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Abstract
(Re)centralizing tendencies within Health Care Services. Implementation of a new idea?
Decentralization has been for many years a widespread trend in health care sectors throughout Europe. Yet, more recently, a new host of reforms is observable implying an ambition of some states to regain lost control. What is the general trend of (re)centralisation about and what happens when reforms promoting (re)centralisation are translated in different national contexts; e.g. in what way contextual factors modify a general trend? The establishment of regional health authorities in Norway and regional hospital agencies in France will be used as examples to analyze the spreading and transformation of (re)centralisation.

Sammanfattning
(Re)centralisering inom hälso- och sjukvården. Implementering av en ny trend?
Decentralisering har under lång tid varit en dominerande trend inom hälso- och sjukvården. På senare tid har dock en ny trend fått spridning som handlar om att vissa stater för makt och kontroll tillbaka till den centrala nivån, dvs. (re)centraliserar. Vad (re)centralisering handlar om och hur nationella kontexter påverkar implementeringen av denna nya trend ska undersökas. Etableringen av regionala sjukhusorganisationer i Norge och Frankrike används som exempel för att analysera spridning och lokal anpassning av (re)centraliseringen.

(Re)centralizing tendencies within Health Care Services. Implementation of a new idea?

Health care is a highly political issue; it is exposed to changes and challenges that continually imply negotiations of how power and authority are distributed between institutions responsible for planning, financing and allocating health care services. The basic framework within health care policies is affected by pressures from inside and outside the health sector. Pressures to keep expenditures under control and increase productivity need to be combined with moral imperatives such as universal access to health care or the improvement of equity with which services are to be distributed. One major challenge with regard to the future of health care systems is the financial sustainability of the system with a rapidly aging population all over Europe and the consequent reduction in the ratio of the number of active workers to the number of elderly retired who are in greater need of health care services (Saltman 2004). Quality of health care is another challenge. Pressures from outside are in contrast not necessarily specific for the health care sector but can consist of a more general trend affecting state-supported welfare programs. Behind that a search for the optimal way to organize public services in a specific context in a specific time can be found. One of the central elements of public service reform is the replacement of centralized hierarchical, rule-driven administrations with decentralised management environments (OECD 1995). A decentralization of administrative and managerial tasks has taken place in many policy areas throughout Europe, a trend that also includes health care sectors (Saltman et al 2007).

Yet, more recently, it seems that in some countries the trend towards decentralization is loosing some ground. It is recognized that decentralization has created new problems, such as poor coordination, difficulties in coherence and accountability as well as unequal treatment of citizens living in different parts of the country (Peters 2008), thus causing a need for new reforms. This new host of reforms is, however, not simply a return to the previous status, but an ambition of some states to regain lost control. Consequently, decentralization within health care has been analysed and studied in a rather great extent (e.g. Saltman et al 2007). This is not the case when it comes to recentralisation. Here our knowledge about patterns and forms of recentralisation are still limited.

Shifting power from lower to higher levels of government can occur in different ways. One way is to transfer power to newly created organisational units on higher levels of government (centralisation) or by transferring power to already existing ones (recentralisation). The introduction of the health regions in Denmark (2007), Norway (2002), and Finland (1990), as well as regional hospital agencies in France (1996) can be named as examples[1]. This type of reform can be found in both tax-financed national health service systems (often described as a Beveridge model of health care) and those operating within an insurance system usually financed jointly by employers and employees through payroll deduction (called Bismarck model of health care).

In this paper we want to study whether it is possible to track what this general trend of (re)centralisation is about and what happens when reforms promoting (re)centralisation are translated in different national contexts; e.g. in what way contextual factors modify a general trend. The notion of contextual factors includes the political and administrative structure of the respective countries, implying regulation (administrative and political levels, stakeholders), funding responsibilities and delivery structure (e.g. private versus public). The more concrete aim of this paper is to analyse the shape (re)centralisation takes in the reforms of national hospital sectors in Norway and France. A hypothesis is that reforms in stronger decentralised countries belonging to the Beveridge system (e.g. Norway) are more likely about shifting power on a vertical dimension (from lower to higher levels of government) whereas in typically Bismarckian countries (e.g. France) reforms will be more about shifting power between various stakeholders (horizontal dimension). The assumption behind that hypothesis is that processes of (re)centralization differ in already highly decentralized countries from those in initially centralized countries (Pollitt, 2005). It might be easier for highly decentralized countries to perform recentralization reforms than for countries where power is distributed among a wide range of different actors building upon negotiations that occur on all territorial levels.

Yet, the article has also a theoretical ambition. It is embedded in the discussion within new institutionalism on why and how organisations belonging to the same organisational field change their form by adapting certain ideas. According to this body of theory, organisations

[1] Another type of reform resulting in (re)centralisation is the merger of sickness funds or the transformation of certain functions from regional sickness funds to national sickness funds that took place in several countries (e.g. Luxembourg, Poland, France, Latvia, Slovakia, and Germany).

are forced to comply with the institutionalized expectations of their environment and adopt expected structures and management practices because they are depended on the environments legitimacy for survival. However, new ideas are interpreted or 'translated' as they travel around the world and are affected by contextual factors when being "reembedded" in a new context (Czarniawska and Sevón 2005).

Methodologically the approach of a "least- similar case study" will be used. That means a similar type of reform, the establishment of regional health authorities in Norway and regional hospital agencies in France, carried out in two European countries with distinct different contexts will be used as an example to analyse the spreading and transformation of (re)centralisation. Norway and France are consequently used as illustrations for the theoretically based analysis. Both countries differ with respect to several important dimensions, such as type of welfare state and type of health care system but also with respect to the political administrative system. France is characterized by a strong centralism with sub-national authorities that may make and implement policy but do so by permission of the centre. A distinctive feature of the Norwegian political administrative system in contrast, is that power to a large extent is decentralised and that local governments enjoy strong autonomy.

The paper is organised in the following way. The article starts with discussing theoretical approaches about how to organise an organization in the best way and by what means and in what way they tend to change. Here the attractiveness of recentralisation will be pointed out. It is followed then by discussing the actual reforms in Norway and France by particularly emphasising contextual factors. In a third part the reforms will be analysed with regard to similarities and differences. The paper ends with a conclusion.

Organizing organizations: different approaches – and different answers

How to organize an organization in the best way is a question that has occupied various theorists since the turn of the last century. The answer(s) to whether essential principles resulted in optimal organizational performance varied depending on the prevailing theoretical perspective on organizations. This understanding has changed and with that the recipe for the most proper way to set up an organization.

New Public Management (NPM) is one of the more recent approaches that have achieved enormous attention since its rise in the late 1970s and early 1980s. NPM as a label is used to define a general trend towards changing the style of government and administration in the public sector and to describe a number of reforms that were performed in many countries during the 1980s and 1990s (Sahlin – Andersson 2003). The concept of NPM is multifaceted and often described as a kind of "shopping basket" filled with different elements for reformers. Some of these elements are the emphasis on professional management, on standards of performance, on output instead of process and on a competitive base for the provision of service instead of hierarchical orders. As Gruening (2001) shows, New Public Management can be tracked back however, to a variety of theoretical origins. It is the mix of different elements in one approach that made NPM unique but also in some way ambiguous.

Its character as a shopping basket filled with different items actually allows reforms to take different shapes with different implications for the balance of power between central and local levels of government. The combination of items based on economic organisation theory and management theory can result in contradictions between the centralising tendencies inherent in contractualism and the decentralisation tendencies of managerialism. Contractualism based on economic organisation theory includes public choice theory and principle-agent theory that focus on the primacy of government over bureaucracy, the reinforcement of the power of political leaders and gives attention to centralisation, co-ordination and control. The primacy of managerial principles is instead the focus of management theory. Increasing the capacity of managers to take action requires therefore decentralisation, devolution and delegation. Thus, the hybrid character of NPM actually to some extent allows centralising tendencies (Christensen and Lagreid 2003).

NPM will certainly not be the last reform wave. Lately the label post- NPM has been introduced, focusing on recent developments in public management and administrative reforms. Post- NPM is about to correct the dysfunctional aspects of NPM, e.g. decentralized, overlapping and fragmented services by improving coordination and control, and asserting recentralization and re-regulation (Christensen and Lægreid 2007). Yet, criticism goes even further. In New Zealand, one of the first countries that introduced New Public Management in the early 1980s serious concerns over various aspects of Public Service management and culture were expressed in the late 1990s and a loss of public confidence in the institutions of government, politicians and public servants was observed (Gregory 2001, Kettl 2005).

Tendency to change

Why should then organizations change, by what means and in what way? One explanation is provided by new institutional theory. As stated by DiMaggio and Powell, "in the initial stages of their life cycle, organizational fields display considerable diversity in approach and form. Once a field becomes well established, however, there is an inexorable push towards homogenization" (DiMaggio and Powell 1983, 64). By organizational field the authors mean organizations that in the aggregate, constitute a recognized area of institutional life, thus not a single organization but the totality of relevant actors (e.g. health care). Once individual organizations are structured in an organizational field powerful forces lead them to become homogeneous. The reason for that phenomenon can be found in the strong influence of the organization´s environment. Yet, this influence is not made up of rational or efficiency-based forces but of socially constructed belief systems and normative rules that control how organizations should be structured and activities performed. Particular organizational forms do not exist because they provide an optimal input–output balance, but because they correspond to institutionalized expectations, e.g. the influence of the societal or cultural environment on organizations (DiMaggio and Powell, 1983; Meyer and Rowan, 1977; Tempel and Walgenbach 2007). The focus is on the legitimacy which is awarded to organizations by the institutional environment and which is necessary for organisations survival. With other words, in order to ensure their survival, e,g. receiving necessary resources (financial and personnel) and support, organizations must comply with the institutionalized expectations of their environment and adopt the expected structures and management practices. The adoption of institutionalized elements leads to an isomorphism of organization and institutional environment by various mechanisms. In a further development of the new institutionalism, however, Powell opened up for the possibility of heterogeneity and change within organizational structures. There is a wide range of institutional influences – even sometimes conflicting influences - and internal responses to these may vary (Powell and DiMaggio 1991). Yet, new institutionalists tend to emphasize the global diffusion of practices and the adoption of these by organizations, but pay in turn little attention to how such practices are interpreted or ‘translated’ as they travel around the world.

This has however been in the centre of the so called Scandinavian School within new institutional theory giving attention to processes of institutionalization and seeing both stability and change as an institutional norm (Erlingsdóttir and Lindberg 2005). By introducing the concept of translation and circulation of ideas, more weight is given to a more

active process of reception. It is recognized that ideas first become disembedded, carried away and on their journey follow different routes and networks, thus may be edited before they get reembedded in a new context (Powell et al 2005). Contextual factors in the new environment may further result in an adaption of the new idea to the domestic preconditions.

Attractiveness of (re)centralisation

Reason for why ideas are imitated by others can be seen in their alleged superiority, both with respect to quality and power – symbolic, or legitimacy in DiMaggio and Powell words) (Czarniawska and Sevón 2005). In other words practices are imitated and spread if they seem to be attractive at a given time and place.

Is it possible then to characterize the idea of (re)centralisation as superior to the popular and dominant trend of decentralisation? To answer this question, let us start with setting recentralization in the context of reorganisation of health care policies. The last decades have seen an ongoing reorganization of welfare policies in general, entailing a shift of power and responsibility from mostly higher to lower levels of government with regard to regulating, administrating and financing welfare policies. This development also included the organisation of health care policies and there is a lot of literature claiming that European health care systems are decentralized or have been decentralized in recent years (Saltman et al 2007). Transferring autonomy to sub- national levels is based on the assumption that smaller units provide services better, that decentralization offers a route to reinforce democracy by moving decision-making closer to the citizens and that governments are better at setting directions for policy than they are at actually delivering those policies (“steering not rowing”, Osborne and Gaebler 1992). Decentralisation has become a central principle of health policy all over Europe, also if one applies a more functional approach, thus distinguishing between political, administrative and fiscal decentralisation (Saltman and Bankauskaite 2006). Political decentralisation has for example spread from Northern Europe to Mediterranean tax-based health care systems (yet in different ways) implying that regional/ local decision makers got increased autonomy to take service-related decisions, while the national level keep regulatory responsibility. Within political and fiscal decentralisation, many countries developed a shared national – regional/local structure for distributing authority. Responsibility for administration and delivery of services has in some countries been decentralised to political or administrative authorities at lower levels but may also be delegated to private not-for-profit or for-profit organisations. In reality, however, these reforms may have reduced the steering capacity of

the public sector by reducing the capacity of elected officials to exercise control over policies. Furthermore, the large number of organizations operating with increased autonomy has enlarged the problem of coordination and coherence in the public sector (Peters 2008). So despite the dogma of decentralisation or because of problems that arose in highly decentralised and often fragmented organisations the dominant principle of decentralisation is more and more questioned. Thus, (re)centralisation could be understood as a reaction against decentralisation that has gone too far. This shift of power back to the centre concerns most regulatory authority. Shift of power to the centre can however; also be understood in a different perspective focusing on actors and not on territorial levels of government. In the sense of reforms that shift power from one actor to another one and imply changes in the arrangement between important institutional players.

Reforms towards centralisation of governance within health systems are observed in various contexts. In both tax-funded as well as insurance-funded health systems (re)centralisation has appeared as an alternative organisational solution especially when it is about key decision-making responsibility. In Australia, 6 of 8 jurisdictions have centralised governance authority for public sector health care agencies at the level of the state or territory health authority (Dwyer 2004). In the Scandinavian countries, belonging to tax-based health care systems, recentralization strategies are mostly concentrated on regaining political responsibility (Norway), and as in Denmark recentralising operating and financial authority (Magnussen et al 2009). Responsibility for service delivery remains decentralized. Recentralization initiatives can be also observed in Poland, the Czech Republic and Slovenia (Powell and al 2005). In Poland and Slovakia for example, previously regionalized sickness funds are transferred into a single national organization, enabling it to be more directly supervised by national ministries of health and finance. Also in Spain, Sweden and Italy one can find recent signs of recentralization, in the sense that the national government is trying to assume a larger role in health coordination and monitoring (Maino et al 2007).

Institutional environment

Yet, an idea needs promotion, needs to be advertised to become a trend and to be spread to other environments. An important role falls to international organisations that can act as supporters or detractors. Major actors are for example the OECD, the WHO and the EU publishing regularly reports and spreading ideas and even more important compare and assess

the development in policy areas in various countries (e.g. the OECD´s Public Management Committee (PUMA), the OECD regulatory reports, the European Observatory on Health Systems and Policies). Since the early 1990s, the WHO Regional Office for Europe has conducted an extensive programme of activities in support of reform development and implementation, established a knowledge base and information system on reforms, developed networks to exchange experiences and support decision makers, and provides direct advisory support on policy and competence building in individual countries. In a similar way diverse country reports that are published by the OECD function. A country report on the Norwegian economy from 1998 pointed to the need to strike a balance between the requirements of a cost efficient health care system on the one hand and the ambition to maintain health service in even the remotest parts of the country as well as the risk of major expenditure increases in the future (OECD 1998). To meet these challenges, several reforms had been introduced, reforms including increased competition and reinforced planning. In its review on regulatory reforms in 2003 the OECD was in large satisfied with the Norwegian Government but criticised the past reforms for leaving too much power for political influence from the top and pointed out that the reforms break with the stated goals of greater subsidiarity. The OECD was neither satisfied with the state being purchaser and provider at the same time (Byrkjeflot 2005). In a similar manner, further reforms were demanded in France to capture health expenditure that in relation to GDP is among the highest in the OECD (year 2000); with regard to the newly established hospital agencies (ARHs) it was criticised that the system was too rigid and did not allow for managerial flexibility. “The role of the ARH should therefore be expanded and these agencies should be made more autonomous to enable them to act as care purchasers and to obtain affordable high-quality care for patients. Tendering could be introduced for the purchase of standardised care in order to promote competition between suppliers on the basis of a harmonised price structure” (Imai et al 2000, p29).

So, is (re)centralisation an idea supported by international organisations being a part of the institutionalized environment of health care policies? The Norwegian and even the French examples points to some criticism regarding increased central power. Yet, there are some more recent signs that even within the OECD the need for a rebalance is assessed as necessary. “Governments have been more successful in introducing performance management. The idea is to give managers the authority, and the incentive, to make decisions and manage resources in the way that they judge best suited to producing the desired outcomes. This requires government to focus on performance, to clarify organisational

objectives and to motivate public officials to achieve them. Governments should, however, beware of overrating performance-based systems' power to achieve change. A key challenge is balancing the increased managerial flexibility needed to operate such systems with continued accountability and control. Too much flexibility could lead to abuse and mismanagement; too little can give rise to an inefficient and unresponsive public service" (Bibbee and Padrini 2006, p. 4). Thus, the risk of fragmenting government into a series of autonomous entities lacking a common purpose or ethos is pointed out clearly and opens the way to some form of (re)centralisation with the aim of a rebalancing. "Innovative administrative structures, decentralised management and market-style service delivery should improve results. Nevertheless, these actions may not reduce the size of central agencies, particularly as governments need to strengthen co-ordination by the centre in the new systems" (Bibbee and Padrini 2006, p. 5).

Thus, (re)centralisation has to be seen in the context of contemporary governance processes that contain a great deal of decentralized activity, but that all tasks cannot be fulfilled by those decentred processes or cannot be fulfilled in a manner that is consistent with overall principles. This awareness has generated the need to incorporate increased control into governing processes, and by that combine autonomy for decentered governance arrangements with a certain degree of central control (Peters 2008, Minas and Overby 2010). However, there are also other more general nation-specific components that need to be taken into account and that transform and modify general reform ideas when they meet the domestic political-administrative tradition. We will take a closer look on the influence of national contexts in the next part. Here the focus will be on political and administrative structures of the two countries, the actual reforms, the reasons behind the reforms, the expression it took and actors involved. This part ends with a summary of the main national factors influencing the structure of (re)centralisation.

Contextual factors

In order to get a further understanding of why similar reforms can take different expressions nationally it is relevant to get an idea of the functioning of the individual national health care systems consisting of specific political and administrative authority structures that influence political decision-making. The institutional setup of health systems can be described by the regulation, delivery and funding structure. Responsibility for regulating includes the system-

level organization that sets the regulatory institutional framework for the scheme. To some extent responsibility will probably always be located at a central level, but certain regulatory tasks can be transferred to decentralized political or administrative units. Delivery management concerns the practical and production-related decisions of services which can be further subdivided into primary, secondary and tertiary care (Vrangbæk 2009). Funding decisions is about the level of resources that a country wants to devote to health care, but also about the distribution of the financial burden between different groups within the population. Generally, European health systems tend to be described as tax or social insurance based: the traditional Beveridge - Bismarck distinction. The distinction provides an organizing and in some way a financing principle.

Norway

When classifying countries into different social policy clusters or regime types, Norway is normally placed in categories such as the social democratic regime (Esping -Andersen 1990) or a universal welfare state. Universal social rights have been at the core of this type of welfare state model. Building on the same principles of universalism and equity, the Nordic health care systems are closely related to the development of the welfare state and are built on the principle of universality: all inhabitants have the same access to public health services regardless of social status or geographic location. This strong emphasis on equity has been combined with a tradition of decentralization, with the responsibility for service provision resting on a regional, county or municipal level; however, often within a framework of centralized supervision and regulation. (Magnussen et al 2009).

Institutional and structural design

The structure of the Norwegian health care system is organized on three levels that mirror the political tiers: the central state, the regions, and the municipalities (Johnson 2006). Overall responsibility for the Norwegian health care sector rests at the national level, with the Ministry of Health and Care Services. The role of the state is to determine national health policy, to prepare and oversee legislation and to allocate funds. Secondary care is since 2002 the duty of four regional health enterprises – although within a framework of centralized supervision and regulation. Until 2002 the counties had for more than 30 years the responsible for institutional health services whereas primary care is the responsibility of the municipalities. Similar to other Beveridge countries, The Norwegian health care system is a predominantly tax-funded health system with only minor supplementary premium-based or

out-of-pocket financing. Funding is a combination of locally raised (and regulated) taxes and matching central grants.

Establishment of regional health authorities

The establishment of regional health authorities in Norway is one part of a larger reform package, the so called hospital reform. The reform was implemented January 2002 and had four main elements (Magnussen et al. 2009). First, the central government took over responsibility of all public hospitals and other parts of specialist health care from the counties. Second, the Minister of Health was given responsibility for the overall general management of specialist care and financially even in the event of bankruptcy. Third, the central government maintained the five health regions established in 1974 as the organizational unit for coordination and steering and established five regional health authorities (RHAs) with the responsibility for purchasing health care from public or private providers (the number was reduced to four in 2007). These three elements together implied a movement towards (re)centralization. The fourth element of the reform represented elements of decentralization, as both the RHAs and the hospitals were organized as health enterprises or trusts. These bodies were set up as independent legal subjects with their own responsibilities for personnel and capital.

The regions have thus two roles, an authority role and an enterprise role: the first role by having a "care role" in providing the population with specialized health care services and the second role by supplying and producing specialized health care since regions own the health enterprises (Johnsson 2006). Most enterprises have further centralised administrative functions of many hospitals according to a cooperation model. The enterprises were initially governed by professional boards with state-appointed representatives with business experience assuming the role of stock-holder representatives in private firms. This was, however, reversed from 2006 as local politicians appointed by the Minister of Health were reinstated as board members. The enterprises have full autonomy for daily operations but are constrained by a number of steering devices from the Ministry. These illustrate the inbuilt ambiguity of the reform when it comes to the balance between the enterprise autonomy and governmental control. Political decisions are made by the Ministry of Health as the ultimate authority of the enterprises. In fact, the hospital law specifies in more detail what tasks and issues must be approved by the ministry than laws regulating other public sector companies (Lægreid, Opedal and Stigen, 2005). Thus, health laws and regulations, policy objectives etc.

are formulated by the national government, and they form the guidelines the Boards are to use in the day-to-day managing of the enterprises.

To understand the reform properly it is important to point to conflicts between county political and administrative authorities, between hospital administrative and professional leaderships but also between national political priorities and county autonomy that have existed over long time. The conflicts were about localization, financing and leadership; conflicts that are deeply rooted in Norwegian hospital history (Gronlie 2006). The framework for the hospital regime was founded in the hospital law of 1970 that made the counties responsible for planning, building and managing hospitals; yet within a system of state-approved county plans. Already then, in the 1970s, five health regions were created to build larger catchment areas in order to secure high-quality services at an acceptable level. This was the first step in moving planning responsibility from the county to a higher level, enforcing the county councils to cooperate. A takeover of responsibility for hospitals by the central government was thus discussed several times by the government. The dependency of the counties on state approval in order to implement their plans on the one hand and democratically elected county councils on the other that defended their autonomy was a source for permanent conflict. The Norwegian counties for example did not have the power to acquire their own funds by increasing local tax rates, and the role as the sole provider of funding gave the state a strong position in the negotiations with the counties about hospitals (Byrkjeflot 2005).

A further step in transferring influence from the county council level was taken with the introduction of activity based-funding in 1997. As a consequence the power of the county councils to make their own priorities in terms of budget decisions was removed making cost control problematic. In order to handle the situation the county councils used waiting lists as buffers when costs became too high. That however, questioned the legitimacy of county councils as health care policy makers (Bleiklie et al 2003). Counties struggled further with localism, where hospitals strongly wanted autonomy from county authorities and struggled against elimination or amalgamation of local hospitals into bigger units. The situation for the counties got even more complicated since hospitals are strongly influenced by powerful professions who act actively to expand or improve their services (Bleiklie et al 2003). The legitimacy of the county councils as hospital owners had over time become seriously impaired and with the hospital reform the process came to an end.

The national government is of course important actors in the distribution and not at least the modification and adaption of more general ideas about how to organize the health sector into a national context. The idea to organize public functions in autonomous or semiautonomous entities was not new and had been proved earlier in the field of industrial policy and development (Statoil, Telenor). These experiences seem to have had a strong bearing on the choice of a new model for the organization of hospitals. The influence of these earlier experiences is even more obvious since central players in the process had earlier been involved in transformations in the industrial and public utilities field. The then newly appointed Minister of Health, Tore Tønne, who personally promoted the Hospital reform, had experience as the head of the Agency for Industrial and District Development, which had a similar organizational form (Gronlie 2006). He strongly argued for the introduction of the state enterprise model and state ownership in the health sector (Byrkjeflot 2005).

Thus, a main goal with the reform was to get rid of an unclear division of overall responsibility and to enhance coordination and efficient utilization of resources. The reform should improve the overall performance of the hospital system, search for greater efficiency, and enhance a more uniform quality of services. Furthermore, the technical development within medical health made it necessary to create larger units of coordination the responsibility for hospitals.

France

The French social welfare system is often considered to be a conservative one with its general aim in income maintenance, rather then poverty alleviation or universalistic redistribution (Hassenteufel and Palier 2007). The social welfare system is mainly based on a specific set of non-state agencies (Sécurité sociale) divided into different sectors such as health care, old age, family and unemployment insurance. Thus the system is highly fragmented into different schemes covering different occupational groups. Schemes are made up of different funds (Caisses) organised at national, regional and local levels and headed by a governing board comprising representatives of employers and employees. All national health insurance funds are legally private organizations responsible for the provision of a public service. In practice, they are quasi-public organizations supervised by the government ministry that oversees French social security (Rodwin 2003).Yet, despite the legal independence of the French social

insurance scheme, the state is involved in multiple ways: as the major employer, as a specific financer since affected taxes represent now 20% of the Sécurité Sociale budget, and as supervisor (Gramain et al 2006). The French nation has been built around a highly centralistic state with the state as a key component of the French system of government. The pattern of central-local relations known as the French "system of territorial administration" is a key feature of the traditional French model of polity and politics. It rests upon the principle of administrative uniformity across the nation building a pyramidal power structure, e.g. a hierarchical mode of top down organisation.

With respect to the French health care system, France is often described as a mixed system lying between the Beveridge and Bismarck models with health insurance funds and strong state intervention. Combining public and private health insurance, public and private care, it is a publicly funded system characterized by freedom of choice and unrestricted access for patients and freedom of practice for professionals. It is complex and pluralistic in its management, with co-management by the state and the health insurance funds (Sandier et al 2004).

Institutional and structural design

Regulation is divided between the state, the health insurance funds and to a lesser extent, local communities, particularly at the department level. Regarding the management of health policies, the division of responsibilities between the state and the health insurance funds is a frequent issue and had been a source of conflict over many years. Traditionally, the compromise was to organize a division along sector lines with the state taking responsibility for public hospitals and drugs and the health insurance funds taking charge of independent medical practice on the basis of negotiated agreements. With the so- called Juppé reform in 1996 the state has taken over new responsibilities by the establishment of an annual Social Security Funding Act that sets ceilings for health insurance spending for the following year and contains new provisions concerning benefits and regulation. The state took also over the responsibility for negotiating with private for-profit hospitals, thus the entire hospital sector. Delivery of public health in France is a complex system involving numerous actors and sources of finance and despite the complexity of the system coordination is absent in many areas. The main health insurance funds have a network of local and regional funds that provide a range of customer services for their beneficiaries. The most important institution for the financing of health services is the sickness insurance funds (the main schemes are the

general scheme, the agricultural scheme and the scheme for non-agricultural self-employed people). Until 1996, the financing of health insurance depended almost exclusively on contributions from employees and employers as a proportion of wages and salaries. Later, coverage was extended to also include benefits recipients. The contribution rates for health insurance have steadily increased to cover spending on health care which has grown faster than the level of contributions. The need to widen the social security system's financial base resulted in an adjustment of the funding system and since 1998 contributions based on earnings are now accompanied by a 'general social contribution' based on total income (Sandier et al 2004).

Establishment of regional health authorities

The institutional organization but also the financing responsibility of the health care system was profoundly affected by the Juppé reform of 1996[2]. The reform introduced two important changes: a first changing the method of funding health insurance by substituting part of the contribution based on earned income (wages) with a contribution based on total income, which was more like a tax on income. A second change concerned the institutions responsible for operating health insurance by explicitly increasing the role of the state. This was done by the introduction of parliamentary control over the health care system and its resources, the creation of regional hospital agencies (ARH) and the establishment of an "agreement on targets and management" between the government and the largest health insurance fund, the National Insurance Fund for Employed Workers.

The intention with the regional hospital agencies (ARH) was to improve the supply of hospital beds at the local level. The ARH are responsible for hospital planning (public and private hospitals), financial allocation to public hospitals and adjustment of tariffs for private for-profit hospitals (within the framework of national agreements). Their role is an operational one. ARH directors are appointed by the Council of Ministers and are directly responsible to the Minister of Health.

Thus, before 1996 health insurance funds were mainly responsible for the private sector (ambulatory care provided by self-employed professionals and treatment in private for-profit hospitals) that was regulated through national agreements between the health insurance funds and the professional organizations. Public hospitals and the pharmaceutical industry were

[2] Alain Juppé, primery minister between 1995-97.

regulated by the government at the national level. Yet, since 1996 the state has taken over new responsibilities (the negotiation procedures with private for-profit hospitals and therefore the entire hospital sector and the involvement of parliament and the annual Social Security Funding Act), yet, at the same time responsibility was decentralised towards the regional level to newly created agencies. There is no doubt that the 1996 Juppé reform changed the balance of responsibilities for the French health care system. The reform has sometimes been described as a double shift of power: from the national to the regional level and from the health insurance funds to the state.

The background of the reform was that health expenditure rose more than receipts. The financial situation of the health insurance funds worsened steadily during the 1980s and the early 1990s and the gap between spending and resources pressed governments to implement a series of stabilization plans. Questions were also raised about the equity and the quality of the health care system and demands for a more efficient public administration were brought up. The reform has also to be seen in the light of a resistance to more profound changes. The administrative and political elite oppose a modernisation of the French public administration and defend against devolving power to lower political and administrative levels (Minvielle 2006, p754). Furthermore a power struggle between the government and the national health insurance funds has in recent years blown up concerning responsibility for cost-containment policy where for example the government has intruded into contractual arrangements between the NHI and the private medical sector. Another point of conflict is poor resources of the NHI services at the local level and their inability to work efficiently, whereas the local government agencies are involved in a large number of activities going beyond hospital care. Finally, the system is in great need of simplification and coordination regarding regulation of the health care system. “The regulatory system is thus a hybrid – even a hydra – with multiple stakeholders wielding power over two distinct sectors (public and private)” (Minvielle 2006, p754).

In summarizing essential contextual features influencing the Norwegian Hospital reform three factors shall be highlighted: i) the tradition of a highly decentralised health care system, ii) traditional conflicts between national political priorities and county autonomy, and professionals and administrators, iii) similar reforms in other policy areas and promoters for the reform in the government. With respect to the French health care system, three points shall be named: i) the highly centralized system, ii) the systems complexity and need for

simplification and iii) conflicts between the government and the national health insurance funds.

(Re)centralisation in different ways

So far we have distinguished quite different contextual features in both countries that likely had an effect on the design of actual reforms. How does our findings so far relate to our hypothesis formulated in the beginning? There we stated that reforms in stronger decentralised countries belonging to the Beveridge system (e.g. Norway) are more likely about shifting power at a vertical level (e.g. from lower to higher levels of government) whereas in typically Bismarkian countries (e.g. France) reforms will be more about shifting power between various stakeholders. To sort out our findings, we will start with discussing the studied reforms in the light of the theoretical considerations discussed in the introduction. We will do that by comparing both reforms and identify similarities and differences with regard to directions in shifts of authority and the superiority of the reform.

Propensity to adapt new ideas

With respect to NPM – inspired reforms both Norway and France have been characterized as reluctant reformers (Olsen 1996, Minvielle 2006). Yet, in the case of Norway that picture changed in the 1990s and Norway became more eager to implement NPM ideas (Christensen et al 2008).

In Norway major public domains were organized as central agencies or government administrative enterprises until the early 1990s. However, since the mid-1990s greater structural devolution has become a major component in the Norwegian-style new public management and public services (e.g. railways, telecommunications, power supply) were reorganized in autonomous or semiautonomous entities allowing for the responsible minister to intervene in matters of public interest. After Statoil (energy company) and Telenor (telecommunication) more kinds of intermediate forms between state public administration and private enterprises were created. The hospital reform is, together with road construction and air traffic control, some more examples of this development. In the case of the health care reform a new kind of hybrid is created, moving even further along towards a combination of enterprise and public administration (Byrkjeflot 2005).

Neither is France known for administrative experiments, the country is rather known for its "administrative conservatism" and as Minvielle (2006) states, especially the hospital sector

has been resistant to the principles of NPM. Ideas originated from NPM such as competition, internal markets and economic decentralization have never been seriously considered in France. The reason for that can be found in French culture and the strong role of the state, but also in the fact that patients already have free choice that fee-for-service payments tend to raise provider activity levels and that waiting lists are rare. Thus the incentive for these kinds of reforms has been lacking (Sandier et al 2004).

Reform as a reaction to coordination problems

A further similarity is that the improvement of coordination was in both countries formulated as a goal with the reform. The Norwegian health regions became the organizational unit for coordination and steering and the regional health enterprises got statutory responsibility for ensuring the provision of health services to inhabitants in their geographical area. Improved coordination might also mean that state ownership of all Norwegian hospitals and other parts of specialist care provides the state with complete responsibility for the specialist health services by uniting sector responsibility, financial responsibility and ownership at the same administrative level (Magnussen et al 2009). As mentioned above, a traditional feature of the French system is the political and administrative fragmentation of the government systems and the problem of coordination that resulted from it. This has for long been one of the most sensitive problems of the French local government system. Coordination is traditionally achieved through vertical hierarchy, but more horizontal, network-type forms of cross-functional working are increasingly being advocated. Coordinating activities and meeting local needs are also tasks the directors of the regional health agencies are required to fulfil, (Minvielle 2006).

Recentralisation to improve efficiency

Another goal of the hospital reform in Norway was to improve efficient utilization of resources, to ensure equity of access to health services for citizens in all parts of the country. This should be reached by stronger central governmental control and responsibility combined with clearer defined responsibilities for the regional health enterprises and increased operational flexibility (Lægreid, Opedal and Stigen, 2005). The goals for the establishment of the regional hospital agencies in France are rather similar in the sense that cost containment and management are the main issues. The regional hospital agencies were given the task to coordinate regionally the health services of the state and the health insurance funds. The goal was to “set up a coherent decision-making authority competent for both public and private

hospitals, to put an end to the current dispersion of responsibilities, means, and skills among the various offices of the government and universal health insurance system" (Minvielle 2006, p. 756).

Recentralisation as a reaction to domestic conflicts

In both countries the reforms have to be seen in the light of struggles between various stakeholders and or levels of government. In Norway, conflicts existed both on a vertical level between the counties and the national government and on a horizontal level between hospital administrative and professional leaderships. Both conflicts have a long tradition in Norwegian hospital history. One intention with the Hospital reform was thus to bring conflicts around responsibility and coordination to an end. In the French case, conflicts arouse mainly between the government and the national health insurance funds concerning policies to restrain health care costs.

Different starting points

With a starting point in a highly decentralised government structure in Norway, the expansion of state functions in the health care sector at the expense of local and regional organization and the establishment of autonomous or semi-autonomous agencies in relation to political or administrative public authorities open for a distinct pattern. Norway took a step away from the so-called decentralized Nordic model by re-centralizing control of all hospitals from the counties into the hands of the national government, a development that marked the end of thirty years of ownership by the nineteen counties and may signify a break with the common Nordic decentralized model of health care. In terms of vertical shifts of power, the hospital reform implied both a centralization of ownership to the state level and at the same time a change from devolution to elected county councils to a 'deconcentration' to semi-autonomous regional health enterprises (Magnussen et al. 2009). By that, the reform includes an inherent duality and with both a shift of power upwards and downwards. Yet, as outlined above the pattern does not only consist of a shift on the territorial level implying a shift of power from lower to higher level of government, but implies also a change in the management structure. Recentralisation has gone hand in hand with New Public Management-inspired decentralisation of management autonomy. With the design of the RHAs and the hospitals as health enterprises increasing state influence is combined with management- and market-oriented ideas. It is a decentralized company structure of managers and health enterprises with delegated responsibility constrained by professional stewardship and integrated into a system

under rather tight executive control and instruction from a central government (Lagreid et al 2005, p1033).

One main feature of the French health care system is its complexity. Government, National Health Insurance (NHI), and trade union representatives (employers and salaried workers) are all involved in the task of regulating the heath system, with the result that nobody has any control (Minvielle 2006). Another features mentioned before is the high degree of centralization and decentralization has been a theme common to many reforms for many years. Attempts had already started in the early 1980s to decentralize and deconcentrate its administrative structure, a process that has continued the last twenty years. Taking the different pieces of the Juppé reform together, also here a double shift of power can be observed: from the national to the regional level and from the health insurance funds to the state. So, in the French case it should be appropriate to talk about an increased role of the parliament combined with - also here - deconcentration. Rather than talking about (re)centralization in a territorial meaning (e.g. on a vertical level) a shift of power between two actors occurred (on a horizontal level), giving the centre more power. The reform can also be seen as a sign towards an increasing regionalization of the hospital sector that can be understood as an increasing state involvement in the health system as a whole.

The different pattern of the up-, down and sideward shifting of power in Norway and France are thus directly linked to the domestic administrative and political structures. It is however also obvious that both reforms have similarities that might indicate a common rationality behind the Hospital Reform and the Juppe Reform. The intention to solve coordination and efficiency problems are important aspects that join both reforms and linked to that the ambition to cope with conflicts between various stakeholders in health care policies. So despite different national preconditions a strengthening of the state role in the health sector seems to be a growing strategy in organizing health care. The initial assumption that reforms in stronger decentralised countries belonging are more likely about transferring power on a vertical dimension whereas in centralised countries reforms will be more about shifting power between various stakeholders is partly confirmed but also somewhat simplifying since the creation of regional hospital agencies in both countries embrace shifts of power in various directions.

More (re)centralisation in the future?

(Re)centralisation and decentralisation is about finding the right governmental level on which decisions should be taken and is about the balance of power between the centre and the periphery. That this is not a static balance has been pointed out already by Fayol who stated that "the question of centralisation or decentralisation is simply a matter of proportion, it is a matter of finding the optimal degree for the particular concern" (1949, p. 33) or as de Vries formulated it fifty years later, shifts of power between various levels of government seem to be ongoing circles (2000). That means that the renewed interest in central control can be partly understood as a result of excessive decentralization and the necessity to strengthen the stewardship function of the state. In this sense (re)centralisation is a general trend pushing originations within the same organisational field to follow its path. Yet, as the analysis showed can the design of both reforms to a great degree explained by the specific national health care history, the political and administrative structures and the relations between stakeholders. What are then the implications on a more general level for these changes?

Drawing a broader picture one can see the state takeover of hospitals as one piece in a more general development. Shortly after the hospital reform, a similar development took place to Norwegian child welfare services and institutions for the treatment of alcoholics (GrØnli 2006). Furthermore, a closer coordination of social benefits, unemployment authorities, and the health insurance has recently taken place. Trends towards recentralisation have also been observed in other policy areas throughout European countries such as elderly care or social assistance, also these areas that traditionally are local responsibility (Minas and Overbye 2010). The trend towards ‘‘more state in the welfare state’’ and a trend away from welfare localism is thus widespread over different policy areas. It seems to be caused by a greater ambition for national welfare equality at the expense of local self-regulation. Equity problems in form of increased local disparities regarding access and quality of health care services due to different local priorities seem no longer to be acceptable. Recentralizing can provide better possibilities for setting standards and holding delivery organizations accountable to uniform principles. The impact of an ageing population on health sector as well as the financial sustainability may trigger stronger central stewardship. There are worries that local finance bases are insufficient to fund expensive future care needs, and that local administrative arrangements are inefficient and duplicative (Saltman 2008). That is particularly an important factor for tax-funded systems where politicians do not want to be blamed for the failure of planning an efficient health care system. Yet, rising health care costs are also involved with

investments, particularly in university hospitals and high-technology equipment that are extremely expensive. The belief that efficiency (cost-efficiency and clinical quality) can be increased by more emphasis on large-scale hospital production; thus the belief in scale effects as a means to increase efficiency resulted in larger hospital districts in several countries. In a similar way Vrangbæk argues that " the pendulum has swung in favour of more state steering and less acceptance of the possible consequences of relying on decentralized democracy. More focus is now on the aspirations of efficiency gains through benefits of scale than on the potential benefits of participation, small-scale systems and proximity in decision processes and service delivery" (2009, p.74).

A question that so far is open concerns the longevity and the strength of the recentralisation trend. Saltman (2008) pointed to the South European countries with strong regions as well as countries with ethnic conflicts as exceptions from the increasing trend towards (re)centralisation across European health systems. This observation even strengthens the conclusion that domestic political and administrative features play an important role in adapting new trends. Furthermore, as new institutionalists have learned us, there is a wide range of institutional influences travelling around and trying to get reembeded. As the Hospital reform in Norway showed some might be possible to combine, such as recentralisation and New Public Management-inspired decentralisation of management autonomy. Many health systems contain already elements of both decentralization and recentralization. Regulative functions such as setting general targets and setting standards are centralized while service delivery is decentralized to lower political, administrative or organizational levels. That (re)centralisation is something more than a flash in a pan seems obvious since it can be found in various policy areas.

For the future one can assume that the importance of coordination and monitoring by the central level will be further strengthened as it is fostered at the level of the European Union and practised through the Open Method of coordination.

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