concerns boards of local health enterprises). The local politicians on the boards are meant to increase the local and regional responsiveness of specialized health care, but they do *not* have political mandates from their constituencies. Their representation is gently spoken, quite ambiguous. The fact that the borders of the regional health enterprises and quite a number of the local health enterprises intersect the borders of the counties and/or municipalities as well as other state regions may further increase this ambiguity.

The introduction of the foundation trusts in the UK may also be interpreted as a means to strengthen the link to the local communities and make hospital policy more responsive to local needs and opinions. As described, at least one member in each Board of Governors in the foundation trusts must represent Local Authorities in the area (cf. note 37). In Denmark the regional politicians *are* responsible for specialized health care. Here it is more a question of if and how the municipal politicians may influence. One instrument is the financial one. As described, the municipalities do share the responsibility with the state for the financing of the regions. Besides, the Health Coordination Committees with members both from the regional and local level is a formal channel for influence.

Concerning the UK and Denmark, it is also worth mentioning that the borders of the British Strategic Health Authorities and the Danish regions are coterminous with the borders of the Government Offices for the regions in the UK and the five bodies of state administration in Demark. This makes the regional and local political/administrative landscape in health politics more coherent than in Norway.

The dominating topic in the (reform) literature has, however, not been the formal and actual distribution of authority and influence between national and local politicians. The question of balance or trade off, between political control and the influence of health managers, bureaucrats and other professionals has gained far more attention.

Our mapping shows that the formal structures of the health system in the countries under study may influence the balance between political control and administrative autonomy differently. The specialized and segregated specialized health structures in the UK and Norway enhance role purification and give less blurring of roles, but the "other side of the coin" may be less and poorer access to political leadership, poorer political coordination and control; probably even more in the UK than in Norway. The UK and Norway compared, the purchaser-provider split is more thoroughly developed (structural "backing" in PCTs), and the organizational forms are more differentiated in British specialized health care than in Norway. The introduction and development of Foundation trusts with extensive autonomy does further challenge the trade-off between political control and administrative autonomy in specialized health care in the UK. In Norway the managerial autonomy of the regional and local health enterprises is constrained by a number of steering devices in the Health Enterprise Act and through additional statutes. The integrated and more "traditional bureaucratic" model in Denmark, on the other hand, indicates tighter political control and more easier access to political institutions and political leadership for bureaucrats and other professionals in health care.

A common assumption and finding in most of the reform literature is that increased vertical and horizontal specialization, combined with more differentiated forms of affiliation and more managerial autonomy has resulted in more ambiguous relationships between politicians and managers, depolitization and arena shifting (Christensen and Lægreid, eds. 2007, Pollitt and Boukaert 2004). Studies in Norway do however indicate that not only structural arrangements, but also context matters. The structural effects are dependent on the character of the policy issue that is on the agenda and the present parliamentary situation (Lægreid, Opedal and Stigen 2005, Opedal and Rommetvedt 2005,Opedal and Rommetvedt 2010, forthcoming).

Last, but not least, the mapping demonstrates how structural arrangements for patient involvement vary between the three countries. Both the UK and Norway have established formal and obligatory arenas

for patient/user involvement, while Denmark seems to be "lagging behind". There are so far relatively few forums for user responsiveness or downward accountability arrangements in Denmark. The greater complexity of the systems in Norway, and especially in the UK, may enforce formal patient and user involvement to a greater extent than the Danish system. The difference may imply that patient groups are more integrated and have more formalized contacts at the hospital level in the UK and Norway than in Denmark. Thus, patients and other interest groups in Denmark probably act more in accordance with a citizen role than a user role.

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Descriptions are traditionally rather poorly valued in political science. The reason is probably that descriptions quite often are done with poor and less coherent analytical dimensions. Comparisons are often single country or single sector presentations with meagre comparative value. In this report a simple, but coherent analytical design is used. The mapping has revealed some major, some moderate and some more modest structural differences between the hospital government systems in Norway, Denmark and the UK. We believe our analytical design is a fruitful base for further studies with more specific analytical questions concerning specialized health care in the three countries. Both in comparative and single-country studies one has to search for and take a further look into organizational peepholes as well as organizational panoramas and windows.

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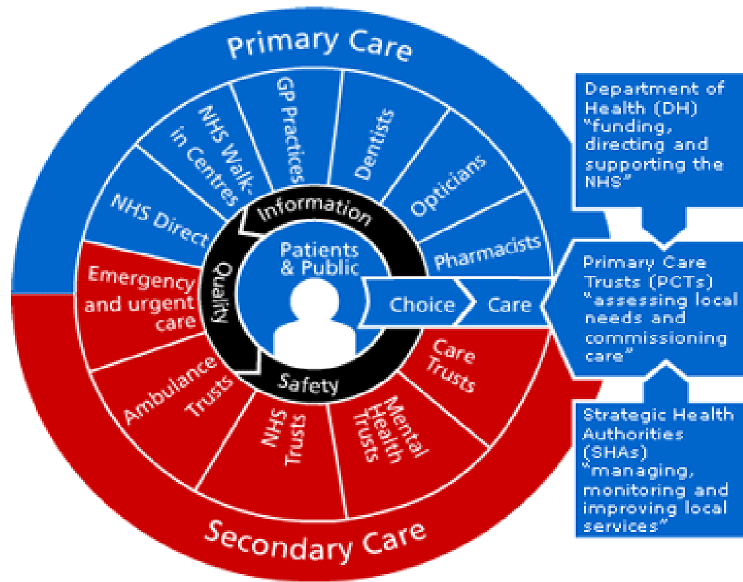
Appendix 1 The UK. Executive agencies, special health authorities and non-departmental public bodies in health care. 2009.

Organizational form:	Function:
Executive agencies	
1. Medicines and Healthcare products Regulatory Agency (MHRA)	Regulatory
2. NHS Purchasing and Supply Agency (PASA)	Central services to the NHS
Special Health Authorities:	
3. Information Centre for health and social care	Central services to the NHS
4. National Institute for Health and Clinical Excellence	Standard
5. National Patient Safety Agency (NPSA)	Public welfare
6. National Treatment Agency for Substance Misuse (NTA)	Public welfare
7. NHS Business Services Authority	Central services to the NHS
8. NHS Appointments Commission (NHSAC)	Central services to the NHS
9. NHS Blood and Transplant Authority	Central services to the NHS
10. NHS Institute for Innovation and Improvement	Central services to the NHS
11. NHS Professionals	Central services to the NHS
12. NHS Litigation Authority	Central services to the NHS
13. Postgraduate Medical Education and Training Board	Regulatory

Non-departmental public bodies	
14. Council for Healthcare Regulatory Excellence (CHRE)	Regulatory
15. Care Quality Commission	Regulator
16. General Social Care Council (GSSC)	Public Welfare
17. Human Fertilisation and Embryology Authority (HFEA)	Regulatory
18. Human Tissue Authority (HTA)	Regulatory
19. Monitor (Independent Regulator of NHS Foundation Trust)	Regulatory
20. Health Protection Agency	Public Welfare
21. Alcohol Education and Research Council	Public Welfare

Source: DH Guide 2008: 40 and Department of health 2009.
(http://www.dh.gov.uk/en/Aboutus/OrganisationsthatworkwithDH/Armslengthbodies/index.htm

Appendix 2 NHS Structure – authorities and trusts.



Type	Function	Number
Primary care trusts	Main duty to secure provision of services in accordance with local needs and manage contracts with various providers. Commissioning of services from NHS trusts and private providers thus a central task. Managing responsibility for the general practioners, Dentists, Opticians, Pharmacists, NHS Walk-in Centres, and NHS Direct in their area	152
Acute (Hospital)Trusts	Hospitals are managed by acute trusts. Some acute trusts are regional or national centres for more specialized care. Some are attached to universities. Acute trusts can also provide services in the community, for example through health centres, clinics or in people's homes.	Approx 180 including foundation trusts.
Ambulance Trusts	Provides emergency access to healthcare and provides transport to hospital for elective treatment	13
Care Trusts	Work both in the social and health care, including social care, mental health care or primary care services. Co-operation between the NHS and local authorities.	10
Mental Health Trusts	Mental Health services can be provided through GPs, other primary care services or through more specialist care. Specialist mental health care is normally provided through Mental Health Trusts.	Approx 66 including foundation trusts.
NHS Foundation Trusts	*Foundation trusts have been given much more financial and operational freedom than other NHS trusts. There are various types: for acute(hospital) functions, for care and for mental health treatment.*	*Approx 120*

Source: http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx)