

Coordinated healthcare, getting the incentives right?

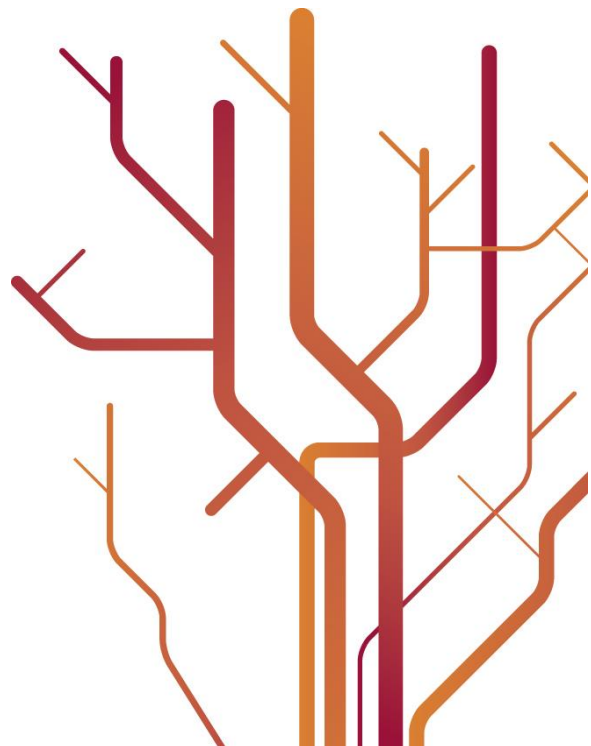
An analysis of the implicit theory of coordination in the Coordination reform

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Abstract:

The Norwegian government has passed a reform for coordinating the activities of the health sector in the future with the goal of providing cohesive patient pathways. This reform is especially meant for patient groups who rely on assistance from multiple providers in a coordinated and rational manner. The reform measures are intended to facilitate effectively coordinated treatment without patients being burdened with the additional worry of navigating through the healthcare system in order to get adequate help. The policy is designed to facilitate cooperative behavior between service providers in collaboration with patients and their organizations. Since there is no obvious reference to an explicit theory of coordination, this thesis asks what implicit social theory underlines the concept of coordination in the Coordination reform. A document analysis of two public documents namely, NOU 2005:3 and St.meld.nr.47 is the approach adopted for answering this question. The documents are analyzed from the perspective of Habermas or coordination via deliberative decision making, rational choice and a scientific concept of cooperation as proposed by Benkler (2009). The implicit theory behind coordination as it appears in the documents is important because it reveals what assumptions policy makers have about actors and which measures will be effective in facilitating cooperation and coordinated action towards optimal outcomes for patients. Of special interest here is if this policy design makes use of an alternative theory to the standard economic model of rational man as might be expected of a New Public Management reform. The implicit assumptions are vital because proposed measures lay the foundation for an institutional framework that in varying degrees will allow genuine cooperative behavior to flourish.

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1 Introduction

This project involves a sociological interpretation of the implicit theory of coordination underlying Norwegian healthcare policy as presented in the “Coordination reform”. A sociological interpretation is justified because the reform seeks to integrate healthcare provision in an all-encompassing manner with the rest of society. The policy makers also mention, parallel with the coordination reform, planned pension and social security reforms and this indicates that coordination is an issue of broader societal importance (St.meld.nr.47 p14). Sociological models provide alternative perspectives on coordination and integration in society. The reform addresses the need to provide well-coordinated and effective treatment that is both economically efficient and also makes sense from the patient’s perspective. The policy makers point out that the current ways of providing healthcare are in many cases inefficient for those patients that need treatment and assistance from multiple providers. Whereas patients with clear diagnosis receive adequate treatment, the dysfunctions of the healthcare system become more evident for those with chronic conditions. Concerns are raised on how long term disability prevents citizens from participating in the workforce and how this negatively impacts the tax funded public healthcare system. The object of research is the implicit theory of coordination present in the documents and is necessary because no references are made to an explicit source of theory pertaining to coordination.

Policy makers rely on models or implicit assumptions on what motivates human behavior. What we assume to be the primary motivational factors of actors leads to measures that are supposed to be effective in steering behavior in alignment with collective interests. If policy interventions are based on an inflexible or over simplistic model of say, rational self-interest, the institutional frameworks that would limit opportunism might also stifle cooperative behavior, reinforcing the belief that actors in society might best be viewed as inherently self-interested. In this sense policy that is intended to solve social problems might itself contribute towards compounding them. Identifying an implicit theory is also important for policy initiatives in general if say, later assessments show that the reform didn’t achieve its aims as hoped for. One would then have something to go on in order to recalibrate or try out alternative approaches with a reasonable chance of getting things right. But the relationship

between theory and policy intervention is more complex. We don't at present have a sociological theoretical framework that elegantly reconciles individual rational action with collectively desirable outcomes. Promising advances have been made by combining the insights gathered from diverse disciplines on the problem of cooperation. Understanding the relationship between individual and society has proven to be a complex problem that has occupied thinkers since antiquity and throughout early modernity. Some insight for social theory might be gained by examining a concrete instance of policy intervention seeking to ensure the continued provision of collectively financed healthcare. But this is not to say that we at some point will possess a perfect formula for implementing cooperation. Perhaps an appropriate attitude as emulated by Karl Popper is that while we can systematically approach scientific truths, we can never be sure when we have arrived at them.

This reform seeks to lay a framework that would encourage service providers to coordinate their contributions with each other and with patients. In order to coordinate successfully, cooperation across organizational and institutions is said to be of paramount importance. Much emphasis is placed on the importance of cohesive patient pathways that appear rational or coherent from the patient's perspective. To what extent is it rational for service providers to take on the administrative costs of cooperation and how is cooperation to be understood from the perspective of rational choice? Some view this reform as an extenuation of the hospital reform (2002) and a further step towards using market mechanisms in healthcare provision. In light of this I thought it would be fruitful to interpret the reform from a rational choice perspective. Is it reasonable to interpret this reform as "technocratic" insofar as a proposed recipe for coordination is imposed on actors, to the detriment of cooperative behavior at the grassroots level?

Perhaps coordination can be understood through the lens of communicative action where actors meet face to face in order to exchange views with the aim of achieving coordination via deliberation. The reform says that patient participation reinforces an important democratic principle insofar as citizens should have a right to influence the course of their treatment. To what extent is public opinion brought into influencing healthcare policy and to what extent is coordination to be understood as being achieved via deliberation and patient participation?

Harvard Professor of law, Yochai Benkler (2009) is in the process of developing a theory of cooperation that can be applied to different contexts such as institutional and policy design.

His work includes contributions from organizational sociology but draws on other academic disciplines as well. He has documented a significant intellectual shift in how cooperation and thus coordinated action can be understood across a multitude of disciplines. The discipline of biology and evolutionary theory has embraced an expanded model of actor motivations as a promising alternative to selfish competitive behavior. Contributions from organizational sociology and experimental economics provide further data that supports the view that actors are more inclined to cooperate than policy designers had assumed in recent decades. Peer based internet collaboration drew Benkler's attention to modes of production that defied the assumption that individually tailored incentive structures were strictly necessary in order to get actors to cooperate. The internet was a new environment in human history and contrary to what many would have expected, actors collaborated in constructive ways without obvious punishment and reward systems being institutionalized in order to guide their behavior. How then do the reform proposals in the Coordination reform look from a cooperative perspective grounded in the design elements that Benkler has isolated?

In the following chapter I will present the theoretical perspectives in more detail. Also included are two perspectives on the reform that are authored by Norwegian commentators. I included them because they seemed to represent how this state initiative has been interpreted and my research might shed light on whether alternative views might also be justified. After going through the literature I will present my method of approach in the methodology chapter. Afterwards I wish to outline the problem of coordination and integration in society from a sociological perspective as well as present my take on New Public Management and the extent to which this might be relevant in discussing an implicit theory of coordination. Following that I will present a brief summary of the explicit contents of the two documents before I present my findings.

2 Literature and relevant sociological theories

I will in this chapter mention the sociological theories I did choose and say something about why these were chosen ahead of other perspectives.

Systems theory as developed by Niklas Luhmann does fit the situation in the healthcare system quite well. The imperative of the medical or health system is often in conflict with, or out of sync with the economic system and the political system has to make collectively

binding decisions that serve the interests of all by limiting individual actions. However systems theory, at least as developed by Luhmann, doesn't allow for the possibility that society can collectively steer itself. This is because, according to his theoretical framework, society cannot observe itself with a view to collective rational action (Hagen 2006:46). There is no point outside of society from which one could observe the whole. Also, systems theory avoids the dichotomy between actor/structure because humans are not a part of society but exist outside of it. So it doesn't make any difference whether actors are selfish, altruistic or socialized, these actor characteristics are not an integrated part of systems theory and have no bearing in accounting for how social order is maintained. Society is communication according to systems theory and doesn't comprise of its members. Since the documents make assumptions about actors that can be analyzed and coded, pragmatic considerations lead me to avoid using systems theory.

Policy makers for their part have to assume that effective measures can be taken in order to motivate relevant actors to contribute towards "cohesive patient pathways" in a way that is aligned with the public's needs. I chose discourse theory instead of systems theory because Habermas argues that societal integration is possible despite or rather because of societal differentiation. In "Between facts and norms (1994)" Habermas is in dialogue with systems theory throughout the work, arguing specifically as to why it is implausible to view the legal system as functionally closed off from the rest of society.

Rational choice has been used in intuitional and organizational design for decades and I believe for good reasons. The model captures important aspects of interactions and after reading Elster (2007) where game theoretical metaphors rendered explanations for everything from the history of constitutional design to the unfolding of Shakespearian plots, I came to appreciate more of the theory's merits. The prisoner's dilemma illustrates why optimal collective outcomes are difficult to achieve and Mancur Olsens work challenged long standing assumptions on the mechanisms involved in group action. It is because of the strengths and weaknesses of the approach that I thought RC would be an appropriate theory to approach the documents' contents with.

If institutions and laws start on the assumption that actors are first and foremost self-interested they might also perpetuate a self-fulfilling prophecy. If actors are constrained by punishment and reward systems, genuinely cooperative tendencies might be obscured from scientific

observation. Benkler's work largely modifies RC theory in light of observations on how people collaborated in online forums without conspicuous monetary rewards. Revised theory highlights environmental or contextual factors that hopefully allow for cooperation with a minimum of hierarchy and external intervention.

2.1 Habermas

I have used Habermas' theory of communicative action in order to examine the texts to see whether the concept of "samhandling" can be understood in terms of using language, dialogue and the system of law as social mechanisms to coordinate action across functionally differentiated parts of society in a comprehensively rational manner. Habermas refers to money, power and solidarity as three sources of macro-social integration. The first two systems function in a manner that is independent of what citizens hold to be right or fair because they work behind the backs of actors. Political systems achieve their collective objectives via administrative power. Authors such as Busch, Johnsen et al. (2011:331) refer to "input" into administrative systems as distinguished from "output". According to a discourse theory of democracy Habermas (1996:356), politically binding decisions can be considered legitimate if communication about different themes is channeled from the periphery according to democratic and constitutional procedures into the parliamentary complex as well as at the exit of administrative implementation.

2.1.1 Societal differentiation and integration

Habermas acknowledges that society has become differentiated into complex systems and that the system of law is itself an ambiguous source of social integration since it is often the interests of powerful groups that influence the legal system (Habermas 1996:40). His theory posits that systems like the money steered economy and the political administrative system are in a sense deaf to the concerns of citizens' concerns communicated via natural language, but the legal system ideally functions as a transformer. The legal system can translate "normatively substantive" messages into legal codes which then steer the economic and administrative systems in alignment with the common will (1996:56). Thinkers such as

Weber, Parsons, Luhmann, Bourdieu and Foucault all conceptualize differentiation of society with their respective conceptual apparatuses but the problem that sociology inevitably tries to account for is how social order and integration of society can be explained. Luhmann reaches the radical conclusion that collective steering of society as a whole is not viable or realistic in complex, functionally differentiated societies that no longer have a center from which one could oversee much less steer the totality. Each system is self-regulating or “autopoietic” and operates according to mutually exclusive codes and “observes” the world from a particular systemic perspective. This means that the political system cannot directly steer the economy or even the health system without compromising the systems’ communications and thus its functioning. From his theoretical viewpoint, the goal of the policy makers behind NOU 2005:3 is unrealistic.

But Habermas argues that specialized systems such as the law are “adaptively open” to their environments even if it is true that they use specialized codes in order to function (1996:55) A communicative theory of society distinguishes between the lifeworld that reproduces itself via natural language use on the one hand and systemic spheres of society that arise from and exist in a dependent relation to the lifeworld. “Lifeworld” is a concept used by Husserl to refer to a familiar reservoir of meanings and background assumptions that everyday communication is embedded in. This taken for granted knowledge facilitates communication and allows actors to smoothly coordinate their action with each other. The lifeworld represents the world that members of society experience and provides an all-encompassing horizon for their meaningful interactions with each other and society. It is itself functionally differentiated into three components responsible for cultural, societal and personality structures that facilitate socialization of members of society. The systemically differentiated systems of society like money and power develop out of the society component of the lifeworld through the course of history via the historical evolution of specialized codes. Habermas contends that the legal system can be understood as a “hinge” that binds the lifeworld to the more specialized systems (1996:56). It is in instances where problems arise that actors are burdened with trying to come to some sort of common understanding with each other. In the context of this reform, patients often experience the functioning of the healthcare administration in ways that deviate from what they initially would have expected of public service provision. The problems that can arise are often complex owing to funding issues, establishing legitimate needs, bureaucratic functioning and so on. In cases like this the need for coordination appears in

stark contrast to the lack of actual societal integration and it is the political and the legal system that Habermas believes can close this gap (1996:321). Habermas includes the lifeworld perspective because coordination of society should take account of the opinions and viewpoints of those (for example patients) that are affected by political decisions, economic and administrative functioning. Discussing problems related to coordinated healthcare can in principle be discussed amongst lay persons, even if this means that matters will have to be simplified to some extent. Habermas describes normal language use as being multilingual so that the lack of specialization is weighed up by flexibility;

With its practically unlimited capacity for interpretation and range of circulation, it is superior to special codes in that it provides a sounding board for the external costs of differentiated subsystems and thus remains sensitive to problems affecting the whole of society (Habermas 1996:55).

Habermas argues that law as a medium can integrate society's different spheres owing to its "positivity" as well as its claim to rational acceptability(Habermas 1996:38) . By positivity I understand Habermas to mean that laws represent a consciously enacted normative framework that exists only as long as laws are not repealed. For Habermas systems like religion, families and education function in such a way as to socialize and integrate members of society and ensure cultural or lifeworld reproduction via communicative action (1996:360). Other systems such as science, the economy and art have evolved and over time become specialized and aid coordination of complex spheres of society via specialized more abstract language use. In contrast to Luhmann, Habermas makes a distinction between the systemic nature of society that can be observed theoretically and the world as seen from the participant perspective;

Modern societies are integrated not only socially through values, norms and mutual understanding, but also systemically through markets and the administrative use of power (Habermas 1996:39).

From the systemic viewpoint, action coordination is simply too complex to be grasped cognitively by individuals so systems provide simplified contexts in which goal oriented action can meaningfully occur. Coordination and integration is achieved objectively, behind the backs of actors, irrespective of the intentions that they individually may have. An example of this would be the marketplace where the price mechanism regulates what actions are rational for actors to take, based on the binary code cost/benefit. Habermas points out that because the workings of systems impact on the everyday lives of actors within

lifeworld contexts these social issues can and should be rationally addressed in public forums which then generate appropriate legislation as a basis for collectively binding decisions made by the political system and translated into legitimate laws. Communicative power is then channeled into the political system that further reinforces the rule of law. These legal codes are sophisticated enough so that they can be adopted by specialized spheres such as the economy.

2.1.2 Communicative action

Communicative action as a model is different from purposive rational action in that actors also take into account relevant social norms as well as the assumption that other participants communicate their views sincerely and not merely in a strategic manner. I understand Habermas to mean that everyday communication is routinely undergirded by such principles and his endeavor has been to conceptualize (and thereby render visible) this by drawing on the pragmatic aspects of speech-act theory (Joas and Knöbl 2009:230). According to the theory, any utterance or action implies validity claims pertaining to relationships to three qualitatively different dimensions of the world (Joas and Knöbl 2009:230),

Constative speech acts relate to facts about the world and can be verified or falsified as either being true or false. Rational choice theory limits itself to validity claims about states of affairs in the world. For Habermas an action or utterance can only be understood as rational if two more validity claims are fulfilled,

Acts and utterances invoke normative standards as to whether they are appropriate from a social perspective and inherent validity claims to normative rightness of actions must be open to questioning. For example, it is not sufficient that a technocratic reform outline a strategic course of action based on valid objective knowledge unless also broader social and ethical considerations are taken into account,

Acts and utterances are also more or less authentic expressions of an actor's authentic view. When a person doesn't truthfully disclose what they really mean by an utterance there is always the suspicion that they are communicating strategically and that they thereby treat others as objects to be manipulated in achieving their own goals.

These three types of validity claims set the framework upon which argumentative discussions can take place in a public setting.

2.1.3 The public sphere

Based on the principle of a necessary division between state and society, citizens are endowed with civic rights that grant them with a degree of social autonomy that grants them the freedom to come together in civil society in order to communicate on issues pertaining to the common good (solidarity), irrespective of differences resulting from class or inherited privilege. The public sphere demotes a space or a situation where actors communicate in a qualitatively different manner than rational success oriented actors would do in a market situation. The public sphere is complemented by the private sphere which is associated with closeness and intimacy. Those aspects of the private sphere that are commonly considered problematic can be appropriately addressed in the public sphere. The public sphere is a “linguistically constituted space”, which stands apart from the specialized political system that is burdened with making decisions that are binding for all members of society. Instead of only observing one another or trying to strategically anticipate what others will say or do next, actors negotiate interpretations of a shared social situation which involves taking on the perspective of others and being prepared to defend their views on the basis of validity claims. The public sphere can be understood as a “reflexive center” in society that enables society to gain a normative distance to itself (Brekke, Høstaker et al. 2003:110) Communication in the public sphere is generally comprehensible and requires only a general competency in “natural” language use. The public sphere refers to periodic interactions between actors in and is reproduced via communicative action.

2.2 Rational choice

In this chapter I intend to briefly outline the principles behind rational choice theory. The theory attempts to explain behavior only on the assumption that actors are rational (Elster 2007:191). The earlier versions of the theory were based on utility models of action and actors’ motivations were then understood to be based on increasing pleasure and avoiding pain Joas and Knöbl (2009:94). Homans was a major proponent of the reward/punishment

view of motivation and attempted to ground explanations for actual human behavior in Skanners behavioral experiments (Joas and Knöbl 2009:101). These experiments on pigeons where meant to demonstrate the effectiveness of incentives on conditioning behavior and research was done on determining their applicability to human behavior. The utility theorist aims to provide a comprehensive framework for understanding society from the micro to the macro-social level by starting with the self-interested actions of actors (2009, 104-105). Homans tried to explain how individuals making choices come prior to institutions in the sense that their actions can affect these instead of primarily interpreting behavior as being shaped from institutions via roles and functions. This way of understanding society seems plausible at an intuitive level but according to (Joas and Knöbl 2009:94); the theory ultimately could not adequately account for a stable social order and had already come under criticism from Parsons who proposed that internalized social norms are what integrate society. The hypothesis of self-interest might be applicable to the economic sphere of society according to Parsons but fails to explain how a stable social order is possible. Utility oriented theorists had in turn claimed that functionalism only describes social reality but fails to explain action in a manner that shows causal links that could be tested empirically. But the concept of utility proved difficult as it could be taken to mean different things. Sometimes utility was presented more altruistically as achieving collective goals in the sense of increasing utilities for as many as possible. But pursuing this strategy only renders the term altruism less meaningful. According to Joas, claiming self-interested behavior as universal proved untenable in the long run and theorists then proposed that rational choice be presented in normative analytical terms. This means that the rational choice model no longer aspires to describe realities as manifested in observable behavior but can serve to illuminate actors on how they should act in order to achieve goals rationally (Joas and Knöbl 2009:97).

Rational choice is a derivative of utilitarian theories and specifically analyses cooperation and the relationship between individual and collective rationality. According to the rational choice theory actors behave and act on the basis of desires and rational beliefs about what opportunities are open to them (Elster 2007:191). Elster's typology starts with the actors' desires serving as the source of motivation to take action based on beliefs that in turn are based on the best available evidence. There is a feedback mechanism between the beliefs that an actor has and the available information. Desires themselves don't have to be stable and beliefs can change subject to new information as in the case of Bayesian learning (2007:202).

Elster describes rational beliefs as beliefs that in the long run are most likely to lead to true beliefs (2007:202). Gathering information represents an “opportunity cost” so that spending too much time acquiring information might also impact on what actions can be taken in a given situation. For an action to be optimal it has to be the best means of satisfying an actor’s desires, based on what the actor believes about different outcomes or consequences.

2.2.1 Preferences

Rational choice abandons the notion of egotistical utilities that was sought explained in psychological terms and uses the notion of preferences instead. Elster points out that desires needn’t be selfish (2007:193) and that equating rational choice with selfish behavior is a common misunderstanding. Rational choice theory goes into considerable detail concerning the actor’s preferences because the actor has to be able to make the “best” choice between a given a list of alternatives based on meaningful criteria. Preferences have to be both transitive and complete in order to be considered rational according to the model of rational choice. Elster explains this by giving an example where an actor has a choice over three options; A, B and C. If A is at least as good as B and B is likewise at least as good as C, then option A should be considered at least as good as option C. Thus the transitivity requirement is fulfilled. Given a choice between A and B, an actor has to make one of three choices, either choosing A, B or stating that she is indifferent between the two options. This ensures that the actors’ choice is complete. Completeness and transitivity are important because having a best option is important for the theory. The rational actor needs to have a clear and consistent list of priorities to begin with, before the best means of action are chosen for achieving ends. However, as (Joas 2009:96) notes, the theory has so far failed to account for how preferences themselves arise or how they change. The theory also has difficulties in accounting for values that actors orient themselves to regardless of utility calculations. Neither has rational choice theory so far given a comprehensive explanation of norms and how they arise and influence action.

2.2.2 The free rider problem and the logic of collective action

So far I have outlined the key premises as well as the objections to the theory which doesn’t mean that it isn’t valuable in perceiving important social factors behind collective phenomena.

Mancur Olsen wrote on the “Logic of collective action” (1971) and raised awareness that common interests don’t automatically translate into collective action or cooperation (Joas and Knöbl 2009:110). From the individualist perspective of rational choice, when trying to explain the occurrence of popular movements such as revolutions or the workings of labor unions it is wrong to assume that common interests among the involved participants explains cooperation in joint action. This is because the “best” option for a rational actor is to not contribute to public goods, however much it may be in her interests to contribute. As groups increase in size, the free riding effects do so to and this provides one explanation as to why rational actors don’t contribute towards public goods. The best option would always be to free ride on the contributions of others if actors behave according to the rational choice model. The chances are great that if one thinks and acts along these lines, others probably do to. This contradicts the assumptions of classical political economy in that one can no longer assume that individual actions of actors in (for example markets) will inevitably lead to optimal results for society (Joas and Knöbl 2009:116). And yet, contrary to the predictions of rational choice theory, labor unions do exist and economic and other organizations are an important part of society. To account for this several features relevant to cooperation were noted by Olsen;

- 1) As the size of a group increases, the likelihood that individuals will be tempted to free ride does to. Smaller groups and organizations are therefore often more integrated and effective at articulating themselves in the public sphere. A form of social control is operative under conditions where actors can perceive each other’s actions which in all likelihood encourage cooperative behavior
- 2) Organizations can use coercive measures to ensure the production of public goods as when the state enforces taxes for financing infrastructure or when labor unions enforce “closed shop” policies where only union members are allowed to work in firms (Joas and Knöbl 2009:110).
- 3) Organizations can offer selective incentives that accrue from membership. One drawback with accounting for cooperation by referring to selective

incentives is that someone also has to initiate their provision and this is difficult to do in rational choice terms as the free riding problem reemerges.

2.2.3 The prisoner's dilemma

Game theory adopts the same premises as rational choice and systematic experiments have further built upon Olsen's insights into group behavior. The "prisoners' dilemma" is widely referred to in literature on cooperation from a RC perspective. In a hypothetical situation two persons stand accused of jointly partaking in a criminal offence. They are interrogated separately and delivered the following ultimatum; if they both admit to the crime they will each receive a five year prison sentence. If they both deny they will receive two years each but if only one admits then he will be acquitted and the other will receive a ten year sentence. For each prisoner the individually rational option would be to confess and risk either five years or eventual acquittal. In principle they would both be better off not confessing so that they both received only two years if both consistently denied. But since it is individually rational to gamble on the chance that the other will not confess, both are likely to think alike (if they are rational) and they will accordingly both confess and be consequently given a five year sentence each. From the individual perspective, not knowing what the other prisoner will decide leads them both to make rational decisions that are sub optimal for both.

2.3 A scientific take on cooperation

I will start this chapter with some brief comments on a paradigm shift in the way in which organizations have thought about management, based on a cooperative model endorsed by Professor Yochai Benkler (2009). Organizational sociology was one of the first disciplines to attempt to analyze instances of successful alternatives to the principal agent influenced management principles, as evidenced in Toyota's teamwork practices in the car manufacturing industry in the earlier 1980's. The implicit theory of coordination can be interpreted through the lens of a scientific conceptualization of "cooperation", based on controlled behavioral studies isolating social mechanisms that have been experimentally proven to facilitate cooperative behavior. There is growing support for the view that we currently live in a world that is structured on faulty or overly reductionist models of human motivation. The empirically false assumption is that people are more or less uniformly self-

interested and that actors are similarly motivated. Based on these axiomatic universal assumptions, workplaces, laws and institutions are implemented and structured to prevent opportunism and guide actions in alignment with collective goals. But according to scientific studies on cooperation, organizations and institutions can be designed in ways that limit the need for hierarchy whilst granting actors more autonomy and allowing for dynamic learning processes to take place in an environment where strict control mechanisms over input and output in production are proving to be less effective. Self-determination theory states that actors possess an innate need for autonomy, relatedness to others and to feel competent. Motivational structures that are imposed on actors externally often override intrinsic motivations to contribute towards collective goals (Benkler 2009:13).

Taylorism had earlier been implemented in production as a means of socially engineering a context where worker's actions were tightly controlled and calibrated by means of hierarchy as well as punishment/reward systems as manifested in principal agent theory and public choice theory. The underlying idea that has persisted for many decades is that workers (on average) are statistically unlikely to go the extra mile without incentive structures and underlying this is a particular understanding of the rational actor model where actors are prone to opportunism. Whereas hierarchical structures and incentive systems managed workers behavior, leaders of companies received well high salaries and shares in companies as a means of aligning their motivations with the overall success of companies.

Benkler (2009) has studied the rise of online internet collaboration and attempted understand what explanatory factors can account for the success of General motors from 1980, after Toyota takeover there. The notable increase in production at the Ford plant in Fremont California is interesting because the same American workers that formerly had high levels of absenteeism under GM leadership became far more productive after new forms of organization were introduced under Toyota. Cultural explanations could be put aside and the alternative system for organizing production could then be analyzed in order to find out why it was so effective at inducing cooperation between workers and leadership. Ultimately one found out that it wasn't any system as such that guaranteed cooperation via some kind of universal formula, rather, the tendency towards constructive cooperation lay inherent in the actors themselves. It was to the extent that organizational recipes didn't interfere or "crowd out" intrinsic motivations that they ensured that workers would cooperate without the

restraints of systems that regarded opportunism and selfishness as a universal attribute of employees.

Benkler has summarized literature coming from studies in evolutionary psychology, organizational sociology, management science, experimental economics and social psychology to name but a few. Interestingly, Benkler notes that many disciplines were coming to perceive cooperation irrespective and in isolation of one another. Since the publication of Dawkin's "Selfish gene" in 1976, biologists now consider cooperation as an astounding achievement that evolutionary processes in nature have facilitated, contrary to earlier social Darwinist assumptions of "survival of the fittest". In his article, Benkler (2009) also mentions the same experiments that have become well known through rational choice and game theory. Social dilemma experiments such as "prisoner's dilemma", the trust game and the "dictator game" have then been expanded on with a view to understanding what mechanisms encourage cooperative behavior. His thesis is that although monetary incentives and punishment /reward systems are important factors in inducing a cooperative dynamic between actors, there are many additional environmental or social factors that have to be carefully considered by policy makers who aim to impose constraints on a social system. He has condensed findings from various disciplines and isolated twelve design levers that increase the likelihood that actors will opt for cooperation instead of pursuing self-interest. Consistent findings in the literature posit that selfish behavior characterizes the responses of one third of the population under controlled experiments. One third of participants respond well to the punishment/reward systems that rational choice theory espouses and these findings can be generalized to be representative for populations. One cannot be sure if selfish tendencies are innate or subject to environmental factors but this still leaves 70% of average populations who are more willing to act cooperatively without incentives and policing than RC models would predict. I will briefly list the design elements below. These represent condensed findings on what facilitates cooperation and the coordination reform can be assessed on the basis of the levers,

- 1) Communication: Allowing participants to communicate, even without expectations of an enforceable commitment, leads to greater cooperation
- 2) Empathy: actors who know even a minimum of the personal attributes of others, are more likely to cooperate with them

- 3) Solidarity: If actors feel part of a larger group with a common identity are more likely to cooperate
- 4) Fairness: actors care about fairness of outcomes and as well as the intentions of others that they collaborate with
- 5) Norms: establish what is expected of whom and what counts as defection/cooperation. Self-chosen norms are even more effective in regulating behavior. So if actors get together and establish common ground rules, these prove quite robust in ensuring cooperative behavior in repeated interactions over time
- 6) Efficacy: actors are more inclined to cooperate if they feel that their contributions are vital in achieving collective goals
- 7) Punishment/reward: such systems keep selfishness and free riding tendencies in check but their use has to be carefully calibrated. Punishment works in a complex manner on cooperative dynamics and the way in which it is interpreted varies across cultures.
- 8) Crowding out: relates to how measures such as punishment and reward can negate inner motivation. Deci and Ryan have gathered evidence that reward systems in schools can actually demotivate pupils, contrary to long standing assumptions (Deci and Ryan 1994). Monetary incentives are especially complex and Benkler documents how blood donor organizations now refrain from offering money in exchange for donations.
- 9) Transparency/reputation: Cooperative platforms that allow actors to observe one another increase the likelihood of long term cooperation. Reciprocity comes to the fore if actors can observe other's actions and characterize these as being cooperative or not.
- 10) Cost: consistent with experimental literature, cooperation is facilitated by the magnitude of cost

- 11) Entry/exit: Cooperative systems have to ensure that it isn't easy for participants to enter the system, benefit from collective goods and then defect. The conditions for entering a collaborative project can be calibrated in terms of cost. In general terms, higher costs of entry and exit tend to deter selfishly motivated actors from entering.

- 12) Leadership: is vital in ensuring continued cooperation but not in terms of hierarchical control. Asymmetric contributions means that participants that involve themselves most in ensuring collective goods should ideally take on a leading role.

Milton Friedman is known for defending the model of *homo economicus* on the basis of the predictions it offers, not on the plausibility of its assumptions. Benkler contends that these predictions have in recent years become significantly undermined under controlled experimental studies. Also, social phenomena such as Wikipedia, online peer-collaboration and innovative production models in the business sector would not be predicted on the assumption of individual solipsism or the need for individualized incentives in order to ensure cooperation. Such findings are useful for my purposes to the extent that they allow me to examine the Norwegian governments' use of incentives on municipal activities.

What has been done with the rational choice model under the cooperation paradigm is reminiscent of epistemological constructivism. The rational choice model hasn't been discarded entirely as punishments and rewards still have their place. The role of monetary incentives is still ambiguous and complex but cannot be discounted as an important factor. Observations of data have rendered the standard RC model less fruitful and efforts have gone into revising the components of a theoretical model of motivations. Cooperation as a theory is not to be confused with behaving "nicely" towards others but is more of a means of deliberately structuring environments in such a way as to get actors to cooperate. Policy makers can reexamine how law and institutional design can deliberately be altered so as to foster cooperative and collectively coordinated action.

2.4 Research questions

- 1) What kind of social theory does the implicit theory behind the concept of coordination resemble?

In order to answer this question I ask three additional questions;

2) Can the implicit social theory behind the concept of “coordination” be identified as rational choice?

3) Can “coordination” be understood in terms of communicative action?

4) Can coordination via municipal co-financing be understood in terms of the scientific concept of cooperation?

3 Methodology Chapter

This thesis limits itself to focusing on the implicit theory of coordination as manifested in NOU 2005:3 and St.meld.nr.47. This is a case study of a specific aspect of Norwegian healthcare policy. Accordingly I have selectively focused on those elements in the documents that I judged to be relevant to coordination. I have not included the role of information technology (IKT) in my thesis as I have been primarily interested in the implicit assumptions on behavior and motivations of relevant actors in healthcare. I limited myself to a content analysis because I was convinced that the written material would be the best source of data pertaining to theory. It would be appropriate to characterize my approach as open ended, following a social constructivist view that public policy is a complex, politically contested process, involving an interplay of economics, ideology and culture (Walt, 1994) cited in (Dingwall, De Vries et al. 2010:90). Therefore it would be fruitful to see the documents as products of complex processes instead of a primarily strategic endeavor mastered by the government. These considerations have implications for my research topic. I might at the outset expect a combination of different social theories and perhaps not realistically hope to identify one coherent implicit theory in the documents. However I think it is reasonable to expect that one theoretical perspective would prove most plausible in making sense of how coordination is implicitly theorized.

The process was not linear and systematic to the extent that I had hoped and considerable effort was devoted to reflecting on how abstract theory could be rendered applicable to

reading the reform. Initially I had an idea that developing an ideal type of each model would make the process easier but I ended up going back and forth between the theories and the documents in a kind of hermeneutic circle. I decided to deductively test the three theoretical perspectives by reading the two documents and isolating passages that seemed to resonate with them. There was an inductive element in my readings to the extent that I recognized that I had to be open minded in approaching the material. I tried to avoid imposing the theories on the material in an implausible manner and in an effort to ensure rigor in the analysis of my findings I have included observations that in a sense falsify each of the perspectives.

3.1.1 Document analysis

Documentary analysis can make use of already existing materials in order to examine “spontaneous expressions of policy rhetoric” (Dingwall, De Vries et al. 2010:95). Publicly available documents can also be revealing of a government’s belief systems, Freeman (2006, p. 66) cited in (Dingwall, De Vries et al. 2010:96). The documents that I used are the constructions of policy makers, used to make sense of realities pertaining to the Norwegian healthcare sector. We assume that they are more or less adequate sources of knowledge for understanding current states of affairs in the health sector. Apart from the factual accuracy of the policies’ descriptions of the sector, the documents are a source of data that can be scrutinized in order to reconstruct implicit assumptions of the policy makers. From a post positivist perspective the documents are a means of understanding the current situation in the sector which enables effective action to be taken to ensure coordinated services. The reason for analyzing them in terms of sociological theory is that such analysis casts light on implicit assumptions relating to actor models and instruments that are believed to be effective in facilitating cooperative behavior. Examining literature references in NOU 2005:3 can give some indication of the kind of scientific grounding the reform bases its proposals on. Since I have already indicated that there is no evidence of explicit reference to scientific theory, document analysis on implicit assumptions is warranted.

3.1.2 Explicit references in the documents

As far as understanding how coordination can be facilitated in public health sector the policy makers acknowledge that not enough research has been done on mechanisms that would ensure it,

Det er også behov for forskning på metoder for samhandling. Det er for lite kunnskap om hva som er virksom samhandling, og hvordan den kan bli mer effektiv og nyttig (NOU 2005:3 s19).

I was confronted with an extensive reference list in NOU 2005:3. In St.meld.nr.47, there are no references to further literature. As I have just stated, the reference list in the first document seemed overwhelming at first. On closer examination I found most of them refer to government funded projects that experimented with new ways of organizing healthcare infrastructure. The literature list does include many references to pilot studies on how hospitals have experimented with coordination initiatives aimed at providing more integrated services. The references that do refer to scholarly work are highly specific to aspects of the reform and not social coordination of collective action as such.

International sources in the list appear to have a health-economic perspective on healthcare management where funding is measured in relation to outcomes on the population. Some of the international references include Hicksen (1987) who focuses on payment systems for doctors and how this can be shown to affect their behavior or “performance” based on randomized prospective studies. Newhouse focuses on reimbursement systems for healthcare providers and Kraznick (1990) also studies how the structuring of primary care doctor’s salaries affects their everyday practice. Donaldson (1989) focuses on general practitioners’ payment structures.

3.1.3 Epistemological constructivism

I will start with an outline of how I understand the relationship between empirical research and theory building. I take my position based on Hagen’s article in “Tidsskrift for samfunnsforskning 04/11”, (Self reference and reflection: Connecting general theory with empirical research). The article discusses fragmentation within social science owing to the split between the ontologically grounded (top-down) “grand theories” as developed by

Parsons, Habermas and Luhmann and more “empirically” (bottom-up) oriented research that attempts to develop scientific concepts by a presumably unbiased or direct approach, to the greatest possible extent untainted by theoretical baggage. A good example of the latter would be qualitative interviews using open ended questions. The crux of the problem is the relationship between empirical data and theory and the tendency to understand theories as either being abstract (tenuously linked to “empirical data”) or “empirical” (less systematized but closer to reality). An important claim in this article is that “empirical” theories do not grant better access to reality than do abstract theories and concepts. All observations come between the observer and the object of observation.

Hagen argues that social research have so far tended to view their access to the external world via two sources, each at their respective ends of a continuum. On the one hand, sociological concepts such as “social action” have been ontologically anchored in metaphysical speculation, in more philosophically oriented discourses on what social action ultimately is. Jeffery Alexander (1982:3) created a diagrammatic representation of theory as comprised of both metaphysical and empirical elements. The more abstract elements of theories such as concepts, models and general presuppositions are located at the metaphysical end of the continuum or in relation to the metaphysical environment. At other end, closer to the empirical environment, research is conducted by observations and questions related to methodology and statistical correlations. “Empirical” observations centered on for example interviews or surveys, are commonly presumed to grant access to “rawer” less mediated forms of social reality. The concept of “coordination” could thus be theorized in either a very abstract manner supported by philosophical ontological arguments or it could presumably be based on more direct empirical observations, that is, within the framework advanced by Jefferys. The dual environment model that Joas and Knöbl (2009:10) base their understanding of theory on is in Hagen and Gudmunsen’s article replaced by the notion of scientific endeavor forming one system with access to one environment. Hagen supports the post positivist view espoused by Popper, that the observer is always separated from the object she observes by the observation itself. Any observation presupposes a theoretical distinction that aids in perceiving certain aspects of social reality whilst remaining blind to others. Direct unmediated observations of reality are not considered logically possible but researchers can attempt to systematically and critically examine the tools that they observe social reality with.

Researches can make observations of the second order, that is, examine the lens that they observe with.

The article advocates *epistemological constructivism* as a systematic means of integrating the activities of constructing general theories about society that can be considered true in the ontological sense, with the ongoing examination of existing social theory in confronting empirical data. Concepts are assessed as to their degree of fruitfulness or “fit” with empirical data. Concepts and theories are not expected to mirror or directly reflect society in a one to one manner. Scientific knowledge aids us in achieving ends by answering “how to” questions and one adheres to a pragmatic concept of scientific truth. Knowledge is a construction of the scientific system and the distinctions that theories imply cannot be assumed to characterize the external world but are seen as projections onto reality that help us understand it more adequately. The distinction between theory and empirical data is a projection onto social reality. In contrast to extreme forms of social constructivism, one starts out with the assumption of a world independent of the observer or else there would be no meaningful criteria for doing systematic research. The criteria for judging the fruitfulness of concepts and their relation to systems of concepts within general theory are the prerogative of the scientific communities own standards. Instead of speculation as to the ultimate attributes of social reality, research can be more profitably directed towards the means of gaining more adequate knowledge. Since existing social theories cannot easily be refuted or validated, it makes more sense to freely choose concepts relevant to “coordination” in order to see how fruitful they prove to be in confronting the empirical sources that I have chosen. The concepts I have chosen are in their own right neither true nor false if one expects them to be literal representations of social reality. Epistemological constructivism endorses a pragmatic understanding of the concept of truth so that knowledge is more or less useful in enabling effective action.

Answering the research questions depends on the possibility of being able to work backwards, from what the documents say about relevant actors concerning coordinated action and how this leads to desirable collective outcomes. By doing this I adhere to the premise that the panel’s observations are filtered through a theoretical framework or background understanding. These underlying assumptions can be identified by isolating passages related

to perceived motivating factors guiding behavior and how they explain actions taken on the part of relevant actors. Reading from different perspectives generates different data and I have tested to see which perspective was most fruitful in the sense of giving the best “fit”.

3.1.4 Coding in terms of communicative action

I chose Habermas’ theory of communicative action based on an intuition that it might be relevant to coordination in this context. Coordination could be achieved by deliberative procedures. At an intuitive level it seemed that coordination pertained to bringing actors together into public forums in order to discuss common hindrances to providing integrated care. The concept of democracy is often mentioned in the documents as is the importance of patients being granted access to channels of collective influence via representative organizations on the health services, a kind of empowerment based on the recognition of the importance of individualism in modern society. Reading the documents in light of Habermas would shed light on whether emphasis is placed on participation in civil society or if patient participation is to be limited to taking place within the healthcare systems, perhaps more oriented towards administrative performance or “output” as opposed to “input” via parliamentary channels.

My aims do not amount to more than answering “what is the case?” I let the concepts of discourse theory serve as categories for my observations of the textual content. I decided to collect what I judged to be relevant passages from the perspective of Habermas. His theory of communicative action provided one means of ascertaining the extent to which communication via dialogue might serve as a means of understanding the concept of coordination.

Accordingly I collected all instances that bore any relation to communication, the media, the public, patient participation in individual and collective forms, democratic dimensions in healthcare provision, dialogue and the relation between the political, legal and economic systems. I also looked for any mention of “civil society”. I bore in mind what Habermas’ theory states about the use of the legal system and how public deliberation can be channeled into legislation. I looked for evidence that citizen concerns about health issues might be channeled into the “input” side of the administrative systems as opposed to the “output side” where citizens exclusively orient themselves to the results or the performance of the health

services. The excerpts that I collected were stored in a file and they served as data which I reflected on further.

3.1.5 Coding in terms of rational choice

Reading the documents in terms of rational choice theory proved challenging. The theory is ontologically based on methodological individualism and society is viewed as the sum of actors and the aggregated consequences of their rational actions. The documents also seem to implicitly take this view of society but this in itself doesn't say much. I didn't expect the calculative rational aspects of behavior to be relevant at the micro level of interactions and indeed NOU 2005:3 does make a point out of basing actions on the "patient's perspective". This implies taking on the perspective of the other amounts to something akin to Mead's "generalized other" and thus would seem to run contrary to the model of the calculative rational actor. Individual actors as well as institutions are also asked to base their actions on the consequences for the "patient's pathway". They are not only asked to perform their specialized tasks well, they are also asked to look at the bigger picture. So at the outset such observations do not seem promising with respect to a rational choice reading. I mention these observations here before the presentation of findings only to show why Mancur Olsen's perspective on the logic of collective rational action (1965), the concept of freeriding and the prisoner's dilemma served as useful analogies for interpreting the policy maker's observations and subsequent proposals for change. I have also looked at the role of incentives and the role they are supposed to play in public sector management. Rational choice theory illuminates the calculative and purposeful aspects of action on the micro level and game theory analogies can be used to analyze how the interplay between hospitals and municipalities is framed in the documents. If actors are viewed as rational one would expect collective coordination to be achieved by a system of rewards/punishment and bargaining.

3.1.6 Reading from a cooperation perspective

Cooperation as an analytical perspective proved less easy to use as a means of categorizing data. This is because Benkler isolated as many as twelve leverage points or generally relevant

factors for facilitating group cooperation. I decided that analysis of coordination from the first two perspectives would give me an adequate overview of who the major actors were that the documents specifically targeted. Only then would an analysis in terms of cooperation provide meaningful data. I have not categorized the documents comprehensively in terms of the twelve design elements but instead focused on the key measure opted for in St.meld.nr.47, “municipal cooperation” and “municipal full financing of patients ready for discharge”. I have attempted to analyze this instrument and discuss whether this institution might have a “crowding out” effect on actor’s motivations to cooperate.

3.1.7 Quality control

I have tried to ensure that excerpts taken from the data are not merely anecdotal or taken out of context (Silverman 2010:235). I have presented aspects of the reform that I judged to be prominent, such as the use incentives. For each perspective I have included instances which seemed to resonate with a given interpretation, as well as anomalies that would not easily fit into a given theoretical perspective. I have been as comprehensible as possible in terms of reading from a deliberative perspective and the RC perspective. The observations I made with regards to cooperative design levers as presented by Benkler, base themselves on what I found to be relevant after both deliberative and rational choice interpretations.

3.2 The problem of coordination in complex society

This reform appears to navigate between two alternatives with regard to action coordination. For the sake of brevity I will simplify these. On the one hand coordination is achieved collectively via administrative managerial hierarchies and the mechanism of authority within the sector. But there are limitations inherent in hierarchically structured organizations, each fulfilling their specialized function and individually contributing toward patient treatment pathways that cut across organizations horizontally. The second foreseeable alternative would be flatter organizational structures and increased use of market mechanisms in the sector but this would likely present politicians with ethical as well as steering dilemmas. It is likely that this reform seeks a middle way between traditional hierarchies on the one hand and extensive use of market mechanisms on the other hand. This might account for the lack of explicit theoretical references in the documents. The policy-makers seem to have tried to achieve a compromise and the task I have set myself is to ascertain the extent to which the implicit

theory can be said to be a departure from NPM or whether the hypothesis of the self-interested rational actor is simply reified.

In the following chapter I will introduce the literature that I have found relevant pertaining to the reform in general. Riise Pettersen (2010) argues in his term project that the Coordination reform is firmly entrenched in NPM practices. Because I have used rational choice as an analytical perspective I think it is necessary to say something about the concept of New Public Management. NPM is said to be less a coherent concept and more of an empirically identified phenomenon (Jespersen, 1997; Pollit 1990; Klausen 1996), cited in Busch, Johnsen et al. (2011). The list of references in NOU 2005:3 includes the aforementioned reference in an article entitled “Bestillerutfører modellen “Utfordringer og problemområder”. The inclusion of this reference in NOU 2005:3 indicates that the policy makers are aware of possible side effects of NPM and that they take this into consideration with regards to the use of “provider-purchaser models”. I intend to briefly outline the arguments and perspectives of Haga and Pettersen, before I present the theories of communicative action, rational choice and cooperation and how I relate these last three to the problem of social action coordination. I will then from time to time use and refer back to all five perspectives in the analysis section.

3.2.1 NPM

The New public Management reform trend is associated with privatizing, competitive deployment of public services and the implementation of organizational ideas from the private sector into public services Mydske, Claes et al. (2007:58-59). NPM as manifested in arguing for privatization is not an issue in the Coordination Reform but NPM is relevant to the extent that public administrations are sought to be steered like private organizations.

Christensen, Lægreid et al. (2009) in their definition, describe NPM as a series of “modernization recipes” for public organizations drawing inspiration on what has proven effective in the private sector. The emphasis is put on professional leadership with leaders granted more autonomy in order to achieved clearly defined goals. Public services are typically split up into production units, the element of competitiveness is encouraged and political control is exercised via contracts (Christensen, Lægreid et al. 2009:80). In the context of Norwegian reforms they note a tendency towards implementing “mål og resultatstyring” or “steering via goals and results”. Also, organizations have been restructured

so that public goods provision has been provided by neutral leadership that is considerably less integrated with political leadership (*fristilling*). A good example is the Hospital reform that replaced county ownership with leadership consisting of professional boards. This is accompanied with increased market orientation, competitive deployment and horizontal specialization with non-overlapping roles Christensen, Læg Reid et al. (2009:157).

Eriksen (2001:215) mentions the use of incentives in order to motivate and discipline actors at the same time as well as decentralizing and delegation of services in order to render public services more consumer- oriented. For him NPM management threatens identities by encouraging patients to see themselves as consumers oriented to service output, more than responsible citizens who have a say in how administrative systems function.

In recent years researchers discern a move away from these managerial principles known as “post NPM” reforms but instead of breaking entirely with NPM these latter reforms encourage cooperation across organizational divides in order to achieve public goals. Post NPM reforms don’t represent encompassing structural changes but are more like adaptations and adjustments that are meant to prevent fragmentation in administrations (Mydske, Claes et al. 2007:88).

With regards to the issue of responsibility, theories such as “principal-agent theory” and “public choice theory” are also closely associated with NPM trends. Principal agent theory is a model of the relationship between principals (leaders) and rational agents who, according to the theory, are likely to maximize on their own benefits if they can. The model builds on rational choice theory and emphasizes the asymmetry in information possessed by agents, compared with principals. Agents require autonomy in order to fulfill their responsibilities flexibly and effectively. In complex environments, principals cannot observe agents and are instead reliant on systems of quality control and result evaluations. Since agents’ opportunities for action cannot be tightly controlled without incurring significant costs, it is then more effective to deploy systems of punishments and rewards (incentives) in order to motivate rational actors to work towards the predefined goals that the principal has set for them. NPM measures are somewhat contradictory in nature since principals themselves are also held responsible via systems of quality indicators or result evaluations. It is often difficult for principles to formulate clearly defined goals that can be meaningfully operationalized so that agents can pursue them single mindedly. In NOU 2005:3 one of the references in the

document, “Bestillerutfører modellen “Utfordringer og problemområder” notes the following features that are said to characterize NPM lines of thinking;

- 1) Citizens should be viewed as consumers who have a free choice between different alternatives in relation to public goods
- 2) “Users” should partake in the establishment of public services
- 3) Monopolies in public goods distribution should be replaced by self-sustaining distributors who compete either in a market or a quasi-market
- 4) Business economic efficiency should be the norm
- 5) Global or block budgeting should replace detailed regulations
- 6) Responsibility for public services should be decentralized and should be replaced by quality indicators and result evaluations
- 7) Organization and leadership principles from the private sector should be implemented in the public sector.

Christensen and Lagreid note that the several reforms in Norway were more or less NPM inspired, starting with the Willoch coalition’s reform “Modernisering av statlig forvaltning”(1986), the Bruntland coalitions’ “Den nye staten. Programm for fornyelse av statsforvaltning” (1987), and finally, the Bondevik coalition’s (Fra ord til handling” (2002) They state that these reforms were not advanced in a linear and coherent manner and that implementation was achieved based on pragmatism and consensus except for “Fra ord til handling” (2002) which more clearly emphasized elements of marketization and competitive deployment in the public sector. It is claimed here that the Stoltenberg coalition signaled skepticism towards NPM measures but as of 2008 had not yet devised a coherent alternative Christensen, Lægreid et al. (2009:157).

I have summarized the main points of NPM but at this stage it is premature to conclude whether the reform can be said to fall within the definition of NPM. I will come back to this in the analysis of findings.

3.3 Interpretations of the reform

3.3.1 Coordinated healthcare via technocratic management?

Stig Riise Pettersen has written a term project concerning the reform and has concluded that elements of the NPM model are implicit in the measures proposed in St.meld.nr.47. For him, “samhandling” or “coordination” *should* be a more of a “bottom-up” process where relevant actors are given leeway and autonomy in order to come up with solutions related to better coordination via consensus. This was his expectation prior to reading St.meld.nr.47 and based on his experiences from participating in a publically financed multi-disciplinary cooperative project between hospital organizations and municipalities. He was involved in the project from as early as 1998. I believe his personal experience, combined with the theoretical perspectives he uses, gives his observations some weight. In any event, he interprets the reform as opening up to marketization whilst supplementing this approach with increased state steering of the sector. Pettersen claims that actors such as general practitioners in the municipalities and doctors employed in the hospitals are sought to be steered via “evidence based medicine” guidelines geared toward a “standardized patient pathway” model.

He focuses on the use of a financial instrument briefly mentioned in NOU 2005:3 and finally proposed in St.meld.nr.47. The measure is known as “municipal co-financing” and Pettersen claims that municipalities are asked to act as “rational actors” because their new role requires them to make a cost/benefit analysis prior to purchasing or ordering services from the hospitals for their patients. Municipalities are to be responsible for financing approximately twenty percent of costs incurred while patients are under treatment at hospitals. He argues that treatment then becomes more of a commodity and that municipalities to an increasing extent are asked to behave as market actors, weighing up costs and benefits in decisions related to expected consequences their allocation of healthcare.

He links the marketization hypothesis to the authorities implicitly taking on an instrumental view of municipal organizations. He bases this claim on Christensen et al. (2009) who analyses organizational approaches as either being “institutional” or “instrumental”. The former approach can be further divided into a “cultural perspective”, based what has worked before and a “myth perspective”, based on what actions are deemed appropriate in any given organizational context. Pettersen believes that the instrumental approach dominates the way in which municipalities are viewed, at the expense of the institutional perspective which states that organizations’ own rules, norms and values determine what actions are eventually taken. The instrumental view is oriented toward consequences of the actions taken and tacitly assumes that organizations can be used as instruments that can be rationally steered by

authorities. As part of an NPM rationale, incentives geared toward self-interest are used in achieving coordination and steering collective decisions. The aforementioned “myth” perspective is relevant according to Pettersen in the way that politicians partake in today’s discourse, dominated by cost issues and the purported need for efficiency. Problems are formulated mainly in relation to cost but as Pettersen notes, this assertion is not related to any specific standard in St.meld.nr.47. He quotes statistics that indicate that in proportion to BNP, Norway scored an OECD average of 8,9 % in 2007 and over a ten year period, from 1997-2007, yearly increase was 2,4 % compared to an OECD average of 4,1% (p, 7).

To further substantiate his claims Pettersen outlines a historical view of the developments within the Norwegian health sector, based on Ole berg’s book, "Fra politikk til økonomikk (2006)". As the title implies, changes in recent decades can be interpreted in terms of a decrease in direct political involvement in the public sector, replaced by an orientation on the part of politicians toward using market mechanisms in order to regulate the public health sector. Historically, healthcare provision was part of a nation building enterprise, especially after the Second World War, with support from both right and left wing political parties. As the proportion of the population employed in public services grew to 61,9% in 1980, cost in the public sector in general, became the dominant factor to be addressed by politicians (Beg 2009:33). The “Hospital reform” is also mentioned as being NPM based as the nation’s hospitals were transformed from management organizations to being run as enterprises defined as autonomous legal subjects. These are run by professional boards, accountable to minister of health and owned by the Norwegian state. Market mechanisms were implemented based on a system known as “Diagnose related groups”, where a bulk of hospitals’ financing is allocated on the basis of what different kinds of treatment are expected to cost on average. There have been numerous criticisms of the unintended side effects of this incentive based system of “production”. Pettersen claims (p, 5) that arenas for discussing coordination issues were adversely affected by the Hospital reform.

Four recently enacted health laws have come under scrutiny, from among others also Berg. These are the “Patients’ rights law”, the “Specialist health law”, the “Personnel health law” and the “Mental health law”. Pettersen is somewhat categorical in labeling these four laws as market oriented. The patient health law is often linked in the literature to patients’ right to choosing which hospital they wish to receive treatment from (*Fritt sykehusvalg*). This law does introduce some ambiguity as patients’ rights can be viewed as collectively empowering

for citizens but they can also be viewed as transforming the patient role into a customer role. Pettersen, quite plausibly I might add, objects that the system of free choice of hospital should have been reconsidered or done away with under the latest reform, in the interests of improved coordination (p, 13). He also cites Berg (2006) who claims that the “Specialist health law” emphasized “integrated leadership” and had the effect of largely reducing the doctor’s role to carrying out a specialized industrialized treatment processes.

3.3.2 One more step in the direction of marketization?

I wish to briefly mention Germund Haga’s article concerning the coordination reform (Busch, Johnsen et al. 2011:319-333). His view is critical because he sees the Coordination reform as largely following on from the Hospital reform with regards to deploying market mechanisms for coordinating primary and secondary health organizations. He refers to Ringkjøb (2008) with regards to the increase of municipal services being reorganized according to business models in recent years, (Busch, Johnsen et al. 2011:325). The implication of this is according to the literature, reduced political steering, a claim that is backed by reference to the “Maktkommisjonen” (NOU, 2003:19). He sees the “Hospital reform” (state takeover) as setting a precedent in Norwegian health and the “Coordination reform” represents an inclusion of the municipal organizations into this market based system of coordination. The general trend in recent decades is understood as a reduction in hierarchies and a transition to market or network steering. He mentions the “Hospital Law” (Sykehusloven) from 1970 defining healthcare provision as a public responsibility with the hospitals being run by the county organizations. Jensen (2010:40) is quoted as stating that the 2002 reform significantly lessened the democratic public control that had become the norm from 1970. State ownership was justified on the basis that services could be allocated in a more secure and effective manner. As of 2002 the hospital organizations have been run according to a business model (foretaksmodel). Haga distinguishes between the “input” channels for public influence of the political system and how these become less effective channels of democratic control when the health sector becomes more oriented towards “output”. He is of the opinion that long term “health-plans” put together by the counties was not necessarily an ineffective means of coordinating the activities of primary and secondary health organizations (Busch, Johnsen et al. 2011:326). Haga asks how legitimate and effective coordination can be achieved when

hospitals orient their actions based primarily on budgetary concerns. He also notes that organizing the hospitals according to business models stimulates competition between hospital regions (p, 326).

As for the “Coordination reform” he also identifies “Municipal co-financing” as the key measure for coordinating health services. Municipalities are to be motivated to spend less on hospital referrals and more on nursing homes, preventative health measures at schools and recruiting general practitioners to the districts. Intermediary care centers are a sensible alternative, in principle. Much emphasis is placed on the principal of equality between municipalities and hospitals in the coordination reform but Haga believes this is unrealistic (p, 327), given vast differences in access to resources and qualified personnel. It is claimed in the documents that a number of patients take up place in hospitals because municipalities aren’t ready to take over care. This claim is contested by Haga, again with reference to Jensen (2010:64). Numbers indicate that as little as 4% of the patients in hospitals fall into this category. So why, given the low percentage, should one expect that public health costs will in fact be reduced?

Based on a case study of a cooperative project between Trondheim hospital and five municipalities, the issue of coordination without clearly defined hierarchical structures is discussed. The three relevant actors in this constellation are municipal authorities, hospital authorities and general practitioners (p, 328). These actors have to cooperate around financing and the daily running of a district medical center or “DMS” in Norwegian abbreviated form. The center has 16 beds, X-ray facilities and municipal health services where health preventative measures are integrated. This intermediary center serves a population of 33 000 citizens. The service production is organized as a mutually owned company and is located in a host-municipality (Steinkjer). Contractual agreements will have to establish agreements in relation to production of services and economic contributions which have to be incorporated into judicial guidelines (p, 329). Publicly appointed boards of representatives are required to negotiate the extent of involvement and influence for each municipality. Agreements with the central hospital with regards to referrals and discharges will likely prove to be more complex as a greater number of actors are drawn into the process.

In practice, coordinating activities in between a group of municipalities horizontally and with hospitals vertically will prove a challenge. This has to be done in a manner that proves to be

more economically rational without relinquishing the political control of local politicians. Lacking competencies in contractual specifications local authorities might have to resort to hiring in external consultants (p, 319).

While my thesis does not pertain to implementation issues I wished to briefly give an indication as to why the reform could be interpreted as a step towards marketization.

4 Background for the coordination reform

The second Bondevik coalition's health minister, Dagfinn Høybråten appointed the Wisløff committee to be tasked with analyzing coordination between primary and secondary health. The functional division between primary and secondary health was to serve as the starting point for assessing how patient treatment could be better coordinated. NOU 2005:3 represents the most comprehensive take on the issue of coordination, whilst the St.meld.nr.47 presents proposals to parliament for final ratification in 2009. The second document refers to a large extent back to NOU 2005:3 but there are some important deviations. The second document was presented under the second Stoltenberg coalition by the then health minister Bjarne Håkon Hansen. The major difference is the standpoint on municipal co-financing that had been considered as an option by the Wisløff committee before being rejected.

4.1 General Outline of NOU 2005:3

From the policy maker's perspective, the core of these coordination issues is the division in healthcare between the primary and secondary administrative levels. Larger, complex regional hospital organizations are tasked with coordinating healthcare provision with smaller municipalities located in thinly populated regions of the country. It is especially patients who have complicated or diffuse diagnoses related to mental illnesses, heart conditions, diabetes and cancer who encounter poorly coordinated care. The policy makers note that difficulties in supplying integrated medical services are also being faced by governments internationally and that the problem of coordination seems to characterize modern healthcare systems as such. Specialized healthcare tends to be difficult to purposefully integrate with primary healthcare and this affects the patient's "treatment pathway". The patient's next of kin are often burdened with trying to navigate through the system in order to ensure that the patient does receive the necessary healthcare services. Whilst the health services are divided into column like organizational units, patients' treatment paths cut across these horizontally. Part of the challenge is to raise awareness on the part of different actors and the reform proposes this be done by actors being asked to base their actions on the patient's perspective. Common awareness isn't enough though; involved actors require different organizational platforms in order to coordinate with each other. The solution is in large part the establishment of intermediary care centers located in the municipalities. Groups of municipalities have to then

agree upon issues of ownership and financing and the centers will then provide healthcare closer to patient's residencies, as an alternative to costly hospitalizations whenever possible. The new municipal role requires that municipalities take responsibility for strategic preventative health measures and are also asked to be more proactive in integrating the general practitioners so that they also contribute toward implementing individual plans.

The panel behind NOU 2005:3 is clear on one point; health services at the municipal level have to be utilized to a greater extent and employees in the specialized sector have to become more aware of both possibilities and hindrances that affect patient treatment after discharge from the hospitals. Especially preventative health measures should be focused on so as to hopefully prevent citizens from becoming unnecessarily debilitated due to ill health that their recovery prognoses are undermined. As I have already stated, the crux of the reform is coordinated care between the two organizational levels in the health sector. The authorities argue that resources can be more effectively used if the two levels in healthcare are able to interact in a manner that assists in providing integrated healthcare for the nation's patients. The panel points to the tendency of actors within the two respective organizations having a tendency to communicate poorly across organizational levels and this leads to less than optimal coordination of services. The general picture is one where communication is sometimes poor due to differences in expertise and culture and misunderstandings arise all too easily in many cases.

4.1.1 Proposed measures in NOU 2005:3

The patient's perspective; the panel emphasizes the need for different actors to see their contributions to treatment from the patient's perspective. Their actions in relation to both the patient and to others in the sector have to take into account the patients anticipated needs on the road to recovery.

Patient participation (Brukermedvirkning); Patients and their collective organizations are formally represented in the regional health organizations according to the (*Lov om spesialisthelsetjenesten*) §-35. The goal is to tailor service provision more accurately in

accordance of patient's needs. The wisløff panel suggests that patient involvement and representation in the workings of the sector are to be formally represented also at the municipal level (NOU 2005:3 s16). The panel cites earlier studies of organizations representing handicapped persons and the interactions they have with municipal authorities. The handicap organizations have complained that they sometimes included late in decision making stages; *“Disse rådene er i de fleste kommuner med i det demokratiske styringssystemet, men mange av rådene klager over at de kommer sent inni prosesser og fortsatt har vansker med å bli hørt (NOU 2005:3s67)*. Still, the concept of interacting in this manner seems to be endorsed by the panel behind NOU 2005:3. That is they are positive towards meetings between patients, politicians and service providers (NOU 2005:3 s67). They describe this as a means of closing the gap between the goals of healthcare provision and reality.

Individual plans; the right to individual plans for somatic patients is warranted by patient rights legislation (pasientrettighetsloven) enacted in July 1999, before the “Coordination-reform”. The right to individual treatment plans doesn't include all patients, irrespective of illness, as this isn't seen as a realistic objective (St.meld.nr.47..). It is especially patients that risk poor follow up that are targeted, such as elderly patients, those suffering from cancer, or patients with psychiatric disorders. Individual plans were intended to be an instrument for ensuring overall coordination for treatments and to assist cooperation by giving different actors a common reference point from which to work from. Also social services, labor services (Aetat), childcare services and the school sector are generally (by law) obligated to cooperate with each other in relation to health needs but the panel suggests that this could be more precisely specified in existing legislation. By harmonizing existing legislation relevant actors would have a clearer picture of what the expectations are in regards to individual plans. There has not been sufficient involvement from GP's in this kind of multi-disciplinary work as noted in NOU 2005:3 although more specific reasons are only speculated on. Also private actors such as physiotherapists should be obliged to participate and this requires more specification in the existing legal framework. Surveys done two years later gave the impression that work was being done on individual plans. Over time the authorities realized that work hadn't progressed appropriately, despite detailed information being distributed nationally (NOU 2005:3s75). The panel suggests that the municipalities are in a better

position to draw up individual plans for patients with complex needs and those actors in specialized healthcare are obligated to contribute.

Pasientansvarlig lege; (Primary responsible doctor); ideally, each Norwegian patient would have a single doctor who oversaw their treatment. The panel proposes that this general measure be done away with and only patients who clearly can be categorized as needing specialized health services over prolonged periods of time should be prioritized.

Pasientopplæring; (*Læring og mestring senter*); it is proposed that centers that train patients to cope with long term disabilities receive increased financing and that this service should be included in the bill of patient rights (*pasientrettighetsloven*) as an individual right. These training centers would be suitable arenas for patient organizations as well as personnel from the both primary and secondary care to cooperate over follow-up treatment in order to optimize recovery processes.

Pasientombud; These organizations did not at the time of writing have a mandate to receive feedback or complaints related to municipal or social services but were restricted to handling cases within specialized treatment. The policy makers proposed that this mandate should be expanded.

Measures aimed at general practitioner's contributions to interactions; the panel's assessment is that the general practitioner-scheme (*fastlegeordningen*) didn't entirely strengthen public health in the manner that it was intended to, partially owing to a lack of willingness on the part of doctors. Also, municipalities haven't taken enough initiative in developing public primary care work where doctors are to have a key role (NOU 2005:3 s18). In 2001 citizens in Norway were granted the right to a primary GP. Gp's were to be allocated fixed lists of patients who would be prioritized in consultations. The primary GP was to be responsible in coordinating their patient's needs for other health services. Doctors were encouraged to partake in interdisciplinary work in order to integrate health provision further. In addition the aim of the reform was to involve GP's in public health measures, especially in contributing to care of elderly patients in nursing homes (*sykehjem*). In principle the doctors are obligated to 7, 5 hours public service per week but the panel observes that many municipalities haven't enforced this measure. There is also evidence that GP's for various reasons have not participated in interdisciplinary activities to the extent that the authorities had hoped. The panel also proposes adjustments in the payment of GP's in such a way that

doctors will have incentives to treat and contribute to work around patients with long term needs. The payment structure should provide less of an incentive for doctors to treat as many patients as possible. The panel has noted that the number of consultations did go up after the GP-scheme was implemented but the average consultation time decreased. The panel reasons that this would unlikely benefit patients with long term needs, namely those patient groups that the reform addresses. The length of their lists should factor in less than the age of the patients they treat. In general there should be more clarity in what is required of doctors with respect to contributing to public health, over and above their daily routines.

Formal agreements between health enterprises and municipalities; the panel proposes that the two parts enter contractual agreements with each other as to how they are to initiate coordination in the future. This is especially because changes at one organizational level will likely affect the other.

Rehabilitation; Task division between primary and secondary healthcare needs to be agreed upon and coordinated since rehabilitation of patients especially requires good coordination and effective interactions at the organizational level.

One locality for coordinating between enterprises and municipalities; There should be an easily identifiable locality for coordinating functions between involved actors. Patients who receive healthcare should be able to easily locate the instances responsible for health services from both primary and secondary care.

Leadership; there should be an awareness of the bigger picture on the part of leaders of different organizations. They should be especially aware of the relationship between the services they provide and what others provide to treatment processes.

Electronic information; The panel points to the legal requirements of personal privacy and states that this must be weighed up against the concerns of effective information transfer between different actors in healthcare provision.

Education; the panel admits that there is little knowledge about interactions in the public domain and that there is a need for research on methods and principles that would facilitate better coordination and integration between organizations. This is said to be crucial in order to achieve long term goals in the sector, especially in relation to vulnerable groups such as psychiatric patients and mental health services in general. The issue of interactions between

the different actors and how they impact on patient treatment should be included in the education of health workers. This might contribute to a collective sense of solidarity and unity between different professions so that they become more aware of what they share in common. The panel also suggests that medical specialists should have experience in ambulatory healthcare, so as to get a perspective on the breadth of challenges to healthcare provision. Such experience should be mandatory training for specialist in the fields of geriatrics, psychiatry and somatic health. In addition personnel should for shorter periods be encouraged to get work experience with other organizations that their respective organizations interact with (hospitaring), so as to get a participant's perspective on the challenges facing others. This would likely improve relations and attitudes towards complementary organizations. Hospital doctors can also be encouraged to participate in practice consultant schemes in the municipalities so as to broaden their experience of the sector.

Reimbursement system; the panel cites cases where patients treatment is divided into several consultations, which means that in extreme cases they have to travel to and from the hospital several times. The current reimbursement system seems to encourage fragmented treatment because the hospital fees are constituted of specialist fees, deductibles (egenandel) and fees for the consultations themselves. It is sometimes easier for the hospital to split up consultations because of the payment system than to organize consultations in one day, which would require greater coordination in the hospital's booking system.

Medical fees; Hospital enterprises are responsible for financing medicines for patients whilst the municipalities are responsible for the patients in their institutions. Non institutionalized patients can apply for medical coverage via national social insurance (folketrygden). Problems arise when hospitals cannot discharge (especially elderly) patients from their care in cases where the municipalities do not have the necessary medicines. Also, it is recognized that nursing homes discharge their patients to daycare facilities (who's medical bells are covered by national insurance), or municipalities redefine nursing homes as daycare facilities in order to cut down on costs. Medicine used in chemotherapy treatment is costly and this affects especially the elderly patients. The panel weighs up the pros and cons of legislation requiring that national social insurance should also cover medical expenses for patients in municipal institutions. They then argue that this would provide little incentive for the municipalities to curb medical costs. The alternative would be for the hospitals to be held jointly responsible

for medical cost in municipal institutions. This would provide an incentive for greater involvement between the hospitals and the municipal institutions.

Guidance duty (Veiledningsplikten); the specialist health legislation (lov om spesialisthelsetjenesten) §-6 obligates employees in health enterprises to give guidance to actors in municipal health in relation to all aspects related to patient treatment so that they can fulfill their duties in accordance with health legislation. This applies equally to individual treatment cases as well as general routines for healthcare. Municipal employees can apply for guidance from those working in state funded institutions as well as doctors and psychologists that receive some of their funding from the state. These requests cannot be denied by state funded agents by citing budgetary limits or workforce constraints. This is meant to enhance cooperation across organizational divides as well as contribute to delivering integrated health services to the public. Municipal workers believe that specialists don't always appreciate the situational contexts under which they carry out their work, both the possibilities and the hindrances they face. The panel sees a potential for collective learning here. In principle the guidance measures are mutual between primary and secondary health but the expectation is that specialists take the initiative to organize courses for municipal employees.

Financial measures; the panel believes it is appropriate for each regional health enterprise and its respective municipalities to come to agreement on financing arrangement in accordance with local variations and needs. In general it is believed that a reduction in unit-price share (stykkeprisandelen) in hospital funding would enhance cooperation. Also third part financing via social insurance (folketrygden) doesn't contribute to fiscal awareness and responsibility. Ideally the municipalities should purchase services from the hospitals and from actor's offering their services in the municipalities, more in accordance with the provider/purchaser model.

Emergency services (Interkommunal legevaktjeneste); the panel approves of existing practices where municipalities cooperate in relation to ER services. Such cooperation eases the workload on individual GP's and should make it easier to recruit new GP's to the municipalities. The details of financing are somewhat vague but the panel concludes that the state should reimburse ER duty so that the municipalities don't end up paying more for such cooperative measures.

Fritt sykehusvalg (The right to receive treatment at a hospital of one's choice); the panel insists that this aspect of “patient’s rights” should be upheld. They acknowledge that this might complicate the general practitioner’s role as coordinator of her patients, should some of the patients on the list opt for treatment in other parts of the country. Likewise, hospitals can expect to receive referrals for patients from areas outside of their normal “up-take region”. This greatly expands the potential number of actors that will have to cooperate around patients.

Municipal joint financing; Here the panel discusses the pros and cons of enforcing a percentage of hospital costs per patient to be financed by the municipalities where patients are registered. Here it is quite clear that the measure is imposed externally on municipalities so that they are encouraged to invest in primary care instead of relying too much on hospital services (121). The measure is also meant to foster cooperative behavior, or at least coordinated actions between hospital organizations and primary care actors as well as a reduction in overall referral rates into the hospitals. There are costs related to the average number of days that patients spend in hospitals and reducing this average would save on overall healthcare expenditure, especially if it can be shown that a significant amount of hospitalization can be causally linked to inadequate care capacity in the municipalities. The panel ultimately opts against this measure as it might lead to a situation where hospitals in turn become too reliant on municipal financing because there isn’t sufficient incentive to discharge patients to their home municipalities. The strongest argument against using an economical instrument is that hospitalizations and subsequent patient discharges are not controlled by municipalities so that they risk financing services over which they have little control;

4.1.2 St.meld.nr.47

I have drawn on the English translation in order to outline the second document. I have used the Norwegian version as a source of empirical data. The reform aims to locate the growth of the health sector in the municipalities. Preventative healthcare measures are emphasized, medical practitioners are to contribute more towards public duties and hospitals are to be unburdened of treatment procedures that can be taken care of in municipalities. The document

states that specialist health should consolidate on its specialist functions and the new municipal role will facilitate this.

The first challenge that characterizes the healthcare services is the division into different organizational units that each tackles only partial aspects related to health. Specialist organizations focus on curative measures whereas municipal organizations understand health in relation to coping and functioning with illness. Patients' rights, healthcare funding and ICT are provided by separate systems and there is a lack of cohesion between them. There is a perceived need for yet another system devoted toward coordinating the objectives of the others.

- 1) The second challenge is that too little emphasis has thus far been placed on prevention of ill health. Services should orient themselves more toward limiting the development of chronic disease in their respective population at large.
- 2) The third challenge facing the welfare model is the growing number of elderly citizens in the population as well as the kinds of illnesses affecting the population today. Sickesses related to heart conditions, cancer, dementia, diabetes and mental health ailments are said to be rising sharply. Common to these illnesses is their diffuse complex nature making diagnosis more difficult and the effects on lifestyle debilitating. There is a concern on how this affects the workforce of the future and what repercussions this will entail for pension payments in the future.

These three major challenges to collective healthcare provision are sought remedies by five measures. They are characterized in the English translation as partially structural and partially related to framework conditions. I interpret framework conditions as applying to how primary care doctors conduct their practices as framework is linked with professional cooperation with the authority's political ambitions for the sector.

A clearer patient role; Patient participation had been limited to the individual services. Patient participation should expand so that their collective organizations can contribute towards more encompassing structural changes that would enhance cohesive treatment. "Patient pathways" as an analytical perspective had been mentioned a number of times in NOU 2005:3 and a search revealed that it appeared 37 times in that document. In St.meld.nr.47, "pasientforløp" appears 92 times. "Patient pathways" is to serve as the common reference point for relevant

actors in the future. Municipalities are to be responsible for assigning one contact person for patients with long term needs for treatment.

New municipal role; the growth of the health sector is to occur in the municipalities. The new role requires earlier intervention targeting vulnerable patient groups and the municipal organizations are asked to view healthcare in relation to society's needs. This applies especially to patients at risk of exclusion from the workforce.

Binding system of agreements must be established between cooperating municipalities and between municipalities and specialist health organizations in each region. The agreements should specify task distribution and cooperation and should be legally binding.

The binding system of agreements should also specify how "outpatient" treatment is to be decentralized to the municipalities. Issues such as knowledge transfer, use of medical internships and the use of general practitioners should be further specified.

Agreements should also include how civil society and non-governmental organizations can be incorporated into municipal healthcare.

Reinforcing preventative healthcare

This includes measures that can reduce the risk for illness and long term disability in the population. Municipalities should receive guidance as to which measures are cost effective from a socio economic viewpoint. An information system for use of specialized healthcare in the municipalities will be established on the initiative of the ministry of health.

Better medical services in the municipalities

Primary care doctors or general practitioners are to be more stringently managed so that they contribute more towards public health. The municipalities are to take on this managerial role. Legal provisions should enable municipalities to ensure that general practitioners cooperate with other relevant actors around treatment of their patients. The pricing system for general practitioners should be revised as a means of ensuring that their activities are in accordance with political health priorities. Their practices are to be aligned with the political prioritizing of vulnerable groups requiring sustained care. The number of hours that doctors can be required to devote towards public health is advised to be increased. More research is to be

done on the practices of general practitioners. Regulations pertaining to “quality and function requirements” concerning medical practice should be reviewed.

Financial measures, Municipal co-financing as well as full municipal financing for patients who are ready for discharge, are the key financial measures to be enacted. These new parameters will motivate the municipalities to consider which options are most effective for healthcare provision. Activity based financing will be reduced from 40-30% in accordance with national healthcare prioritizing. Further specifications are required in order to avoid putting smaller municipalities at financial risk. Municipalities cooperating with each other need to have sufficiently large populations in order for the model to work. The flow of funds between municipalities and hospital organizations has to be worked out.

Enabling the specialist healthcare sector to apply their specialized competence

If the municipalities fulfill their role then specialized health services should be freed up to focus more on their specialized functions. Administrative systems should be established for curbing rising costs in the sector. These administrative systems should be integrated with the ministry of health at the top, down to regional health authorities and individual health authorities. Specialist health services should contribute to building up competence in the municipalities.

Facilitating more defined priorities for the sector

There is a lack of cohesion between authorities as to how healthcare issues should be prioritized in the future. The system of decision making is not sufficiently coordinated and it is proposed that the national health plan (2007) should be used as a tool for focusing on cohesive patient pathways instead of a partial focus on individual services.

5 Findings from the documents

In presenting excerpts from the documents relevant to each of the documents, I have structured the analysis by continually arguing for the interpretations and their relevance to coordination. In ensuring rigor I have included excerpts that don't fit into any particular interpretation in order to avoid being merely anecdotal or biased in the presentation.

5.1.1 Habermas and societal integration

This chapter presents findings in the documents relevant to the question;
“Can coordination be understood in terms of communicative action?”

The concept of communicative action might be relevant to this reform because democratically elected government administrations face problems inherent in the use of hierarchies and authority, as mechanisms of coordination and control. The panel behind NOU 2005:3 notes that patients, individually and as a group, are increasingly challenging the existing the traditional “sick role” as well as expertise within the sector;

“Den nye pasientrollen i vestlig medisin har utviklet seg fra å være passiv og autoritetstro til å bli langt mer aktivt medvirkende og bevisst. Parallelt med dette har pasientene fått definerte rettigheter. I tillegg har det vokst fram sterke brukerbevegelser. Disse pasientorganisasjonene har fått innflytelse gjennom formell representasjon i offentlige råd og utvalg. I tillegg utøver disse organisasjonene betydelig påvirkning gjennom den offentlige debatt (NOU 2005:3 s49).”

According to my own understanding of Habermas' theory, channeling communicative action into communicative power via the legislative process could ensure coordination between the imperatives of the economy with the political ambitions for the health sector (integrated care). The rationality inherent in coordinating the systemic sub systems of politics and the economy with the actors' lifeworld lies in the deliberations between actors oriented to coming to understanding with each other at the municipal level. The healthcare apparatus as a whole doesn't fully “know” what kinds of everyday burdens citizens encounter and that impact on their health and well-being. Neither do actors necessarily have a conscious or good

understanding of the social, environmental and economic factors affecting their health individually, that is, not until they are included in appropriate arenas in civil society where communication is open, unconstrained by issues of power and where individuals can come to see what commonalities they share with others. Public discussions about common issues should not be too closely tied to actual decision making. The public discussions are the starting point for organized “will formation” and can be channeled or “operationalized” into legal codes via legislative procedure and thereby be “understood” by the political and especially the economic system. Coordination should be mobilized at the grassroots level because hospital organizations cannot be expected to possess information concerning the patient’s lifeworld to the same extent that smaller municipal administrations are. The solution would be broadly speaking, to extend the depth and reach of democratic processes, down to the municipal level. One could improve the quality of the health services by improving the extent of inclusion of all relevant actors, while at the same time taking into the account the need for national steering mechanisms such as municipal co-financing. The principles of discourse ethics emphasizes the principle of inclusion in decision making and requires that all actors such as patients being affected by the actions of public workers would have an reasonable chance to influence the course of their treatment. In NOU 2005:3, the intention seemed quite obviously, to include all actors who in some way affect or are affected by the patient’s health issues, coordination is in this document defined as follows;

Med ”samhandling i helsetjenesten” mener utvalget aktivt samarbeid og handlinger mellom alle som direkte eller indirekte er involvert i pasientbehandlingen. Samhandlingen vil kunne gjelde pasienter, pårørende, pasient og brukerorganisasjoner, tjenesteutøvere i ulike deler av hjelpeapparatet, interesseorganisasjoner, besluttede myndigheter, ombudsordninger, kontrollmyndigheter og klageinstanser. I tillegg kan ulike fagmyndigheter og fagmiljøer, utdanningsinstitusjoner og forskningsmiljøer være viktige premissleverandører for hvorledes det samhandles mellom disse. Det samme kan blant annet media være (NOU 2005:3 s13).

It seems that “coordination” is understood to be a group activity or process and medical and academic institutions are encouraged to have their say in how coordination is to be achieved. The concept is thus relatively open but the emphasis in this definition seems to be based on a principle of inclusion of relevant actors. In NOU 2005:3 the panel claims that no single actor has all the answers concerning coordinating care;

“Helsetjenesten må bygge på at aktørene har gjensidig respekt og tillit til hverandre. Dette må

gjelde mellom kommuner og foretak, og mellom tjenesteytere på tvers av fagkompetanse og erfaring. Spesialiseringen og kunnskapsutviklingen i helsetjenesten betyr at stadig flere yrkesgrupper og spesialister må yte sine delbidrag inn i en helhet. Det er ingen yrkesgruppe som har spesialkompetanse på helheten. Forutsetningen for god samhandling er at de ulike aktørene har en faglig kompetanse å bringe inn i samhandlingen og at denne kompetansen blir anerkjent. Likeverdighetstekningen må være utgangspunktet for samarbeid på alle nivå i helsetjenesten (NOU 2005:3 s15).

Generally one gets the impression that coordination is to be achieved by improving the quality of the communication between relevant actors and that it is seen as crucial that they be brought together in order to agree upon an overarching perspective;

Samhandling og kommunikasjon forutsetter to likeverdige parter med felles interesser. Det forutsetter felles arenaer der partene kan møtes, interesse for hvilke problemer den annen part har, og vilje til felles løsninger. Graden av samhandling mellom tjenestenivåene er en viktig kvalitetsindikator”(NOU 2005:3 s90).

Note that in the above excerpt, “coordination” is distinguished from “communication”. Actors are asked to contribute towards coordination in a process where the principles of trust, respect, and recognition of other alternative viewpoints is required. Also issues pertaining to unequal distribution of power in the relationship between healthcare employees and patients are addressed;

I et større perspektiv har det skjedd viktige positive endringer. En demokratisering og brukerorientering i helsetjenesten har ført til at forholdet mellom tjenesteyter og pasient i større grad er basert på samarbeid, medbestemmelse og medansvar. Pasientrettighetsloven slår fast at det skal være et samspill mellom pasient og tjenesteyter i behandlingen. Regelverket er et utslag av en erkjennelse av at samarbeid mellom helsevesenet og pasienten er viktig for å oppnå god effekt av helsehjelpen, jf. Ot. prp nr. 12 (1998/1999) (NOU2005:3s67)”.

The political aspect of healthcare provision is again mentioned in the following;

I et demokratisk perspektiv må det også sees på som en rettighet at vi som borgere kan øve innflytelse på beslutningssystemene (NOU 2005:3 s15).

It is significant to note that actors are expressly asked to take on the patients’ perspective or the “generalized other”, in their encounters with patients;

Alle som arbeider i helsetjenesten har en plikt til å legge pasientperspektivet til grunn for sine handlinger. Dette innebærer også en plikt til å se utover egne faglige rammer og forsøke å se pasientens helhetlige situasjon. Det er utvalgets oppfatning at mye manglende samhandling skyldes manglende oppmerksomhet på helheten. Pasientperspektivet skal ikke bare ligge til grunn for de som yter tjenester direkte til pasientene. Også tilretteleggere og planleggere av helsetjenestene på ulike nivå må arbeide med dette som utgangspunkt (NOU 2005:3 s16).

Taking on the patients' perspective involves face to face encounters between patients and various actors in the sector but also in the planning processes directed towards the health services in the future. St.meld.nr.47 also places some emphasis on the importance of political involvement in the sector and the need for input from patients;

“Likeens vil prioriterings- og verdispørsmål, som etter sin art bør avklares på politisk nivå, stå sentralt i arbeidet med pasientforløp. Sentralt i arbeidet med samhandlingsreformen vil være å utvikle prosesser som legger bedre til rette for medvirkning fra alle berørte aktører slik at det i større grad enn i dag utvikles felles forståelse om hva som er gode pasientforløp, og hva dette medfører av krav til samarbeid mellom aktørene (St.meld.nr.47:25).”

The link between the concerns of the citizenry and the political system is often repeated and is said to take precedence over and above economic concerns;

Politiske prioriteringer skal knyttes til helhetlige pasientbehov og ikke til delbehov som gjør seg gjeldende innenfor de ulike ansvarsområdene (St.meld.nr.47 s25).

5.1.2 Patient participation input or output?

As far as I can ascertain from reading the documents, patient participation seems to mean direct feedback on healthcare services and not a comprehensive deliberative process in broader civil society. In the following excerpt the documents claim on behalf of patients;

Fra pasientens ståsted er det viktigste at det ytes god hjelp, ikke hvem som gir hjelpen, hvor vedkommende er ansatt eller hvilken tjeneste eller nivå som er ansvarlig. I utgangspunktet er det heller ikke interessant for pasienten å vite om noen har samhandlet, bare resultatet er bra (NOU 2005:3 p67).

This is a reasonable assumption in cases where citizens are in dire need of medical assistance. But citizens might wish to discuss the organization of health services in a more

comprehensive way. The above statement assumes that while coordination issues are important, citizens will not typically have an interest in these before illness episodes.

Christopher Pollitt is referred to in Christensen, Læg Reid et al. (2009:136) concerning public management. He created a typology of ways in which citizen interactions with public organizations can be organized. The level of intensity of interactions between citizens and public can vary. Starting at the low end of the scale where citizens take on a consumerist role, communication can be one-way, from organizations to citizens. A market model of organizing public relations would rely mostly on distributing information to actors with preferences. “Consultation” implies greater intensity and is operationalized via citizen polls or focus groups. The third category of interactions is closer to a “deliberative model” of communication and is known in Norwegian as “medbestemmelse basert styring” or active citizen participation. Interactions between public organizations and citizens are seen as a supplement to parliamentary channels of influence via periodic elections. Public organizations can use the feedback to improve services, galvanize public support on policy decisions and increase the legitimacy of public organizations (p, 136);

Brukermedvirkning på systemnivå skal også gi myndighetene mulighet til å kvalitetssikre sin virksomhet ved å få tilført kunnskap om hvordan brukerne opplever dagens situasjon eller tilbud (NOU 2005:3 s70).

“Medvirkning” also implies patient’s “informed” contribution and is linked in NOU 2005:3 on page 68 to the need for realistic information about services. They state that existing information has been available to researchers but should ideally be rendered more assessable to the wider public. Patient influence is also linked to offering individually modified services, based on specific individual needs and as a means of avoiding costly “over treatment”.

In NOU 2005:3, “medbestemmelse” is linked to increased democratization of the health services where “clients” or “brukere” are included in decisions affecting services in an excerpt that is already referred to on page 67;

En demokratisering og brukerorientering i helsetjenesten har ført til at forholdet mellom tjenesteyter og pasient i større grad er basert på samarbeid, medbestemmelse og medansvar.

In St.melding.nr.47, “medbestemmelse” appears on two occasions in the documents;

Et vesentlig element i integritetskravet er også individets rett til medbestemmelse og medvirkning. Det vil si at tjenestemottaker opplever å få innvirkning på tjenestetilbudet (51).

The above excerpt was found under the chapter concerning the patient's role and relation to health services (5.3 *Pasientens rolle i helse- og omsorgstjenesten – forholdet til medvirkning*). The chapter begins with reiterating the collective goals of healthcare provision to citizens in all parts of the country, irrespective of age, sex or ethnicity. The need for an all-encompassing perspective is emphasized in relation to patients with needs for coordinated care, needs that no single institution or administrative level can satisfy alone. Active participation is linked to the individual's sense of integrity and the need for services to view patients with a "helhetlig menneskesyn" or from a social perspective;

Perspektivet innebærer at det er den enkelte tjenestemottakers behov for hjelp som settes i sentrum. Det krever at tjenestene er lett tilgjengelige, helhetlige og sammenhengende og tilpasset tjenestemottakers individuelle behov, ønsker, levesett og evner. Det krever også at den enkelte gis et realistisk bilde av hjelpen som gis, blir hørt og får medvirke i gjennomføringen (51).

5.1.3 Cohesive patient pathways

Riise Pettersen claimed in his article that evidence "based medicine" and the use of "clinical guidelines" in specialist healthcare would largely determine the nature of patient treatment in the future (p, 16). He linked evidence based medicine to authors who see the use of evidence based medicine as part and parcel of NPM practices and standardization of medical practice. I found no mention of "evidensbasert medisin" in the documents but I did find evidence of planned quality controls targeting GP practice in the municipalities. In St.meld.nr.47, (p, 94) the need for data on GP practices was required in order for municipalities to be in a better position to steer them.

In the chapter on patient pathways in St.meld.nr.47; "5.2.1 *Arbeid med pasientforløp*" mention is made of a project initiated for discussing problem areas related to coordinated treatment. Included were actors from the Health department, municipalities, hospitals as well as employee organizations. They state that projects such as this are a supplement and not a replacement to work done on pathways by the health directorate or established methods used in hospitals. They point out that time and resource issues placed constraints on the project and

that not all actors agreed with the outcomes and conclusions (St.meld.nr.47, p51). Full consensus was not achieved but the initiative can be seen as the start of a process;

Det gir en vesentlig styrke at representanter fra de ulike aktørgruppene «setter seg rundt samme bord» og utvikler en felles og overordnet forståelse av dagens praktiske situasjon. En god forståelse av i hvilken grad det foreligger systemsvikt som gir åpenbare avvik i forhold til en målsetting om helhetlige pasientforløp, er en del av dette (St.meld.nr.47 p51).

They state explicitly that the goal of such a project is “common understanding and that the process itself is just as valuable as the outcome;

Et sentralt poeng med å arbeide med pasientforløp er at de ulike deltagende aktørene kan gå tilbake til sine livs-, ansvars- eller driftsposisjoner og ha med seg bedre forståelse av andre aktørgruppers erfaringer og synspunkter. Verdien av aktiviteten ligger både i selve prosessen og i eventuelle felles dokumenter som lages (St.meld.nr.47 p51).

There is an admission that the discussions were undertaken under short time frames and not all participants were willing to subscribe to the conclusions that they had come to. Also relevant to a Habermas reading is that inclusion of regular citizens outside of the health services is not mentioned. The process did not yield optimal results but the health department considered this way of discussing coordination as the start of a process which they believe worthwhile continuing;

Helse- og omsorgsdepartementet mener at arbeidet har gitt viktige impulser til arbeidet med samhandling, men fra departementets side er det også viktig at arbeidet sees på som starten på en prosess, der også det videre arbeidet på de enkelte områdene forutsettes å kunne ta opp i seg nødvendige utdypinger og kvalitetssikringer (p51).

5.1.4 The use of normative instruments

From a Habermasian perspective one would pay attention to how the legal system is used to regulate society and to stabilize expectations. It is at this juncture that the policy documents seem to be somewhat at a loss in a theoretical sense. Although there isn't specific legislation concerning coordination in the sector, previously enacted legislation implied integrated care, steering actors toward cooperative/collaborative efforts. Measures such as “individual plans” were intended as instruments for coordinated care. Also, the GP reform (*Fastlegereformen*)

was meant to ensure better health surveillance by allocating fixed patient-lists which would ideally cut down on waiting cues for consultation and less pressure on ER (*Legevakta*).

Det finnes imidlertid en del enkeltstående bestemmelser om plikt til samhandling i de ulike tjenestelovene. For eksempel inneholder mange av lovene bestemmelser om individuell plan for visse grupper tjenestemottakere. Andre eksempler er spesialisthelsetjenestens bestemmelser om pasientansvarlig lege og om spesialisthelsetjenestens veiledningsplikt overfor kommunehelsetjenesten. I kommunehelsetjenesteloven er kommunehelsetjenesten generelt pålagt å samarbeide for å yte enhetlige helsetjenester og spesielt pålagt å samarbeide med sosialtjenesten (St.meld.nr.47 p52).

This doesn't appear to have been sufficient since the goal of well-functioning and integrated care still hasn't materialized, based on feedback from the public. The use of legislation is discussed,

Disse lovbestemmelsene kan ikke ha bidratt til å fremme samhandling i tilstrekkelig grad i og med at det er konstatert at manglende samhandling er et problem i dag. Hvis man skal bruke lovgivning som styringsvirkemiddel på en effektiv måte, er det behov for kunnskap om hvilke betingelser som må være oppfylt for at de ønskede virkninger skal oppnås (p, 52).

The author(s) of St.meld.nr.47 admit that there isn't at present requisite knowledge concerning the effects of legal instruments on society;

Det er for liten tradisjon for å evaluere lovgivning og dermed vanskelig å finne systematisk underbygget kunnskap om i hvilke tilfeller lov fungerer godt som styringsvirkemiddel innenfor de ulike samfunnsområdene (St.meld.nr.47 s 52).

One last observation in the documents that runs counter to a Habermasian interpretation follows,

Hovedutfordringene er knyttet både til et pasientperspektiv og et samfunnsøkonomisk perspektiv (St.meld.nr.47:13).

For Habermas society can be observed from an abstract theoretical position as well as from the participant perspective, the above excerpt indicates that policy makers emphasize the patient's perspective and the economic perspective and not the all-encompassing societal perspective.

5.1.5 Conclusion

In conclusion, there are undeniably many instances in the documents where actors are expected to take an “other” perspective in their dealings with each other. This applies not only in face to face contexts but also for those responsible for planning of future health services. Clearly, dialogue and equality are emphasized in arenas where actors meet together around “the same table”. With regards to negotiations around providing cohesive patient pathways, the documents refer to arenas where this was discussed and consensus was sought achieved. Even though full consensus was not achieved, the process of bringing relevant actors together for discussing and negotiating issues related to coordination was considered valuable in and of itself. But the deliberations on providing cohesive patient pathways only included members of the health sector and there is no mention of broader public participation. If one pays attention to what is said of legislation, it is clear that normative measures don’t seem to have been effective in ensuring coordination overall. They admit that there isn’t any tradition in Norway for evaluating the use of laws. There is no evidence of reflection over translating citizen input into legal coding as a means of integration.

6 Findings from the rational choice perspective

In this chapter I present data that I have produced by a deductive reading of the documents in order to answer the question;

“Can the implicit social theory behind the concept of “coordination” be identified as rational choice?”

To start with I will look at how incentive measures are discussed in the documents and I will pay attention as to whether rational cooperation is encouraged or whether competition is implied as the mechanism of coordination.

6.1.1 Getting the incentives right?

One telling characteristic of both NOU 2005:3 and St.meld.nr.47 is the number of times “incentives” are mentioned in the documents. Christensen, Læg Reid et al. (2009) state that recent reforms in Norway have generally been characterized by an “incentive mentality” based on an expectation that organizations and employees will often act in ways that serve their own interests. Self-interested behavior is countered by the use of punishment and reward systems (Christensen, Læg Reid et al. 2009:188). Eriksen (2001) also mentions the “incentive model” which he understands to be a component of an “efficiency discourse” based on understandings of what motivates individual behavior and how actions can be steered via punishments and rewards (Eriksen 2001:214). I focus on incentives because it might indicate rational choice assumptions that are made about the relevant actors in the sector. I will briefly mention the places in the first document where incentives are mentioned and what issues they are linked to. I wish to go into more detail on some of these points later on in the analysis, especially with regards to general practitioner’s salaries, financing of medicines across organizational divides and municipal co-financing. In NOU 2005:3, incentives are mentioned in relation to;

1) In (NOU 2005:3 s12) a model for coordinating emergency medical centers (*legevakta*) is proposed. A host municipality would share this facility with nearby municipalities and economic incentives are mentioned as a means of making this an attractive solution.

2) To increase “activities” in the sector in a cost-effective manner;

“Utvalget mener at helsetjenesten trenger økonomiske insentiver som stimulerer til høy aktivitet og effektiv tjenesteproduksjon...”(NOU 2005 p, 20).

3) Economic incentives are discussed in relation to medical practice in municipality with a view to aligning medical practice with political goals.

4) “Negative” incentives are discussed on page 117 in relation to patient’s consultations at hospitals. The funding system at the time had created incentives for hospitals to divide consultations up unnecessarily.

5) Incentives are discussed on page 121 in relation to municipal co-financing as a national strategy in order to give municipalities incentives to cut down on unnecessary hospital referrals.

6) Incentives are mentioned on page 124 where the policy makers propose that hospitals be tasked with financing a part the costs of medicines in municipal care institutions. Giving hospitals this responsibility is supposed to give them incentives to cooperate on patient discharges with municipal facilities;

7) Earmarked grants for activities related to coordination on page 131.

8) The system of Unit price payment for hospitals where state funding is based on the number of referrals.

In NOU 2005:3 incentives are mentioned either as a means of correcting negative externalities or as a means of rewarding or compensating coordination activities that do not in themselves lead to direct rewards for involved actors. Examples of an unintended negative externality that affect patients are instances where patient's consultations are divided up so that the hospital gets extra reimbursement;

Det er i dag økonomiske insentiver som innebærer at det som er mest lønnsomt for sykehuset, kan være mest besværlig for pasienten; nemlig gjentatte besøk. Et eksempel er at pasientene i dag ikke betaler mer enn én egenandel hvis de besøker to sykehuspoliklinikker for samme lidelse samme dag. Poliklinikkene kan da fristes til å sette opp undersøkelsene på to ulike dager. I tillegg til økte inntekter betyr dette at man slipper å koordinere timene og unngår diskusjon om hvilken av spesialistavdelingene egenandelen skal tilfalle (NOU 2005:3 s117).

Earmarked grants (point 7) can perhaps be understood better as compensatory, based on an assumption that actors will be motivated to cooperate on coordination issues if the costs do not outweigh the benefits. Incentive components are also used in structuring general practitioners salaries in order to influence their behavior. The belief in the "correct" use of incentives is implied in the following passage;

Selv om det i litteraturen er stor grad av enighet om effekter av ulike avlønningskomponenter på legenes adferd², er det lite kunnskap om hva som er den "riktige" fordelingen (NOU 2005:3 s78).

In NOU 2005:3 the policy makers seem aware of possible negative effects of incentives on coordination in general;

Spesielt framheves at det er en fare for at systemet med innsatsstyrt finansiering over tid påvirker både private og offentlig eide sykehus til å ha mindre fokus på samhandling (NOU 2005:3 s113).

Activity based financing is mentioned in the documents as an important component in the funding of the nations' hospitals. ABF is an incentive based model based on the average cost of Diagnosis Related Groups (DRG). The instrument encourages hospitals to increase the number of patients and thereby lessen patient queues. Funding via block grants didn't seem to be effective in getting patients through the specialized healthcare system fast enough in order to avoid queues. St.meld.nr.47 states that activity based financing will be reduced as a component of specialist healthcare funding from 40 to 30 percent. It is interesting to read the justification for this in rational choice terms. The argument is that ABF –financing is based on the number of referrals and not the amount of days spent in hospital for each patient. This would ideally give the hospitals an incentive to discharge patients at an optimal rate for further rehabilitation or follow up in the municipalities. But this system has a downside in that there is little incentive for hospitals to reduce “emergency” or “øyeblikkelig-hjelp” referrals. Many of the “ER” referrals are deemed unnecessary by the policy makers as they argue that more robust municipal services would take care of treatment and the number of referrals could be reduced (especially for older patients).

6.1.2 Actor motivations

The documents ask actors in healthcare to orient their actions according to prevailing norms related to what is best for the patient. This is stated quite explicitly, not just in face to face settings but also in cases where administrative planners are asked to think holistically around patient's needs. I have already noted that the documents expect that actors are capable and willing to place themselves in the “patient's shoes”, to see things from her perspective. One wouldn't plausibly expect actors to be portrayed as narrowly rational in the context of the health sector. But if one pays attention to how the documents portray interactions between

organizations in relation to other indirect issues such as financing of medicine and participating in work around individual plans, game theory analogies are more fruitful;

Det er ulike betalingsordninger for foretak og kommuner med ulike insentiver. Det medfører at det kan lønne seg for en tjenesteyter å skyve kostnadene for en pasient over til en annen tjenesteyter med mulighet for samfunnsøkonomisk tap, og i verste fall en forverring av pasientens situasjon (St.meld.nr.47 s50).

Here the issue of cost is linked to providing coordinated care. Providers are not cooperating optimally and in a sense they are free riding on the contributions of others. The above excerpt doesn't explicitly say who is doing the free riding but the dynamic has been noticed. In a situation where communication between hospital organizations and municipalities is poor, one has something akin to the prisoner's dilemma. The economically rational actions taken on the part of one actor often lead to sub optimal outcomes for patients and ineffective allocation of tax payer revenues.

6.1.3 Structuring of GP salaries

In the documents, incentives are also mentioned in connection with the organization of primary health and the behavior of general practitioners. Here it is more obvious that the panel has relied on research on incentive components as a proportion of GP's salaries and how this affects behavior. General practitioners' salaries are partitioned into different components. The salary components can encourage doctors to treat as many patients as possible and thus spend a minimal amount of time on each individual consultation. What then happens is that GP's have a tendency to refer patients to specialists. Overburdening the specialist sector increases costs related to transportation and hospital stays and represents unnecessary usage of tax revenues. The policy makers back their discussion on international literature such as "Donaldson, C. and K. Gerard (1989). "Paying General Practitioners: Shedding Light on the Review of Health Services" (Taken from the reference list), and "Lurås, H. (2004). General Practice. Four Empirical Essays on GP Behaviour and Individuals Preferences for GPs. Working Paper 2004:1, Health Economic Research Programme".

Valget av en blandet finansieringsmodell er blant annet begrunnet med at dette både bidrar til at legen vil ta ansvar for en bestemt pasientpopulasjon, samt at det bidrar til at legen yter tjenester til personene på listen. Selv om det i litteraturen er stor grad av enighet om effekter

av ulike avlønningskomponenter på legenes adferd², er det lite kunnskap om hva som er den "riktige" fordelingen (78).

There is no indication that doctors will be rewarded for treating more patients but the intention is to motivate them to fulfill their coordinator function with other actors in the municipal organizations and contribute towards public health. Steering GP's behavior is complex. General practitioners are meant to have a "door-keeper" role in controlling the number of referrals to specialist services. Their social dilemma arises when the situation is such that they compete for patients with other GP's and patients become more demanding,

... fastlegene i større grad enn før opptrer som pasientens hjelper ("advokat" eller "portåpner") og i mindre grad ønsker å være "portvakt" og ivareta samfunnsøkonomiske hensyn. Dette forklares med økt konkurranse legene i mellom og endrede holdninger/større forventninger hos pasientene. Knyttet til endring i maktbalansen i legepasientforholdet er det blitt mer problematisk for legene å fungere som portvakt i forhold til å begrense unødvendig bruk av helsevesenets ressurser (NOU 2005 p78).

I mention the activities of regular general practitioners because their role is described as integral in achieving coordinated healthcare in an economically efficient manner. The majority of the nations' doctors run private practices (NOU, P 77). Their activities can therefore not be regulated in the same way as other actors in municipal health work. The parliamentary hearing (p, 94) portrays GP's as an important tool for ensuring economic steering in between municipalities and hospitals. Municipalities are required to exercise greater control over GP practices in the future based on data (*nasjonale funksjons og kvalitetetskrav til fastlegevirksomhet, p94*).

6.1.4 Coordination from a profit perspective

The most telling evidence that pertains to the rational-choice hypothesis is the section in NOU 2005:3 entitled "Er samhandling lønnsomt?" (p 116-118). Here the Wisløff committee asks explicitly if "coordination" in the sense in which they use it, can be considered to be in the individual interest of any given actor. The answer that they come up with is "not necessarily". Instead they point to "society's" interest in sustaining universal health coverage within the boundaries of publicly funded healthcare. They describe "coordination" as a way of looking at

the sector's activities, over and above the individual interests of the different actors of the health sector;

Det som i særlig grad preger samhandlingen i helsetjenesten er at den er sektorovergripende, både innenfor et nivå av helsetjenesten og mellom de to nivåene (NOU 2005:3 s117).

They draw a distinction between profit (*bedriftsøkonomisk lønnsomhet*) for any single actor within the financial year and “cost effectiveness” (*samfunnsøkonomisk lønnsomhet*) for society as a whole;

Et eksempel er at tidlig utskrivning fra sykehus kan gi dårligere behandlingsresultat og/eller økte kostnader i kommunehelsetjenesten. Det kan også gi et velferdstap for pasienten, pårørende og evt. et produksjonstap. Tidlig utskrivning kan fremstå som ”lønnsomt” for sykehuset, men representerer derfor ikke uten videre god samfunnsøkonomi. Det kan med andre ord ligge i sakens natur at det er vanskelig å gjøre samhandling bedriftsøkonomisk lønnsomt (NOU 2005:3 s117).

“Samhandling” as the panel understands it, doesn't necessarily mean that a hospital will come out of interactions with other relevant actors profitably. The above excerpts indicate an awareness of how narrow economic considerations on the part of involved organizations don't automatically harmonize for society as a whole. This is because the output (economic benefit for society) is too complex to measure. Even if it can be argued that increased levels of coordination would reduce public expenditure, this would be near impossible to establish meaningfully for a single financial year, as stated in NOU 2005:3. Cooperation costs for different actors but the benefits affect everyone, though these results would be ever so difficult to define or measure. Cooperation is not sought justified from the perspective of individual utilities but emphasis is placed on benefits for the public services as a whole.

6.1.5 Financing medicines across organizational divides

Utgifter til legemidler dekkes av trygden også i heldøgns pleie og omsorgsboliger. Dette har ført til at noen kommuner har spart legemiddelutgifter ved å omdefinere sykehjemsplasser til heldøgns pleie og omsorgstjenester (NOU 2005:3s123).

The above explains reimbursement of medicines used in treatment. Hospitals are responsible for financing their own medicine expenditure. Municipalities are responsible for paying for medicines in institutions under their jurisdiction. Patients who are not institutionalized can apply for social insurance to cover for medical expenses. Day-care homes are financed by the national social insurance when it comes to medical expenses and the panel claims that municipalities have accordingly redefined their institutions as such in order to save on expense. The municipalities might well have acted so in desperation, especially if one considers the costs of medicine for cancer patients. The above passage simply suggests opportunistic behavior, even if it most likely didn't serve the interests of profit. But principle-agent theory posits that agents can have a higher risk aversion than principles might have (Busch, Johnsen et al. 2011:108). In this case, municipalities acted opportunistically by cutting corners in the interests of their patients. This can be interpreted as risky behavior in line with principle-agent theory,

Dersom helseforetakene dekket alle legemidlene i institusjonene (sykehjem), kunne dette gi helseforetakene incentiver til å dempe de kommunale institusjonenes legemiddelutgifter. Dersom foretakene overtar finansieringsansvaret, kan det stimulere til bedre samhandling mellom nivåene om forskrivning”(p124).

The state steers via regional health organizations down to municipal institutions and improved cost control can be achieved if hospitals are made financially responsible for financing medicine contribution.

6.1.6 Free riding

The concept of freeriding pertains to situations where actors benefit from interactions with others without contributing anything themselves. The authors of *St.meld-47* interpret the dynamic between primary and secondary healthcare organizations in a manner that lends itself to this type of rational choice interpretation. Actors in primary healthcare don't fulfill their functions because doing so would incur costs for them whereas the hospitals could potentially benefit in the event of a decrease in admissions. Even though actors in municipal healthcare are legally obligated to invest in preventative measures and rehabilitation and indeed have this

as their main function, they have too often opted to refer patients upwards to specialist healthcare;

Noen aktiviteter foregår på sykehus ikke fordi de må foregå der, men fordi forholdene ikke er lagt til rette for at kommunene selv kan utføre dem og/ eller fordi kommunehelsetjenesten ikke har noen kostnader ved å henvise pasienter til sykehus og la sykehus ta vare på dem (St.meld.nr.47:97).

A well-integrated health service is a public good in the sense that health in the population on average affects levels of employment. Well-coordinated treatment routines and follow-up procedures are in the public interest and benefit all citizens. The reform explicitly states in St.meld.nr.47 that the goal of the reform is to run the sector in a more rational manner. In light of this it is relevant to consider what the concept of rationality means in the context of actors' behavior in the sector. Excerpts suggest that treatment procedures have to make sense from both an external economic perspective as well as the patient's perspective.

In relation to the free riding analogy I noticed a passage related to the implementation of individual plans. Individual plans for patients requiring sustained treatment over time would ideally contribute toward coordinated treatment. Individual plans provide a reference point for actors from different institutions so that they could regulate their contributions in relation to what others had already contributed. NOU 2005:3 an entire chapter is devoted towards examining why progress had gone more slowly with implementing this measure than anticipated;

Når både kommunen og helseforetaket har en selvstendig plikt til å sørge for at det utarbeides individuell plan til en pasient, fører dette gjerne til at ingen tar ansvar, man venter og ser om den annen part starter opp arbeidet (NOU 2005:3 p74).

Major actors in the Norwegian health sector interact with each other in an interdependent manner and the consequences of their actions, intentional or otherwise, affect both each other and other parts of society. The Coordination reform might be interpreted as an attempt to solve the problem of "freeriding" by changing the cost structure for the participants involved (municipal/state). Municipal actors are to be discouraged from avoiding the financial burden inherent in healthcare provision by means of "municipal-co-financing". Actions that

municipal actors take (hospitalize patients, or, invest in preventative measures), affect hospital activities (discharge patient early due to capacity issues).

I argue that the authorities don't assume that actors in the health sector are motivated by individual profit, instead they emphasize the role that financing of the sector has for enabling/constraining which actions are likely to be taken. They point out systems of financing are the most important factor in the interactions that do transpire across organizational levels in the sector. Aspects of game theory do cast light on a dynamic between actors that does arise between municipal and state actors. One consequence of the Norwegian public sector being divided into two administrative levels is the grey area between primary and secondary/specialized healthcare. St.meld.nr.47 states that current financing encourages healthcare actors to view their activities as primarily consisting of diagnosis and treatment instead of thinking also in terms of prevention;

Finansiering av spesialisthelsetjenesten og kommunehelsetjenesten bidrar til å sementere og forsterke fokuset på diagnose og behandling framfor forebygging og mestring, og legger i for liten grad til rette for å stimulere til alternative løsninger både innad og mellom forvaltningsnivåene. Det er i dag et problem at tiltak med tilhørende kostnad settes inn av en aktør, mens det er andre aktører som får gevinsten (nytten) av tiltaket. Eksempelvis vil økt vekt på forebyggende tiltak være en kostnad for kommunene, mens gevinsten dels kommer i spesialisthelsetjenesten i form av færre sykehusinnleggelses og for staten ved reduserte utgifter over trygden

Further;

Det er vurderingen at svakheter ved finansieringssystemet og insitamentseffektene ved dette er en vesentlig årsak til at en over så mange år har slitt med å finne fram til strategier og tiltak som kan bedre samhandlingen (St.meld.nr.47:30).

If municipalities were to cooperate and accordingly invest in preventative health measures, this could conceivably lead to fewer hospital admissions which would benefit the hospitals (in principle) since these are also aiming to slow down the increase in yearly activity.

6.1.7 Municipal co-financing as a means of ensuring collective goods

At first glance this instrument appeared to be an example of a punishment/reward system. If one didn't analyze any further one could interpret the use of such a policy measure as a means

of encouraging municipalities to behave as if in a market situation. But municipalities are encouraged to cooperate and not compete with each other in production of services. There will undoubtedly be elements of strategic behavior in cooperation but this is something that second order rational choice models take into account.

The 429 municipalities in Norway can be considered a latent group Olson (1971:50) insofar as noncooperation on the part of one municipality will not have a noticeable effect on the sectors' total expenditure. Therefore it will not be rational for any single municipality to contribute alone (by investing in preventative health) since their small contribution won't make much of a difference. But if municipalities cooperate in groups of about 5, contributions will become more noticeable for those participating in what Olson calls intermediary groups. These groups are large enough to ensure that a collective good is obtained (cooperation around a DMS) but not so large as to tempt individual municipalities to free ride. Olsen posits that individually tailored selective incentives are necessary in order to motivate individuals to cooperate. The government has proposed to compensate 20% co-financing with a portion of the grants that at the outset flow from the state to regional health organizations (St.meld.nr.47, p102). I'm not sure if these grants to municipalities can be rightly understood as selective incentives but in theory, individual municipalities will stand to benefit from cooperation with others.

I think there is further evidence that suggests that the policy makers believe that coordination can be achieved via cooperation between rational actors. As one of the prerequisites for co-financing to work effectively they state that;

Ordningen må være enkel og oversiktelig både for kommunene og sentrale myndigheter. Videre må ordningen være kostnadseffektiv; besparelsene ved økt kommunale innsats må være større enn transaksjonskostnadene ved en betalingsordning (faktureringsystem) som omfatter pasientbehandling i spesialisthelsetjenesten(St.meld.nr.47, p103).

I noticed the mention of administrative “transaction costs” and how these cannot be higher than the long term benefits for municipalities in investing in preventative health measures. Based on Mancur Olsen's analyses of collective action, co-financing can be seen as a means of ensuring municipal contributions to healthcare provision. As things stand, one can view excessive referrals as a form of freeriding by the municipalities at the state's expense. But if

all municipalities refer an unnecessary number of patients to hospitals then everybody will be worse off in the sense that hospital costs will only keep rising. The states' revenues are funded through taxation so this freeriding leads to a comparatively worse outcome for all patients than is ideally possible. If each municipality contributed to developing robust alternatives then patients would also have alternatives to hospital treatment closer to home. But increasing municipal health provision will require increased organization and coordination via inter-municipal cooperation. Reducing the number of municipalities is not a popular idea amongst the Norwegian public so it is conceivable that municipalities will organize their services as mutually owned companies, as noted by (Busch, Johnsen et al. 2011:325). This division of the municipal health sector into fewer units will likely diminish the free riding (unnecessary referrals) by the municipalities since this will automatically incur a 20 percent hospitalization cost which presumably will be registered by the mutually owned municipal service providers. Actions taken by municipalities (refer/not refer) will be more visible to other municipalities in the same group. There will be a clearer feedback between contributing and long term rewards for each municipality. In this sense municipal organizations will clearly be acting as collective rational actors, taking costs and benefits into account.

Innføring av økonomiske insentiver i form av kommunal medfinansiering og fullfinansiering av utskrivningsklare pasienter vil også inspirere til å utvikle roller og løse oppgaver som samsvarer med de helsepolitiske målene (St.meld.nr.47:26)."

As it stands the proposal is to channel revenue that would have flowed directly to the hospitals from the state coffers is instead transferred to the municipalities. Municipalities are then presented with a choice. To the extent that municipalities are economically rational they will make a "rational choice" for long term rewards. The more they invest in infrastructure and preventative measures the less they will be billed for costly hospitalizations. As far as the "new municipal role" goes; inter-municipal organizations would be able to pool their resources and offer healthcare that no individual municipality would be able to do single handedly.

6.1.8 The provider-purchaser model and the element of competition

Provider purchaser systems are seen as one of the cornerstones of New Public Management Busch, Johnsen et al. (2011:106). Although the provider-purchaser model is only comprehensively discussed in NOU 2005:3, there is reason to believe that contracts will increasingly replace hierarchy in the production of public health services.

Et offentlig utvalg drøftet nylig mer inngående hvordan konkurranse generelt kan brukes som en del av moderniseringsstrategien i Norge (se NOU 2000:19 "Bør offentlig sektor eksponeres for konkurranse?"). Utvalget tilrår at en vurderer bruk av konkurranseeksponering på flere områder uten at de vil peke på noe særskilt område. Utvalget anbefaler også at det arbeides med å videreutvikle den offentlige kompetansen til å styre gjennom kontrakter. De sier at den hierarkiske styringen bør suppleres med en større oppmerksomhet på kontraktstyring basert på bestiller-utfører forhold(NOU 2005:3 s 114).

In NOU 2005, the model is described as a component of "modernizing" that is also evident in other nations. The use of provider-purchaser models is effectively endorsed after taking into consideration the various organizational and demographic (population size) requirements, as well as the need for competence in contract specification. They also note concerns that administrative costs in implementing contracting might be quite high. Tellingly, the Wisløff committee says it's unsure as to how this model contributes to coordinated services;

Forskningen gir ingen klare svar på hva som kan oppnås gjennom bestillerutfører modeller i forhold til samhandling(p, 114).

Generally this model is oriented toward providing output that is aligned with user's preferences which reinforces the impression that the authorities seek feedback from citizenry based on output;

Mange peker på at det nettopp her er mulig å innrette et press mot helsetjenesten som kan få den mer fremtidsrettet, mer brukerorientert og med bedre kvalitet og ressursutnyttelse (p,114).

Contracts can be specified in various ways and they can more or less accommodate trust as a social mechanism in order to ensure that partners fulfill their respective commitments. In local municipal settings, actors will likely gain a reputation based on prior actions. One shouldn't

be too hasty in assuming that the use of contracts will automatically lead to competition between service providers, even if this can be a political goal. Provider-purchaser models can be sought utilized in different ways and in NOU 2005:3, experiences from the UK's experimentation with using market forces are cited (p, 114). There fragmentation of health services was later sought remedied by measures aimed at integrating the sector. One gets the impression that the Wisløff committee takes a nuanced view on the role of this model and that competition is not necessarily endorsed as the means of coordinating effective healthcare production.

6.1.9 “Fritt sykehusvalg”

The free choice of hospital for patients does present an element of ambiguity. On the one hand this might encourage competition between hospitals who seek to establish a reputation for delivering results that satisfy patient's preferences. Patients might be then seen as empowered consumers. Such an interpretation would support the marketization hypothesis. This in itself would not contribute towards rendering cohesive patient pathways an easier task. But choosing which hospital one wishes to receive treatment from is also a patient right and it would be difficult to come up with good arguments that would deny patients this right.

6.1.10 Conclusion

The documents portray actors as economically rational to the extent that their decisions take costs into account. Using GP's as instruments of health economical control make sense from a rational choice model. The same can be said of the institution of co-financing. Municipalities are to be made aware of the costs of using hospital services. Municipalities are encouraged to cooperate in public goods by providing adequate health services for their populations. To the extent that local authorities make economically rational decisions, they will weigh the long term benefits in cooperating with the state and providing preventative measures and integrated services. Hospitals will receive approximately ten percent less of their funding in the form of Activity Based funding and will have accordingly less incentive to accept patients that could otherwise receive treatment locally. The general practitioners will also be steered by local authorities and their salary components will compensate them for providing more

comprehensive contributions for patients with long term multiple needs. In short, the entire reform makes most sense in terms of Mancur Olsens' take on public good provision where large groups (429 municipalities) are galvanized into contributing to public health.

Cooperating municipalities then consist of smaller groups which then enter into binding agreements with hospital authorities. Smaller groups render individual contributions more visible (in theory), thus reducing the temptation to free ride.

What emerges as implicit theory from an inductive reading of the documents is a model of an actor who is rational but not in the sense of only calculating consequences for themselves. The actor is individually rational to the extent that she realizes that acting alone entails disproportionately high costs and that actions can only be effective if she is reasonably assured that others are also likely to act cooperatively. The actor can and is willing to reflect on the possible consequences of her actions for patient's recovery. Further, the individual's interests are inseparably linked with the generalized interests of others. To the extent that economic interests enter the actor's calculations, it is in the interests of society to use collective resources effectively so as not to undermine publicly financed health. Municipal co-financing raises local authority's awareness of the actual costs related to healthcare and the rationality inherent in cooperating in order to secure local health centers as a public good.

7 Cooperation

In the previous chapter I concluded that the implicit theory of coordination could be understood in terms of inducing rational actors to cooperate in providing coordinated healthcare. The use of economic incentives could from this perspective appear relatively benign and justifiable in achieving collective outcomes in healthcare provision. But although rational choice theories have tried to explain collective action in labor unions they have ultimately not provided convincing accounts of other collective phenomena such as revolutions where unpopular governments have been overthrown. There are aspects of collective action that rational choice has not thus far been able to capture based on the assumption that actors ultimately act in a self-interested manner. The weakness of the rational choice model is the assumption that all actors are approximately, to the same extent self-

interested and that one can implement policy measures with predictable outcomes based refined models of this assumption.

Analysis of the Coordination reform in terms of cooperation reveals aspects of the implicit rationale that might prove to be counterproductive and in fact detrimental for cooperation. The instrument of co-financing looks quite different from a cooperation perspective. It is highly uncertain that economic incentives will ensure high commitment from municipal actors in achieving health political objectives. Commitment will depend on how municipal actors interpret the context which the policy measures introduce. In this chapter I will focus on issues of fairness, crowding out and intrinsic motivations with regards to co-financing and municipal steering of regular practitioner' practices. The explicit arguments behind the reform make sense insofar as healthcare provision can be made more efficient if alternatives to costly hospitalizations can be established. The argument makes sense for citizens; insofar as those living at some distance from the larger hospitals should have alternatives closer to home. I am not arguing that there isn't a need for a reform of the health services but in terms of cooperation I think it is warranted to reexamine how this is sought to be achieved. One gets the impression that this reform is more "top down" than "bottom up" with regards to citizen influence and my findings support the sentiments expressed by both Pettersen and Haga in this respect. It is not that competition and marketization are proposed as mechanisms of ensuring effective production of healthcare so much as the notion that relevant actors can be coerced via incentives to cooperate. It is quite telling that economic instruments are deployed and that the policy makers explicitly state that normative instruments, as enacted in legislation so far has been largely ineffective (St.meld.nr.47 p, 52). I have earlier concluded that broad public deliberations are not a component of seeking public input on issues related to healthcare, at least there is no evidence of this in the documents.

Co-financing is imposed on all municipalities based on an implicit assumption that powerful incentives are sufficient in order to guide municipal organizations' behavior in relation to referrals and investment in preventative health. The instrument purposefully introduces an element of financial risk and in this sense can also be interpreted as a form of discipline. In St.meld.nr.47, the policy makers state that municipalities should be exposed to an "unreasonable amount of risk" (p, 102). But in NOU 2005:3, co-financing as earlier introduced in Denmark had been considered and ultimately rejected due to the perceived unfairness of the measure (p, 121). The Wisløff committee reasoned that municipalities in

many respects couldn't control sickness episodes as they occurred in the short term, neither could they exercise control on the decisions relating to patient discharges from hospitals. Smaller municipalities would be exposed to an inordinate degree of financial risk because in smaller populations, sickness episodes requiring hospitalization would greatly affect their health budgets. In order for co-financing to be viable, populations need exceed a certain minimum which means that dissolution of smaller municipalities into larger entities would be more efficient. The measure is politically contested as citizens in Norway have traditionally expressed aversion to the idea of joining municipalities together into larger municipal regions (kommune- sammenslåing). When the government signals that municipal cooperation is desirable, municipalities might interpret this as a step closer to grouping municipalities together into larger regional territories.

7.1.1 Steering of GP practice

From a cooperation perspective it is important to reflect on what policy measures imply about identities and intrinsic motivations. General practitioners are vital actors in the health sector and their cooperation is necessary in ensuring the continued provision of well-coordinated public health. The policy targets the structuring of their salaries and local authorities are asked to take a leadership role in steering their decisions. One could ask what this implies about how GP's motivations are characterized in the reforms. Under the proposed regime one wouldn't be able to tell if doctors complied with state directives because they were coerced into doing so, or if their choices reflected intrinsic motivations to cooperate. Clearly there is a need to regulate and cooperation theory predicts that one third of the nation's approximately 5 thousand GP's respond well to punishment/reward structures. But that leaves a large majority who would be inclined to cooperate without explicit policing from the authorities.

7.1.2 Communication/empathy

I have already argued that coordinated healthcare provision could be seen as a public good that can be provided by cooperation amongst rational actors through the implementation of municipal co-financing. Municipal cooperation will lead to a division of the municipal sector into smaller groups of cooperating local authorities. The Coordination reform creates a new or at least altered environment for local municipal organizations in which increased

responsibility also comes with greater freedom in determining exactly how health political objectives can be realized at the local level. To the extent that local authorities collaborate, they will be communicating presumably in face to face settings. Communication facilitates cooperation even if no binding agreements are achieved on every occasion. To the extent that municipal cooperation does become more extensive, in line with the reform's visions, communication and reciprocity will increase the likelihood of genuine cooperation.

7.1.3 The issue of hierarchy

Busch, Johnsen et al. (2011:330) noted a conspicuous lack of hierarchy at the level of municipal administrative level in his article concerning the reform. He goes so far as to describe the reform as a “disintegration project” at the municipal level. From a cooperation perspective granting municipal actors flexibility and autonomy in how they will solve problems will be vital in achieving good outcomes. At this point one can perhaps only speculate on whether economic incentives threaten municipal autonomy and their degrees of freedom in acting collaboratively. What is certain is that policy proposals act externally on local authorities and so there is a danger that co-financing might crowd out motivations for cooperating.

7.1.4 Transparency

Inter-municipal cooperation will render actions more and thereby facilitate reciprocity, in theory. Ideally participants should be able to observe each other so as to monitor cooperation versus defection. However, as has been pointed out Busch, Johnsen et al. (2011:330) coordination might be quite difficult as the processes involved in municipal collaborative processes seem chaotic or opaque, even for those closely involved. To the extent that municipal bureaucracies can adjust in the long term, transparency will be an important issue.

In concluding, co-financing does not imply trust in the municipal authority's willingness to use hospital services appropriately.

7 Summary

This thesis started with the question of what kind of social theory was reflected in the concept of coordination. I examined two publicly accessible documents (NOU 2005:3 and St.medld.nr.47). In order to answer the question I asked three additional questions; 1) can coordination be understood as a process of public deliberation? 2) Can coordination be understood as rational action? 3) Can coordination be understood via the concept of cooperation that Benkler (2009) advanced in his article?

The deliberative approach entailed looking for how evidence that public opinion was to be used as a resource and that broad public deliberation in civil society be channeled into legislation. In the documents I did find evidence that democratic aspects were mentioned in relation to patient's perspectives. On closer examination I ascertained that this was to be operationalized via individual and collective patient participation based on administrative "output" or levels of satisfaction with services and this seems to substantiate Haga's observations on the reform. I found little or no evidence that healthcare coordination was to be discussed comprehensively in (face to face) collaborative public forums so that broader public opinion and "will formation" affect administrative "input" in accordance with the parliamentary model of democracy. There is no evidence in the documents that something akin to public deliberation is proposed as the means of coordination. There is no evidence that public opinion is to affect legislation in the accordance with the deliberative model. Tellingly, the policy makers note that normative instruments for steering behavior have proved to be insufficient as means of ensuring coordinated care (according to St.meld.nr.47 s52). Even if patient participation is mentioned and NGO's from civil society are encouraged to provide input in future, deliberation as a model isn't the primary emphasis of this reform with relations to coordinating cohesive patient pathways.

A rational choice reading proved more fruitful and reflected several observations related to how organizations failed to act in implementing individual plans because delegation of responsibility between municipalities and hospitals was unclear and each side waited for the other to act. Instances of "free riding" became more evident as being a concern that the policy makers had in relation to inappropriate rates of referral, splitting up of patient consultations, complex issues around financing of medicines in local institutions as well as a lack of participation from GP's in contributing to individual plans. The list of references in NOU 2005:3 shows that health economists have provided the theoretical basis for how to optimally

structure general practitioner's salaries. Doctors are assumed to be rational actors that need to be coerced into contributing more towards public health in local communities. Political decisions are then translated into legislation that gives municipal authorities the means of steering GP practices in line with collective interests. This is to be done by structuring their salaries so that they won't narrowly focus on treating as many patients as possible. Local authorities are required to more closely manage medical practice in order to ensure that doctors fulfill their public duties. Municipal co financing is the primary instrument to be used and its implementation assumes that local authorities are rational actors insofar as they will orient their actions in relation to long term benefits and costs in relation to "appropriate use of hospitals".

Initially the rational actor- model lead me to reflect on how competition and marketization might be inherent in the policy rationale. Patient's right to choice of hospital didn't seem to align well with the goal of coordinated treatment pathways but this component of patient rights is ambiguous. The use of contracts was comprehensively covered in NOU 2005:3 and I found no evidence that competition was endorsed as a means of achieving cohesive patient pathways.

A more fruitful approach opened up after examining Mancur Olsen's "The logic of Collective Action". Here the dilemmas confronting rational actors in providing collective goods is clearly outlined. Smaller groups will more likely induce rational actors to cooperate as opposed to larger groups, even if larger groups would in theory have much to gain from coordinating activities cooperatively, they will unlikely initiate organized and coordinated actions. My perception of the rational actor changed and instead of a narrow focus on utility maximizing behavior in market contexts, I began to think of individual rationality when confronted with choice between contributing to public health measures and continuing with the status quo. Olsen's explanatory framework enabled me to view municipal co-financing as a necessary coercive measure implemented by the state as an organization acting in the generalized interest of Norwegian citizens. Insofar as tax-funded collective healthcare can continue to retain popular support amongst the public, some compulsory measures are collectively rational (such as citizen taxation). If universal healthcare is to be a viable collective good in the future welfare state then municipalities cannot continue with the current rate of referrals, especially in light of the ageing population's needs. Municipal services have

to be more robust and a future municipal role involves cooperation around local medical centers. The totality of the nation's 429 municipalities can be viewed as a "latent group" that will not contribute toward public goods unless coercive measures are introduced. The same might apply to the nation's 5000 general practitioners. Even if there existed a common understanding or consensus about what needed to be done, no action partaken by an individual municipality would have been decisive or even marginally affected the nation's total expenses on healthcare. To the extent that an actor is rational, any actions taken would take into account likely future consequences. If acting alone, the individual GP or municipality would find that complying with existing legislature to the letter would entail costs that they alone would have to bear without any guarantee that others would follow their example. Mandatory co financing gives the local authorities assurance that others are acting under the same constraints. Municipal cooperation around local medical centers effectively divides the nation's municipalities into smaller groups cooperating around local medical centers. As long as the administrative costs do not outweigh the potential benefits it will be rational for local institutions to mobilize towards providing an "inclusive" collective good. Even if Olsen's explanation of collective goods provision based on a rational individualistic theory of society doesn't prove to be ultimately convincing for Joas (2009), it does support the hypothesis that rational choice is the most fruitful analytical perspective for making sense of this reform.

If the reform can be understood in terms of the state encouraging cooperative behavior between economically rational actors then it follows that there might be a danger of undermining genuine cooperation between relevant actors. I have argued that this is due to the emphasis in the reforms in "getting incentives right". Implementing Co-financing doesn't imply trust or confidence in the municipality's ability to cooperate or to utilize specialized health services appropriately.

My research question asked if there is an implicit social scientific theory of coordination in the documents. I found that all three models provide data for different observations but the rational choice model based on cooperative contribution to public goods was most plausible as a means of understanding the documents. The theory illuminated an underlying logic but ultimately my research has not provided evidence for a clear and consistent scientific theory underlying the concept of coordination.

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