

# The Scandinavian Model in Healthcare and Higher Education: Recentralising, Decentralising or Both?

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## Abstract

The public sector in the Nordic countries has been subject to substantial reform in recent decades. The article explores the changing reform dynamic in Denmark and Norway, focusing on centralising and decentralising trends in two prominent sectors: higher education and health care. The main question is: How can the reform dynamics over the last decade explain changes surrounding decentralisation and/or re-centralisation? A new trend can be observed in both sectors, namely the rise of re-centralisation and the concomitant growth of state responsibility in matters pertaining to political and fiscal decision-making. Both hospitals and universities have been given increased (procedural) autonomy. At the same time there is stronger centralised planning and management of performance management, which means that (substantive) autonomy has been reduced.

## Introduction

In the last two decades or so in the Nordic countries, substantial reforms of various arms of the public sector have been undertaken. These have primarily been driven by an impetus to increase efficiency, accountability, user centeredness and responsiveness to societal demands (Christensen & Lægred, 2011). In the public sector, the gradual but steady move from government to governance has implied shifts in the degrees of discretion or autonomy (Schmidlein & Berdahl 2005<sup>1</sup>) enjoyed by service providers and other key actors at the system level (Kickert 1995, Saltman, Duran & Dubois, 2011). Comprehensive reform pressures have challenged the Nordic welfare states, but also made them more sustainable (Einhorn & Logue, 2010). Healthcare (HC) and higher education (HE) have also been affected, e.g. with regards to how the systems are structured, organised, managed and regulated, and how governance patterns have changed over time (Pierre, 2000). During the rise of the welfare state, the dominant issue

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in HE was to decentralise authority, whereas in HC the pendulum has moved back and forth between decentralisation and centralisation. However, in the last decade a new trend can be observed in both sectors: namely the rise of re-centralisation or de-decentralisation and the concomitant growth of state responsibility in matters pertaining to political and fiscal decision-making (Saltman, 2008, Stensaker, 2014). Nevertheless, at the same time, managerial authority and operational decision-making has increasingly been decentralised (Saltman, Vrangbæk, Lehto & Winblad, 2012, Vukasovic, Maassen, Nerland, Pinheiro, Stensaker & Vabø, 2012). Given this, the remit of this paper is to both explore and compare the complex interplay between centralising and de-centralising governance trends across HC and HE in Denmark and Norway. In doing so, we shed light on the main driving forces and consequences of this process, and highlight similarities and differences across the two sectors and national jurisdictions. Empirically, four aspects are analysed in detail (financing, structure, procedures, performance criteria) as pertaining to *political*, *administrative* and *economic* dimensions underpinning governance arrangements over time.

## Research questions and methods

We address the following research questions:

- How can historical shifts in the degree of autonomy enjoyed by higher education and healthcare providers be characterised?
- What is the interplay between centralisation and decentralisation?
- How can shifts in the direction of de-centralisation and re-centralisation be explained?

The empirical, largely qualitative material draws upon existing literature on the topic and on ongoing and recent investigations by the authors, some of which are also comparative in scope. Primary sources include semi-structured interviews with system-wide stakeholders at various levels. Our method is comparative, and is aimed at describing and explaining recent and current developments across the two sectors or organisational fields (Pinheiro et al. 2016). The cultural differences between neighbouring Denmark and Norway are small (Hofstede, Hofstede & Minkov, 2010), with both countries possessing well-established welfare systems (Haave, 2008). Thus, we follow a most-similar case research design where the purpose is to accumulate knowledge and develop an in-depth analysis of recent developments regarding de- and re-centralising trends, and to develop new theoretical and empirical (comparative) insights on the changing nature of the (Nordic) welfare state.

We resort to process tracing as an analytical tool for drawing descriptive causal inferences from diagnostic pieces of evidence, understood as part of a

temporal sequence of events (Collier, 2011). Such events include, but are not limited to, ‘critical junctures’, and are essential building blocks of the historical institutional perspective which is our theoretical point of departure. We build on extant scholarship tracing decentralising-centralising reform trends in European HC and HE (Saltman, Bankauskaite & Vrangbæk, 2007, Saltman, 2008, Saltman, Duran & Dubois, 2011; Vukasovic, Maassen, Nerland, Pinheiro, Stensaker & Vabø 2015). That said, the primary foci of our analysis are on the macro-level (governance arrangements), rather than shedding light on dynamics at meso and/or micro levels, e.g. how institutions/actors respond to governance shifts. Agency issues are thus restricted to the role of the state as a collective actor, therein black-boxing organisational life (for a recent comparative analysis of HC and HE focusing on meso and micro-level dynamics, see Pinheiro, Geschwind, Ramirez & Vrangbæk, 2016).

### **Changing governance in the Scandinavian welfare model from an historical institutionalism perspective**

Historical institutionalism (HI) provides the ability to analyse large reforms and structural changes, and carry out country comparisons (Tilly, 1984). Proponents of HI contend that political choices at one point in time will affect choices in the future (Steinmo, 2008). Reforms and changes tend to follow an evolutionary and incremental pattern, because actors are bound to historically drawn paths: “once policies are adopted and organizations are created those structures will persist until some major event – a punctuation in this equilibrium – occurs” (Peters, 2013:80). Following Peters (2013:81) we argue that an institutional approach towards governance emphasises the predictability of policy responses within governance. The latter is conceived as a process in which the state plays a leading role in terms of setting priorities, defining objectives and coordinating activities (Pierre, 2000). Governance can take place by coercive and hierarchical steering, as well as “softer means” of coordination. In this way, governance reflects the transformation rather than the decline of the state (Ansell, 2002). It is thus possible to influence, without coercion, since the underlying agencies and actors can govern themselves in accordance with state interests (Dean, 2010).

Starting in the 1990s, the Scandinavian welfare states have undergone major transformations, with many neo-liberal reforms resulting in the introduction of new governance modes (Saltman, 2008). In the realms of HC and HE, these included the introduction of free choice and performance-based funding, increased user fees, changes in leadership structures, benchmarking, quality audits, etc. More recently, both sectors have been challenged by the financial stringency resulting from the 2008 financial crisis (Vis, Kees, van Kersberg & Hylands, 2011, Vrangbæk et al in this volume). Despite this, scholars suggest that the Nordic welfare model remains relatively robust, with the Nordic countries being on the leading edge in the wake of globalisation and increasing competition (Einhorn & Logue, 2010, Lehto, Vrangbæk & Winblad 2015). Cox (2004) argues that there is a strong commitment to the idea of the Nordic welfare model,

and that tendencies to expand its conceptions appear to be in accordance with the basic features and appropriate policy logics prevalent in the Scandinavian model. Thus, when taking into account new policy and reform initiatives, these are framed and interpreted in the light of core Scandinavian welfare-values, such as universalism, solidarity, democracy, tax-based funding, freedom from markets, and decentralised service delivery (Cox, 2004). Decentralised health and welfare, operated by local government and local political bodies, is a core feature of the model (Haave, 2006), with HE run by central government agencies instead. The publicly operated and funded Nordic welfare/health and HE models have been under increasing reform pressures in recent decades, yet many of their traditional characteristics persist (Hagen & Vrangbæk, 2009; Pinheiro, Geschwind & Aarrevaara, 2014). Radical structural change is unlikely to occur in fields like HC and HE, which are characterised by strong institutionalised traditions (Pinheiro et al. 2016). Instead, following HI, we are much more likely to observe gradual, subtle institutional change (Mahoney & Thelen, 2010), with existing (“old”) institutions and rules of action co-existing with “new” features resulting from reforms and restructuring attempts (cf. Gornitza & Maassen, 2000).

When exploring changes in de- (re)centralising reform-dynamics, we apply the seminal work of Streeck & Thelen (2005) and Mahoney & Thelen (2010), consisting of four alternative modes of institutional change, namely: 1) *Displacement*: which means the removal of existing rules and institutions and the creation of new ones; 2) *Layering*: where new institutions are added to the existing (old) ones; 3) *Drift*: when old institutions are no longer capable of handling new situations because of change in the institutional environment; 4) *Conversion*: when rules formally exist, but are interpreted, acted on and applied in new ways. As alluded to earlier, our analysis focuses on four key dimensions that were selected since they match our understanding of the reform dynamics that have taken place in HC and HE, thus providing a platform for comparisons. The first dimension, *structural changes*, relates to whether operational responsibility is allocated to central or local government, and how changes in management/leadership and/or changes in formal structures (e.g. mergers) can contribute to the centralisation of decisions. Secondly, we investigate the impact of changes in standard operating *procedures* and guidelines. Thirdly, *performance* pertains to the process of monitoring the effects (e.g. as regards quality). Finally, we analyse how changes in *financing* impact tendencies towards either centralisation or decentralisation.

## Case descriptions

### Nordic health care

#### Norway

The hospital sector in Norway can historically be described, along with the equivalents in the other Scandinavian countries, as a decentralised system. In

1975, 19 county councils had responsibility for steering the hospitals spread out across the country. This was the heyday of the decentralised hospital model, which can be traced back to the beginning of the 20<sup>th</sup> century. Throughout modern history, Norwegian local communities have been somewhat “avant-garde” when it comes to new initiatives in health and welfare, a phenomenon labelled ‘welfare localism’ (Grønlie, 2006). When hospitals were first established in the early 1900s, they materialised as a result of local initiatives and enterprises in tight cooperation with civic society (NGOs), committed district doctors and small towns. However, the politically decentralised system, which later manifested itself in the form of the county council system, experienced latent tensions and conflicts regarding the management of hospitals (Byrkjeflot & Neby, 2008). In the 1990s, the counties became overburdened with political debates, and increasing demand for better hospital services combined with growing hospital budget deficits acted as key reform drivers (Berg, 2006).

In 2002, a centralising hospital reform was launched to overcome the steering problems and growing budget deficits. Ownership was handed over from the counties to the state, with hospitals becoming autonomous state health enterprises. In many respects, a heavy centralising pendulum has changed the Norwegian hospital sector in the last 15 years. In 1999, the country’s hospital structure consisted of a total of 54 hospitals. Fifteen years later, these had been merged into 18 health enterprises serving four health enterprise regions (Pinheiro, Aarveaara, Berg, Geschwind & Torjesen, 2017). Contrary to the situation prior to the reform, the boards of health enterprises are not political bodies but professional boards held at arm’s length, as it were, from the owner, the Ministry of Health and Care (Magnussen, Vrangbæk, Martinussen & Frich, 2016). The boards are responsible for setting up the budget and delivering specialist health care services to the population in a specific area. In the wake of the health enterprise reform, the state has enforced “a tight grip” on the hospital sector in the form of enhanced centralised steering, control and accountability systems: detailed reporting and budget requirements, activity based funding, performance management, and so on (Kjekshus, Byrkjeflot & Torjesen, 2013). Central government has achieved greater control over funding through the use of semi-hard budget constraints and a stronger control of adherence (Magnussen, 2011). Nevertheless, hospitals continued to overspend, and the government launched a new health reform in 2009, the so-called ‘Coordination Reform’ (Romøren, Torjesen & Landmark, 2011). The latter decentralised some services (e.g. for the elderly and chronically ill), and tried to change the dominating logic from a hospital-centred focus on ‘cure’ into a new logic substantiated on ‘integrated care’ (Torjesen, Kvåle & Kiland, 2011).

From 2012 onwards, some tasks (local medical services, dental health, etc) have been transferred from the state-owned hospitals to local authorities, but the latter were forced to establish mandatory network governance structures with the state health enterprises (Torjesen & Vabo, 2014). Empowering local authorities to take greater responsibility in HC is further supported by an ongoing municipal merger reform (Askim, Klausen & Vabo, 2016). The Norwegian government is

taking a comprehensive repertoire of governance mechanisms into use, i.e. mandatory governance networks, clinical pathways descriptions, quality monitoring, performance standards and earmarked grants. Since Norwegian municipalities lack the ability to collect taxes, financing primary health depends largely on central government grants and the allocation of tax revenues to the local authorities (Byrkjeflot & Neby, 2008). The historically strong decentralised traditions have been contested as the government has enacted reforms to re-centralise steering and control in the hospital sector (Byrkjeflot & Guldbrandsøy, 2012), but also by using softer means of governance in the primary health care sector (Torjesen and Vabo, 2014). This process, however, is laden with tensions and contradictions. The health enterprises currently suffer from low levels of legitimacy (Kvåle & Torjesen, 2014), and there is a growing demand to reorganise the hospitals back to regional political administrative bodies (Rommetsveit, Opedal, Stigen & Vrangbæk, 2014). However, a national committee delivered a report to the Norwegian parliament in December 2016 after assessing alternative models for organising the future hospital sector. The majority in the committee are in favour of continuing the existing model with four regional health enterprises, which means that central management of the Norwegian hospital sector is likely here to stay.<sup>2</sup>

In short, we observe two distinct trajectories. Strong central oversight and steering is unfolding in the hospital sector, while steps for administrative and operational decentralisation (from higher to lower local authorities) is taken regarding certain health care tasks. This however does not necessarily mean we are observing a decentralising movement in Norwegian health policy per se. Current dynamics are more about the implementation of state regulated health policy (in both secondary- and primary care) where the state is using mandatory network governance measures in tandem with tight financial budget monitoring and procedural adherence.

### **Denmark**

Danish HC was originally developed as a hybrid system, based on sickness funds and locally managed public provision. In 1970, a major reform changed the system to a public, integrated health system with the counties as the main governance units for hospitals, general practitioners and practicing specialists. Most hospitals were owned by these counties, while general and specialist practices remained privately owned but subject to public planning and operating under general contracts with the counties. The sickness funds were abolished, and HC financing became tax-based through a combination of county and state taxation (Olejz et al., 2012). State taxation was redistributed to the counties as block grants. This system of financing continued throughout the 1970s and 1980s, but the economic downturn and the subsequent problems for public finances made it necessary to develop governance structures to strengthen control of expenditure and performance in the public sector. Due to the decentralised nature of many welfare services, the main instrument became the introduction of negotiated agreements (containing target levels for expenditure in the municipalities and

regions as well as policy objectives and new initiatives) between the state, the counties and the municipalities. These agreements were linked to the national budget, as the formal allocation mechanism. This structure worked relatively well as a coordinating mechanism in the 1980s, but budget deficits remained a problem and state level actors were often frustrated by the independence of regions and municipalities and their occasional hesitancy to comply with new policy initiatives. This frustration, combined with an overall ambition to strengthen the steering capacity in the sector, fuelled several developments. First, the introduction of a Danish version of the DRG<sup>3</sup> system enabled more detailed monitoring and control of performance (Byrkjeflot & Torjesen, 2010). This was used in discussions with the counties and as a way to foster transparency about the relative performance of the different regions and hospitals. It also paved the way for experiments with activity-based payment schemes within the counties. Secondly, a major reform of the administrative structure was agreed in 2004 and implemented in 2007. The reform affected the tasks, financing and administrative structures of counties and municipalities. Within HC, the most important elements were: a) mergers of the previous 271 municipalities into 98 new and larger municipalities, with stronger roles in providing local health services, rehabilitation and health promotion; and b) mergers of the previous 13 counties into five new regions, with HC as their main responsibility. The new regions were not allowed to levy their own taxation, with the majority of HC financing being centralised to the state level. In spite of this centralisation, at the national level there was a continued feeling that the regions needed stronger incentives to increase their activity and stay within budgets. This led to the introduction of an activity-based payment scheme, whereby the regions had to reach a pre-determined baseline activity level in order to receive full payment from the state. On top of this scheme, in 2012, formal legislation with automatic sanctions for budget deficits were introduced. All in all, these changes in the financing and payment schemes imply a significant centralising shift in the balance of power in the economic governance relations between the state and the decentralised levels of regions and municipalities.

The administrative reform also strengthened state influence as regards the location and development of HC infrastructure. The role of the Danish Health Authority (DHA) was strengthened in terms of its planning capacity and ability to intervene at the regional level. Allocation of funds to the regions became contingent on the development and approval of new hospitals adhering to guidelines from the state and subject to DHA's approval. This has enabled the DHA to impose its preference for mergers and collections of specialties, and it clearly demonstrated the shifting power balance in the sector. Another indication of stronger state level power is the development of standards, guidelines and 'patient pathway descriptions' by the national authorities. This is further reinforced by the implementation of quality monitoring instruments focusing on service and clinical quality. Waiting times and patient satisfaction are routinely measured and published. Clinical quality is monitored in databases and through register-

based analyses, with some of these measures becoming available for the direct comparison (benchmarking) of different hospital departments.

Table 1: Historical trends in the governance of the hospital sector

	NORWAY		DENMARK	
	Decentralised Model (1970s-1990s)*	Centralisation trends (2000->)	Decentralised Model (1970s-1990s)	Centralisation trends (2000->)
Financing				
-Tax collection	Regions/ counties	State	Regions	State
-General budget	State – soft budget constraints	State – semi-hard budget constraints	Regions/state: soft budget constraints	State: (Budget law with hard constraints)
-Allocation to regions**	Block grants	Activity based financing (30-40%) and block grants (60-70%)	Block grants	Block grants subject to activity targets
Structure				
-Ownership	Region	State owned enterprises (mergers of hospitals)	Regions	Regions
-Infrastructure planning	Region/counties National hospital planning	Stronger role for the state	Regions (few mergers)  Regions w/state input	Regional plans subject to state approval (mergers and new hospitals) Stronger role for the state
-Specialisation	Regions w/state input	Transfer of certain tasks from state (health enterprises) to municipalities from 2012	Variations of “troika” management w/general, medical and nursing managers	Unitary management with central structures in many hospitals
Leadership & Management	Dual (nurse and physician) administrative structures	Unitary management from 2000		
Procedures				
-Standards/guidelines and control of procedural adherence	State (Norwegian Health Authority), but with limited control of adherence	State (Norwegian Health Authority), with higher density and stronger control of adherence	State (Danish Health Authority), but with limited control of adherence	State (Danish Health Authority), with higher density and stronger control of adherence
Performance criteria				
-Activity level (patients/students)	No activity targets Limited quality measures.	Activity based financing. Waiting time guarantees	No activity targets  Monitoring and interventions mostly by regions	Activity targets linked to economic incentives. Waiting time guarantees State: monitoring and publication of service and clinical quality
-Quality measures and monitoring	Monitoring mostly by regions.	State: monitoring and publication of service and clinical quality		

\* Time periods are approximate as it is a gradual development.

\*\* Regional variation in the mix of activity based payments and global budgets to hospitals



An interesting development in the governance of HC performance was the decision to reorganise the national quality control system in 2016. Under the new system, the regions will be benchmarked against set targets on an annual basis, but are otherwise free to develop their own local quality assurance systems to support their activities. This can be seen as an example of decentralising operational power, while centralising the power to set the overall direction.

## Nordic higher education

### Norway

Up to the early 1990s, the then (4) publicly run universities enjoyed considerable levels of autonomy, including over student numbers. A 1991 white paper to Parliament proposed changes in the way in which the entire system was coordinated, in the form of a 'Network Norway', focusing on stronger coordination and oversight by the Ministry. The government enhanced control over *substantive* matters, namely, the location of the various types of study programmes being offered by universities. In turn, universities were given strengthened autonomy over *procedural* issues, i.e. deciding how these study programmes ought to be designed and implemented (St.meld. 40 1990-91). In the mid-1990s, a series of mandatory mergers involving non-university institutions and a common law regulating universities and colleges were enacted. Both measures aimed at enhancing the government's ability to steer an increasingly decentralised, complex and fragmented, binary HE system.

Prior to the early 2000s, the basic funding formula for universities was based on an educational component and a research component, with little attention paid to efficiency. The expansion in university enrolments throughout the late 1980s and 1990s, and its associated costs, brought efficiency concerns to the top of the policy agenda, alongside quality-related issues (Pinheiro & Antonowicz 2015). This set in motion a discussion concerning the need to enact changes at the organisational level, not least in the leadership structures of universities which were thought to be slow in responding to external events. The momentum created by the NPM-inspired reforms during the late 1980s and 1990s (Christensen & Lægveid 2001), in tandem with three conservative governments (1983-1990), made 'managerialism' an appealing concept to be applied to the governance of Norwegian HE. Rationalisation, bureaucratisation and the professionalisation of administrative affairs came to the fore (Gorntizka, Kyvik & Larsen 1998).

On the administrative front, a number of policy measures increased the autonomy of universities. National responsibility for several academic specialisations ('nodes') was given to a number of institutions during the 1990s. In 1995, a new set of regulations for the promotion of university professors (away from the Chair-based system and towards a meritocratic one) was approved by Parliament. The 2003 Quality Reform (QR) strengthened institutional autonomy alongside stronger accountability measures and a strengthened emphasis on performance (Stensaker 2014). It also set in motion changes in the governance and leadership structures of universities, aimed at enhancing their capacity to

react to external circumstances by speeding up (centralising) decision making. Interestingly, the QR is a product of historical circumstances. Its many elements were the result of the concerted efforts (late '90s/early 2000s) of no less than three different governments (two of which were conservative), building on the recommendations by the ministerially appointed, yet politically neutral 'Mjøs Commission'. Since 2004, universities have been financially rewarded for having both productive students (credit production and on-time graduation), and researchers (publication points)). In light of stronger accountability measures, the budgetary process has also changed, with universities providing the Ministry of Education with an annual report on both results and future plans, which forms the basis for annual consultations between the parties (Stensaker 2014).

Increasing accountability and a focus on quality have resulted in the establishment of a new, 'independent' quality assurance agency (NOKUT), responsible for accrediting institutions (e.g. after mergers) and programmes (outside the university sector). Universities enjoy full freedom to set out new degree programmes at all levels, with boards at the faculty and university levels acting as supervisory bodies. Universities are also responsible for devising and implementing their own system for quality assurance, which requires approval from NOKUT. Recruitment procedures are shifting to take into consideration competences other than scientific publications, such as the ability to attract external funding. Universities enjoy greater autonomy over recruitment, and this is making HR policy more strategic. Likewise, universities have been awarded greater freedoms to choose their internal leadership models (Stensaker 2014). In the so-called 'dual-leadership model', which respects historical traditions, the Rector, who also acts as the Chair of the University Board, is elected by the university staff and works alongside an appointed Faculty Director responsible for administrative matters. The alternative model is based on the concept of 'unitary management' (Berg & Pinheiro 2016), with the Rector being appointed by the University Board, which is headed by an external member appointed by the Ministry. Finally, as an illustration of the recent trend towards re-centralisation, the Ministry has given strong signals that it wants fewer and stronger institutions (through mergers), a move towards appointed leaders at all levels and a prevalence of external board members. This is an attempt to shake up universities' internal status quo and foster alignment between university strategic priorities and the government's economic and political imperatives.

### **Denmark**

Patterns of (de)centralisation have changed over time in the Danish university sector. In the late 1970s and 1980s the sector was characterised by a high degree of centralised control by the state. Student enrolment on educational programmes was centrally planned on the basis of forecasts for labour force demand. Separate budgets for educational and research activities were allocated directly to the faculties. The centralised control regime reflected the shift from a period of economic growth to that of economic scarcities, substantiated on a policy logic aimed at balancing supply and demand. Political mistrust towards the democratic

organisation of decision-making within universities acted as an additional driver for the high degree of centralisation (Hansen 2000).

In the 1990s a management reform introduced external representatives into the governing bodies of the universities and at the same time re-introduced increased institutional budgetary autonomy. In addition, control of student enrolment was removed, opening up institution-based decision-making except within highly expensive educational programmes like medicine. In the early 2000s, a new (rather radical) management reform was introduced. Universities were given a new status as self-owned institutions with boards with an external majority, and the principle of elected leaders was abandoned in favour of appointed ones. The role of academic councils shifted from co-decision-makers to merely advisory bodies. Bottom-up decision-making was replaced by top-down strategic decisions (Degn & Sørensen, 2012). Organisational autonomy was strengthened, as was internal institutional centralisation. The reform reflected a wish to transform universities into 'strategic actors' (Whitley 2008).

The concept of self-owned institutions, however, turned out to be ambiguous and a discussion and negotiation about organisational autonomy has been ongoing since 2003. Later, in 2011, universities were given increased autonomy over the design of their organisational structures. The top-down leadership model remained, but it was no longer mandatory to organise academic activities within the classic form of faculties and departments. The topic of ownership of buildings has been controversial. In spite of the emphasis on organisational autonomy in the rhetoric of the 2003 reform, in subsequent years more issues arrived on the centralisation radar. In 2007, an accreditation institution with a very strict mission was established. Every single existing and newly proposed educational programme had to undergo accreditation. Universities were given no mandates to develop new educational programmes (Hansen, 2014). In 2007 too, a "forced-voluntary" merger reform reorganised the university sector. The number of institutions was reduced and most former governmental research institutes were integrated into the universities. The main goals of the merger reform were to create synergies and obtain economies of scale (Aagaard, Hansen & Rasmussen, 2016). However, one may wonder whether a hidden agenda of the reform was to make it easier to exercise control from above within the organisational field, e.g. by using contracts. With a smaller number of institutions, the costs involved in the Ministry negotiating contracts has decreased.

Financial incentives aimed at increasing student throughput were introduced in 2009, followed by new rules demanding that students study full-time. In 2015, centrally planned enrolments for fields with high levels of unemployment were introduced, alongside a new generation of contract steering using partly compulsory goals, e.g. related to quality development and relevancy. Results-based funding has become increasingly important. Funding for education has been results-based since the 1990s, as universities receive resources for every student passing an exam, but the system has been further developed over time. Since 2010, a bibliometric indicator system (inspired by Norway) has formed a part of the funding system for allocating basic resources for research. Although the

system only re-allocates a minor portion and only within (and not between) scientific fields, it does affect researchers' behaviour (Dahler-Larsen, 2012). The principles guiding resource allocation in the different funding streams are centrally decided, but the resources are provided for the universities as lump sums, hence giving them considerable autonomy over how to distribute them internally. From 2016 hard budget constraints have been introduced, forcing several universities to make staff redundant.

Table 2: *Autonomy and centralisation trends in public universities*

	Norway		Denmark	
	Organisational autonomy model (1990s ->)*	Centralising governance (2000->)*	Organisational autonomy (1990s->)*	Centralising governance (2000->)*
<b>Financing</b>				
-Tax collection	State	State	State	State
-General budget	State (lump sum)	State (Negotiated contracts, combination of lump-sum and earmarked upon agreed formula)	State (hard budget constraints)	State (lump sum, hard budgets constrains from 2016)
-Allocation to universities	Based on student numbers and research (but not output)	Since 2004, financially rewarded for student and researcher performance	Some results-based payment introduced in 1990 (number of students passing exams)	Results-based payment further developed (students passing exams, bibliometric measures, "employability" of students)
<b>Structure</b>				
a) Legal				
-Ownership	State	State	State	(Partially) self-owned
-Location	State	State	State	State
-Structure (mergers)	State (no mergers)	State (voluntary mergers under increasing pressure)	State (no mergers)	State (forced voluntary mergers)
-Specialisation/types of study programmes	State with operational discretion at the organisational level	Universities pushed to develop distinct institutional profile – selected areas	Universities subject to state approval	Universities subject to stricter state approval and accreditation. Emphasis on "employability"
b) Leadership & Management	Internal leaders elected by academic peers ('primus inter pares')	Hybrid system, but increasingly moving towards top-down appointments, including of external actors or outsiders ('managerialism')	Internal leaders elected by academic peers ('primus inter pares')	Internal leaders appointed top-down

<p><b>Procedures</b> -Standards/ guidelines and control of procedur- al adherence</p>	<p>Autonomy to establish new programmes (little over- sight by state agencies)</p>	<p>Quality dele- gated to the universities, combined with increasing, supervisory role by national agency (NOKUT) Full freedom to establish new programmes, but increasing ex-post over- sight (student feed- back/quality control, etc.) Mandatory (contracts) and annual budgets</p>	<p>University autonomy</p>	<p>Accreditation of new and existing study programmes</p>
<p><b>Perfor- mance criteria</b> -Activity level (pa- tients/studen ts)  -Quality measures and moni- toring</p>	<p>No output- based measures  University autonomy</p>	<p>Credit produc- tion and on- time gradua- tion. Biblio- metric measures of researchers Stronger em- phasis on 'social impact' of research (return on public invest- ments) Focus on at- tracting exter- nal funds – research coun- cil &amp; EU (en- hances re- sources &amp; prestige)</p>	<p>No activity targets  University autonomy</p>	<p>Activity targets linked to economic incentives.  Bibliometric measures linked to economic incentives. Exter- nal/internatio nal assess- ments of research quality. University contracts with quality targets</p>

\*Time periods are approximate as it is a gradual development.

A 2013 reform of the accreditation system will, in the coming years, delegate authority to develop new educational programmes to those universities which attain an institutional accreditation, meaning that their internal quality assurance

systems are approved. However, this delegation of authority is combined with re-centralisation, as it is a precondition that the Ministry approves the relevance of new programmes. As in Norway, universities now enjoy greater autonomy over personnel/HR policy. External committees composed of academic peers are still used to assess applicants, but the former system of ranking applicants has been abandoned, leaving much more room for managerial decisions. To some extent, salaries have also been set free. Finally, although the influence of supranational collaboration in the Bologna process as well as in European Union research policy has been increasing, national policies are still very important in Danish HE (see also Hansen 2012). Overall, the governance structures in the university sector are complex and steadily evolving. The question of the universities' organisational autonomy seems to be an ongoing discussion. The concept of autonomy is both multi-dimensional and relative.

To sum up, the Danish case illustrates three fundamental trends. First, an ongoing conflict and negotiation between the state and the universities regarding organisational autonomy. Second, decentralisation, in the form of increased managerial autonomy for universities, has been combined with internally centralised decision-making structures. In this regard, there appears to be a coupling between centralisation and political mistrust in the internal decision-making and management structures of universities and, likewise, a coupling between decentralisation and increased trust in internal decision-making and management structures. Third, recent decentralising and centralising initiatives have occurred parallel to one another. Once again, this situation seems to be explained by the economic context, with scarce societal resources in the wake of the 2008 global financial crisis.

## Discussion

The data presented above show that both sectors have been the target of major state led reforms, but the pendulum has not necessarily moved in a single direction. Change in managerial structures have enhanced autonomy at the local level (for universities and hospitals), yet this has been accompanied by stringent mechanisms for *ex-post* control and accountability (cf. Diefenbach 2009). In HC, institutional change is intrinsically linked to field level dynamics such as the creation of regions (Denmark) and of health enterprises (Norway). Likewise, in HE, wider efforts across Europe associated with both the Bologna process and the Lisbon strategy have had significant impacts on the restructuring of the two domestic systems.

Revisiting our adopted typology of institutional change (see table 3 below), in both sectors and countries a considerable amount of *layering* is visible, reflecting the importance attributed to path dependencies. More radical (less evolutionary) reforms have also led to the *displacement* of old mechanisms and institutions. Examples include; the state take-over of the hospitals in Norway and the establishment of regions (replacing counties) in Denmark.

Table 3: Mapping institutional change across two organizational fields

Institutional change*		
	Health Care (HC)	Higher Education (HE)
<b>Drift</b>	Change in managerial structures and functions to accommodate new demands for competitive and entrepreneurial behaviour from the institutional context	Change in managerial structures, from elected to appointed leaders  The prevalent role of external actors in strategic decisions
<b>Layering</b>	Stronger roles for municipalities/local governments in health care to accommodate the changing context of the aging population and growing long term condition needs NPM-inspired governance combined with professional networks and public bureaucracy. Hybrid management with professionals, bureaucrats and public entrepreneurs Fiscal steering, parallel with ex-post control.	Hybrid combination of elected and appointed leaders at some institutions and across the system (NO) Performance funding alongside basic formula based on historical considerations. Bibliometric mechanisms in research HR policies: decentralisation of authority to the universities but at the same time increasingly centralisation of decisions internally to university managers Ongoing transformation of the accreditation system into a system combining institutional and program accreditation
<b>Displacement</b>	Creating regions (DK) and health enterprises (NO) replacing counties.  Mergers and closure of hospitals (DK and NO)	Management reforms: Principle of elected leaders abandoned in favour of appointed ones Collegial bodies substituted by committees or boards with external actors From voluntary to 'forced voluntary' mergers Accreditation systems for overseeing quality (2000-2005)
<b>Conversion</b>	Formal autonomy of regions/regional health enterprises but increasing state intervention	Different understandings of autonomy

\**Legend: 1) Drift: when old institutions are no longer capable of handling new situations because of change in the institutional environment; 2) Layering: where new institutions are added to the existing (old) ones; 3) Displacement: which means the removal of existing rules and institutions and the creation of new ones; 4) Conversion: when rules formally exist, but are interpreted and enacted on and applied in new ways.*

The reduction in the number of hospitals and universities through mergers and the introduction of new funding structures and quality assurance mechanisms are other (less radical) examples. Changes in managerial structures within universities and hospitals towards the increasing centralisation of decision-making are a manifestation of *drift* tendencies, representing adaptations to changing demands in the institutional environment. Finally, different understandings regarding the types and degrees of autonomy enjoyed by universities and hospitals in both countries suggest the role played by *conversion*.

When we consider HC, we observe that the role of the state (as a key agent) has been gathering strength in both countries, with respect to structural changes in ownership, infrastructure and planning, as well as in managing the sector. Instead of reinforcing the continued decentralisation of authority away from national governments, state institutions have reversed course and are now seizing responsibility for substantive political and fiscal decision-making. It appears that, in the near future, only administrative and managerial authority, i.e. day-to-day operational decisions, will remain decentralised to lower levels and/or within non-state actors such as non-governmental organisations (NGOs). Increased fiscal pressures, new technological innovations and insatiable public demands for more advanced hospital services resulted in a *drift* of the decentralised hospital sector in both countries in the 1990s. The old institutional arrangements were no longer able to handle the new situation, thus triggering institutional change (Mahoney & Thelen, 2010). Hence, the system based on decentralised ownership of the hospitals was replaced by a more centralised sector, owned and operated by either the regions (DK) or the state (NO). This process has, in turn, led to significant concentration through mergers. Furthermore, the role of the state has been considerably strengthened in relation to financial aspects, with tighter economic steering of the hospital sector; from soft- to hard- budget, from block grants to activity-based financing. As a parallel trend, one can observe increases in procedural adherence in the form of tighter professional procedures, standard guidelines, as well as performance criteria imposed and monitored by the state's health authorities. In short, in both Denmark and Norway the central government increasingly determines the structure, organisation and financing of the HC system.

In the realm of HE, the state's role and steering ambitions have also changed significantly. In both countries, we observe that universities have become subject to stricter state approval and accreditation rules, in the same manner as the public hospitals. In addition, one can identify similar trends in the adoption of (new) centralised forms of management and governance structures, which, on the whole, tend to concentrate strategic decisions in the hands of a smaller group of individuals, alongside the strengthened influence of external actors over university affairs. In short, universities are expected to respond more swiftly and strategically to societal demands, with the state and its various agencies acting as a watchdog. Line or unitary management has enhanced coordination efforts by centralising authority and ensuring that key individuals are accountable for the decisions made. This represents a significant break from the past and the notion



of democratic participation in the form of a ‘community of equals’ (Olsen 2007), where accountability was, first and foremost, to one’s academic peers.

The aforementioned developments point to two interlinked dimensions that are often not taken into account when devising new policy measures. First, the need to pay attention to cross-sector dynamics; i.e. the fact that changes in one policy sphere enable or constrain changes at other levels (Pinheiro et al. 2014). Second, and related to this first factor, developments at different policy levels, e.g. supranational (EU) or regional (Nordics), show the need to take into consideration multi-level governance arrangements (Piattoni 2010), whilst attempting to interpret and predict reform trajectories and their subsequent effects, both intended and otherwise. As discussed earlier, HE dynamics at the national level have been strongly influenced by EU-wide initiatives, while in HC the role of local government and the various challenges facing municipalities should not be underestimated.

Gornitzka et al. (2007) have argued that the complex interplay between national and supranational dynamics is resulting in the search for a new ‘social contract’, brokered via the state, and existing between public welfare providers and society. The ‘old’ contract was substantiated on mutual trust, ensuring institutions both autonomy and legitimacy to go about their business in ways that were relatively decoupled from major external events. It also meant that institutions like universities and hospitals enjoyed considerable degrees of both substantive and procedural autonomy (Schmidlein & Berdahl, 2005). In contrast, the basis of the new, emerging contract lies in public providers having to constantly demonstrate (‘accountability regime’) that their internal structures, policies and activities are a direct reflection of the various demands being imposed upon them from a multiplicity of external stakeholder groups, the government included. In such circumstances, the state tends to enlarge the degree of procedural autonomy (means) enjoyed by providers, whilst controlling the types of outputs (ends) that are thought to be desirable from a political, economic and social standpoint.

Rather than being conceived as dichotomies, centralising and decentralising tendencies in the governance of modern welfare systems should be approached as two sides of the same coin. Devolution in certain areas, which is more often linked to issues of procedural autonomy, such as managerial responsibilities, often implies strengthened centralisation in other domains (e.g. substantive aspects, like goals and results), considered to be strategic from the perspective of the central government (Schmidlein & Berdahl 2005). Historically, this tendency towards re-centralising activities is particularly acute in periods of financial stringency, such as the one caused by the 2008 financial crisis. This suggests a return to a stronger state-centred supervision regime. This phenomenon is aligned with broader trends (other countries and sectors) towards the rise of the New Weberian State (Politt & Bouckaert, 2011), and the return of the bureaucratic mode of governance (Olsen, 2006). What is more, decentralisation and centralisation are tightly intertwined. Enhanced levels of autonomy for both HE institutions and HC providers have resulted in greater centralisation of decision-

making within universities and hospitals, through managerialism (du Gay, 1996). Yet, given the historical (path-dependent) nature of both sectors and the fact that certain features (e.g. professional autonomy) are highly institutionalised and thus resistant to change, the infusion of a managerial logic has led to the rise of hybrid-steering and governance approaches (Gornitzka & Maassen, 2000; Berg & Pinheiro, 2016).

## Conclusions

In this paper we provide evidence that centralisation and decentralisation patterns across HC and HE occur in tandem. Both hospitals and universities have, in the last decade or so, been given a greater degree of procedural autonomy whilst suffering a loss of freedom as regards more substantive matters. Growing centralisation is intrinsically linked to external calls for increasing efficiency, responsiveness and accountability. A major consequence of NPM-inspired reforms, based on “soft” steering mechanisms and accountability regimes, is that both universities and hospitals are now striving to become more strategic organisations accountable for their own actions and responsible for their own destinies (Whitley, 2008; Ramirez, Byrkjeflot & Pinheiro, 2016).

The jury is still out on whether such reform processes have enhanced effectiveness or not, since they have also led to a rise in internal transaction costs due to the increasing need to coordinate activities across sub-units and managerial levels, as well as reporting to the various governmental agencies. More recently, and as result of the financial and fiscal pressures facing the Nordics, partly resulting from the decline in oil prices (Norway) and global competitiveness (Denmark), there are signs of policy convergence in the direction of more market (output-based) mechanisms on the one hand, and new measures to ensure greater oversight and accountability on the other. These two sectors reflect the current dynamics within the Nordic region, where societal (macro level) pressures to reform the welfare state, beginning in the late 1980s, are part and parcel of the changing nature of the social pact between the state and society when it comes to the provision of public services.

An added value of such comparative studies across sectors and national jurisdictions lies in the recognition that, despite similar reform dynamics and tendencies towards greater centralisation, historical specificities and institutionalised features associated with each sector do result in particular combinations (hybrids) and a series of unintended effects. Going forward, we appeal for more comparative studies, preferably using mixed methods and a longitudinal design, as a means of assessing the circumstances under which certain domains of policy (funding, management, quality, etc) are either centralised or decentralised. In addition, we appeal to new quantitative insights on the effects – as regards performance, trust, coordination, long-term outcomes, etc – the above measures have had at the system level.

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## Notes

<sup>1</sup> The authors distinguish between substantive ('what') and procedural ('how') types of autonomy. Increases in one type do not necessarily entail increases in the others, and vice versa.

<sup>2</sup> Report to the Storting no 25 (2016)

<sup>3</sup> The DRG system (Diagnosis Related Groups) classifies patients into over 500 groups, and can be used for many purposes: reimbursement, cost control, benchmarking, and performance management.