

**Reforming Hospitals through New Roles of Management**  
**Hospital managers' interpretation of leadership conditions in Denmark**  
**and Norway**

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21 pages

ISSN: 1503-3724

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Design: Agder University College  
Cover and binding: Agder University College  
Typesetting and printing: Agder University College

## Introduction

The Public Health Service has been an important theme on the political agenda in both Denmark and Norway over the latest decades. In Norway this led to a structural reform being carried out in 2002. In Denmark something similar is now being considered, and the Danish Liberal/Conservative coalition government presented in April 2004 a proposal for a new structure in the public sector, involving, amongst other things, abolition of the counties and creation of larger regions. In both Denmark and Norway, one of the main themes of the debate has been the need to strengthen leadership at hospital level. The implicit suggestion would here seem to be that leaders need better competence and more autonomy in order to make leadership decisions. There is a need for professionalisation of leadership and a greater degree of freedom from the political sphere of influence.

Stronger leadership and a looser connection to the political/administrative authorities can in theory emerge as an attractive response to the complex problems of public hospital leadership (Hughes 2003, Osborne and Gabler 1989). Previous studies call, however, for a certain scepticism with regard to the effect of leadership changes in hospitals (e.g. Bentsen, Borum, Sahlin-Andersson and Erlingsdottir eds.1999, Ferlie, Pettigrew et al 199x, Spångberg 2003). Furthermore it should be taken into account that both organisational theory and management literature points to the complexity of the tasks and objective functions involved as fundamental conditions that can create hindrances for new leadership models in the public health service.

In this article we will compare development tendencies in Danish and Norwegian hospital managers' comprehension of leadership conditions. The comparison between the two countries is especially interesting because they started from more or less the same structure with decentralised democratic management of the public health service. The roads divided, however, in 2002, when Norway introduced a larger structural reform, moving the responsibility for hospital management to decentralised state health concerns with appointed boards rather than democratically elected leadership. At the same time greater freedom was introduced for the individual hospitals. These reforms should be seen in relation to extensive use of activity-based financing based on DRG points (nearly 40% of hospital budgets), and a strengthening of patients' choice opportunities. Ideas concerning structural reform and a free position for hospitals are also being considered in Denmark (The Government's Advisory Committee 2003, the Structural Commission's consideration 2004, The Government's proposal for structural reform 2004). It is therefore useful to compare Norwegian hospital managers' understanding of the leadership situation after the reform with Danish hospital managers' understanding. We would especially like to focus on the following four dimensions: 1) understanding of change in hospitals' placement in relation to the outside world, 2) understanding of motivation for hospital personell, 3) understanding of change impulses and dynamics and 4) values orientation. These four themes represent core elements in the description of the leadership function and should therefore capture important change tendencies.

The main issue in this article thus becomes: are there major differences in understanding of the leadership situation, and especially in relation to the outside world, personell leadership and motivation, change impulses as well as values orientation? Can possible differences be put down to the structural reform in Norway? Have the attempts to strengthen hospital management through formal separation of politics and daily running in Norway led to a substantially different understanding of important leadership dimensions than in Denmark?

## Method

The study of leadership conditions can be carried out by using various methods. In this article our work is based on questionnaire responses from Danish and Norwegian hospital managers. The questionnaire replies reflect the respondents' interpretations and reflective reactions to the question and answer categories we constructed in advance. The element of interpretation means that the response occurs in a certain cognitive context surrounded by the broader organisational opinion creation and discourse at a given point of time. That there is here an issue of reflective reactions means that the questionnaire response also contains elements of personal presentation. The replies depend to a certain extent on what picture the respondents wish to paint with respect to their surroundings. The answers to the questionnaires give therefore an indication of leadership understanding and self-presentation at a given point in time and based on the concrete organisational context. When we compare the questionnaire results from Denmark and Norway, we can gain pieces of the picture of leadership discourse and leadership conditions in the two countries' health systems. We cannot maintain, however, that we have here a comparison of "objective" leadership conditions, but rather, of how opinion creation and function conditions become interwoven and presented by leaders in the two countries. This picture can then be collated with other sources, aiming to describe either opinion creation or function conditions from another angle. In relation to the Norwegian case, qualitative interview data is, for example, used as a supplement, whereas the Danish case is enriched with references to other recent studies of leadership conditions.

The questions used in the article have been translated, so that they should have the same meaning in both countries. But there are some language nuances and a somewhat different context. This must be considered in the comparison.

The Danish questionnaire contains answers from hospital managers all over the country. Questionnaires were sent to, in all, 74 hospitals, i.e. the total population. Questionnaires were sent to the top leadership, and the hospitals have themselves been able to decide which respondent from the top leadership was to answer. Answers have arrived from 50 leaderships meaning an answer rate of 68%, but with less variation as regards the individual questions (compare n-readings in the individual tables below).

The Norwegian questionnaire was to be answered with matching variables by hospital managers in Norway's 5 health regions. The study was firstly distributed to 145 leaders and achieved an answer rate of 55%. The study was backed up by a study carried out amongst all leaders in two local "health concerns"/hospitals with in all 53 answering respondents. The number of answering respondents thus constitutes, in all, 133 Norwegian leaders distributed between 58 top leaders and 75 department leaders. Based on the geographical and hierarchical distribution one can assume that the answers received are more or less representative for leaders of Norwegian hospitals. In this article only answers from top leaders in regional and local health concerns are used in order to achieve the greatest possible comparability with the Danish respondent group. The quantitative data is supported by qualitative data consisting of, in all, 15 semi-structured interviews with leaders at different levels (regional directors, local health concern directors, heads of clinics, and departmental leaders).

Right through the whole questionnaire it is evident that the figures for the Danish leaders have a higher value than their Norwegian counterparts. This may be due to cultural differences between the two countries with regard to how the questionnaire should be answered, and also how likely one is to use extreme answer categories. Whatever the case may be here, caution is

called for with regard to direct comparison of size relationships between the two countries. We therefore use, as a general rule, the relative weighting within each of the two countries in drawing our conclusions.

### **New Public Management and changes in leadership conditions**

A dominating trend in the development of leadership in the public sector during recent years has been thoughts concerning New Public Management (Kettl 2000, Pollitt and Bourkært 2000, Barzelay 2001, and Hughes 2002). Even if NPM does not constitute a completely coherent and consistent thought universe, several elements can be pointed to, which fall within the broad title (Hood 1991, Kettl 2000). We would especially like to focus on thoughts concerning leadership development and about separation of leadership and politics, because these elements have been important for both countries' reform rhetoric.

Thoughts concerning separation of politics and leadership through decentralisation of leadership responsibility and greater autonomy for operational units play an important part in NPM. The main thread is that public leaders should be given greater freedom to take strategic and operational decisions. Thus one moves away from the basic conditions of political/administrative systems, this inferring that far too many differing interests have to be heard and taken care of, and that the work process becomes slower and the objectives complex and difficult to practice.

This line of argument builds on rational choice theoretical conceptions regarding "administrative failure", as a result of unclear incitements- and responsibility relationships in public organisations. This leads to a tendency to hand on responsibility and limited motivation.

Another underlying rational choice conception concerns "principal-agent" chains (Stiglitz 19xx). The line of thought here, is that the public sector can be conceived of as a chain of principal-agent relationships, in which e.g. hospitals are agents for the regional health concerns (in Norway), and county management organs (in Denmark). The problem complex is, however, how one gets the agent to do what the principal wants. It is namely taken for granted that the agent will always seek to maximise his own benefit by creating slack and focusing on activities in accordance with the agent's own interests. In complex systems with highly specialised work tasks it will be difficult for the principal to see whether the agent is living up to his full potential in relation to fulfilling the principal's requirements. There is a high degree of "information dissymmetry" between the principal and the agent.

The answer to "administrative failure" and "principal-agent" problems are according to a NPM line of thought to separate politics and leadership, so that it becomes easier to place sole responsibility, and build incitement systems, which can in turn lead to effectivity and innovation. Other elements from the NPM universe, such as steering by incitement and introduction of new forms of monitoring and measuring instruments, are then woven together together with autonomisation of leadership, and are part of a general change tendency moving through the public sector during recent years (Kettl 2000, Politt and Bourkært 2000, Pedersen and Læg Reid, Klaudi Klausen, Greve 2003).

The various different NPM elements constitute, however, neither theoretically nor practically, a harmonious and coherent entity in relation to creation of leadership conditions in the health sector. For example, there can exist a conflict between more space for leadership on the one hand, and cohesion of measuring and incitement steering on the other. Measurement systems in relation to activity and quality impound a lot of resources at hospital level, and have even had a tendency to standardise work forms and fields of effort. Thus the individual

hospital's room to act is restricted. This line of thought is also illustrated in international literature regarding experience with NPM, Hanson & Adams (2001) for example, reckon that NPM can be a set of techniques to control leadership, just as much as providing room for leadership.

NPM elements have during recent decades been put to use in the hospital field in both Denmark and Norway (Vrangbæk 1999, Kragh Jespersen 1999, Møller Pedersen 2003). This has resulted in several conflicts with existing management ideas, as could be expected in this complex and profession-dominated field (Vrangbæk 1999, Kragh Jensen 1999). The main picture anno 2004 is that modern hospital leaders have to handle a whole range of paradoxes between being made responsible, market orientation, control and measurement. All of this happens in a dynamic environment with frequent changes in political demands and hasty developments in underlying technological, organisational, personell, and epidemiological conditions and challenges (Borum ed.2003).

Summing up, one could say that, with the entry of NPM, greater attention is paid to leadership, and there is also a great belief that strengthened leadership can provide a solution model with regard to some of the current problem complexes in the health field in Denmark an Norway. On the other hand, control and steering mechanisms are also developed simultaneously in a way which provides limitations in the possibilities for autonomous decisions and variation (measurement of waiting time, quality, production mixes etc.) When Byrkeflot (2004), for example, writes that NPM and recent reforms in the health field have meant a greater emphasis being put on leadership; this is, thereby, probably correct in relation to some dimensions, but wrong with regard to others.

One way of understanding these partially contradictory tendencies is to see leadership in the health field as consisting of several overlapping and partly connected chains, benefiting different types of demands and tasks. One chain of leadership is connected to economic management parameters with cost control and effectivisation objectives. Another chain is related to user/citizen contact, service provision and co-operation with other parts of the treatment system. A third chain is related to clinically professional management decisions concerning organisation of practice, introduction of new forms of treatment, locating specialised functions, development of practice-related expertise etc. Finally, a fourth chain can be identified concerning democratic decision-making, public insight and control based on responsibility mechanisms in relation to the parliamentary management chain as well as media coverage.

Two points are important in this picture. Firstly, the chains are not necessarily concurrent and well co-ordinated. They certainly interact with one another, for example in the form of economic decisions taken in democratic fora with consequences for clinical practice, but there is not necessarily concurrence in the management logic and method of function. This means, furthermore, that NPM can make different impacts in the various different chains. The clinical management chain can, for example, still be expected to be very dominated by medical professional logic with its special comprehension of control through education, scientific evidence and the professional community. Hospital leaders depend on all these different management chains. Their different and partially contradictory methods of function meet and are broken by hospital management level, and the hospital managers' task is to balance, integrate, protect or change the individual management chains' demands at certain points of time. Some observers would maintain that this task has become more difficult as some types of management requirements (economic/administrative) have received greater emphasis in relation to others (democratic/political and clinical/professional).

It is therefore possible that hospital managers, formally speaking, have obtained more room to move, but realistically speaking, they are more bound up by several contradictory requirements and incompatibilities. It may also be the case that hospital leaders experience greater space to manoeuvre, but that other and more functional leadership levels in the organisation (for example heads of departments and heads of clinics) on the contrary feel limitations in their leadership autonomy. In this way it may be that leadership in a Nordic NPM context emerges as more important and meaningful (Byrkjeflot 1997, Christensen and Læg Reid 1997) for a few persons (centralisation into greater treatment units and administrative units, such as for example regional health concerns), whereas others feel a greater limitation (heads of departments and clinics).

Based on the above, we can through questionnaire results build up a complex picture of leadership, in which NPM elements have a stronger impact in some areas than others, and in which leaders' questionnaire answers will reflect differences in the relative dynamics within and between the different leadership parts of the chain in the two countries. NPM is expected to be a founding element for description of leadership conditions in the two countries' health systems, but it is also expected that there will be differences in interpretation, volume and timing, amongst other things as a result of the different reform paths taken in the two countries. Furthermore, it is also expected that the rhetoric surrounding NPM can be created somewhat differently in the two countries, dependent on the different background conditions and historical development.

The expectation of uniformity as regards the idea platform, but variation in translation processes as a result of opinion creation and local conditions fits in well with the literature concerning dissemination and translation of form elements in organisational fields (Røvik 2000, Czarniawska and Joerges 1996). The expectation of complexity in the practical management of leadership roles corresponds to the conclusions of Bentsen, Borum et.al. 1999 as well as Borum ed.2003. Here one can also refer to Pollitt 2000 with regard to corresponding analyses in relation to TQM in the health system. Thoughts concerning split-up, but overlapping management chains are inspired by Beck Jørgensen and Melander 1992, Melander 1999, Christensen and Læg Reid 1997 as well as Kvande and Rasmussen in Byrkjeflot (ed.) 1997. The conception of the strength of and dynamics in the special expert professional management chain answers well to Minzberg's illustrations of the professional bureaucracy's mode of function. We maintain, however, that this figure should be reinforced by several management functions, and that professional bureaucratic management is to a certain extent challenged by NPM thoughts. This provides the opportunity for theses concerning shielding, which in turn are inspired by Brunsson and Olsen 1989 amongst others.

### **Leaders' interpretation of changes in surrounding world relations**

The first set of questions concerns leaders' interpretation and presentation of surrounding world relations. Based on the above description of NPM tendencies we might expect that hospital managers would experience greater autonomy in relation to superior authorities, especially in Norway, after the 2002 reform. Taking this point further, we would also expect more indications of change in formal organisational status in Norway than in Denmark. Both countries have introduced free choice of hospitals (Denmark in 1993, and Norway in 2000). Collated with stronger incitement management by way of financing based on patient treatment figures, this can lead to an expectation that organisations to a greater extent close themselves in, and consequently do not pay so much attention to network participation. This

tendency should be strongest in Norway, where a larger proportion of hospital budgets are activity financed. On the other hand there has, both in Norway and Denmark, been a good deal of talk about the establishment of “shared care” and treatment in network type of constructions. In Denmark there has, furthermore, been a strong focus on the establishment of function-carrying units across physical matrices. This can be seen as a kind of network organisation, and we would therefore expect positive outcomes on this variable. We would, moreover, expect some consolidations of organisational units in both countries.

**On which of the following points have changes occurred in their organisation’s situation with respect to the outside world**

	Denmark(%)	Norway(%)
Increased participation in various networks	62	32
Increased competence in relation to closest authority/unit	58	38
Consolidation with other organisations	40	30
Splitting up the organisation/unit into several organisations /units	38	29
Reduced competence in relation to closest superior authority/unit	28	10
Formal organisational status (e.g. through change from public to private status)	20	74
	n=43-47	65-68

*Reply category: “Especially major changes” + “major changes”. Other reply possibilities were: “not so important”, “more immaterial”, “no changes” and “do not know”*

**Possible interpretations**

The first observation worth remarking in the questionnaire is that leaders in the two countries give the questionnaire’s change categories different priority. The most important category in Denmark is “increased participation in various networks”. An interpretation of this could be that the reply reflects the conception of county hospital systems in Denmark, and especially recent years’ growing focus on creation of function-carrying units across physical hospital matrices. The opposite is the case in Norway after the concern reform, in which one rather focuses on the individual hospital managers’ individual production (though the use of financing based on patient treatment figures), and therefore on organisations as “closed” units rather than members of broader production networks. The interpretation could then be that the health concerns in Norway can be considered as relatively closed activities, having more than enough coping with their own problems, or attempting to achieve a high degree of autonomy. Experience has to a certain extent also shown that the local health concerns partly compete regarding resources and patients, and that there is, in Norway, a game going on between the local health concerns concerning resources and patients in the ongoing structural rationalisation within the individual regions. A common identity is in a way lacking within the regions, and the regional leaders work hard to establish such an identity. At the same time legal jurisdiction concerning the Patients’ Rights Law and free hospital choice stimulates competition between the hospitals. Competition will normally mean the opposite of co-operation (and network).

A further interpretation of the relatively closed situation in Norway could be what has been experienced and observed in other studies with regard to the concern reform, namely the lack of dialogue between municipalities, local communities and health concerns. In other words a

transparency problem. The concerns have indeed been criticised for their lack of insight possibilities in current change processes. It is considered that change processes in relation to closure of local units and structural rationalisation have occurred too quickly, without a basis and dialogue with local community interests. Considerable opposition and local mobilisation in the form of demonstrations and appeals to Parliament and the Health Minister have been part of the Norwegian picture after the reform.

The objective of the transfer to health concerns was, amongst other things, to create rational running and management through hospital amalgamations and a better functional distribution. Hospital amalgamations do not, however, represent anything new in Norway. In the period before the reform (1992-2000), 16 percent of Norwegian hospitals were involved in amalgamations. Whereas these amalgamations especially concerned fusing small hospitals together with bigger ones, the current amalgamations concern possibilities for creating greater specialisation of functions while taking so much into consideration local geographical wishes (Kjekshus and Hagen 2003, Kjekshus 2004).

Another ongoing trend with respect to Denmark versus Norway seems to be that Danish hospital leaders experience a greater degree of changes in outside world relations than their Norwegian counterparts. This may seem strange bearing in mind the Norwegian reform background. One explanation could be that Danish hospitals, over many years, have been subjected to constant pressure to change (Vrangbæk 2003), whereas Norwegian hospitals, apart from the financing reform, have been relatively shielded until the 2002 –reform, which so far has primarily had an impact with regard to formal status. An additional explanation is that change rhetoric in Denmark has been stronger regardless of whether volume and speed of changes can actually substantiate this.

In relation to the autonomy discussion it is interesting that increased competence ranks as nr. 2 in both the Danish and Norwegian studies. In the Norwegian setting it was expected that the figure would be relatively high, but one can also see that other data in the study points in the same direction. For example 70 percent of Norwegian leaders experience their influence as leader in a health concern as being large. (Own study variable 28). These leaders also have bad experience with regional health concerns which are experienced as a delaying and “bureaucratic” connection. In a telephone survey amongst local health concern directors carried out by the Norwegian paper “Aftenposten” recently, 3 of 4 answered that they thought it would be useful to remove the regional health concerns. Their trust and legitimacy is through and through low, both amongst leaders and in the broader public eye. They have, moreover, to a poor extent succeeded in establishing network co-operation between the hospitals. It is more a question of competition and a struggle for scarce resources between the various units in the local health concerns.

The relatively high percent of Danish hospital leaders who also experience increased competence in relation to their closest superior authority can be interpreted as an expression of NPM thoughts concerning strengthened leadership. It is, however, remarkable that all of 28% of Danish hospital leaders reply with the opposite, namely that their competence in relation to superior authority has decreased. It looks as though the tendency may be a little different in different parts of the country or in different types of hospital.

### **Personell relationships and leaders’ comprehension of what motivates personell in hospitals**

These questions provide a picture of leaders' interpretation and presentation of the employees, and thereby, primarily, the expert professionals' motivation factors. The results then present a picture of how leaders see their room to move in relation to the personell. The answers must be interpreted as a mixture of common conceptions and factually experienced conditions.

#### Personell motivation

	Denmark	Norway
Professional/expert commitment	100	87
Development in the job situation	98	90
Good relationship to users	96	88
Colleagues' respect	89	68
Social factors such as e.g. good co-operation	89	91
The leadership's respect	67	80
Commitment to the organisation's role/mission	65	81
Career opportunities	61	51
Good salary	35	47
Keeping to budget limitations	24	48
A good relationship to superior authorities	22	33
	N= 46-47	53-58

*Reply categories: "very great importance" + "great importance". Other reply options were "some importance", "less importance", "no importance" and "don't know".*

#### Possible interpretations

Keeping to budget limitations is an interesting find from a comparative point of view. Norwegian hospital directors believe, relatively speaking to a greater extent than their Danish colleagues, that their personell is motivated by this concern. This can be interpreted as an illustration of the above-mentioned point that leadership occurs in several chains, and that Danish leaders to a lesser extent achieve breakthroughs in the clinical/medical professional chain. Said in another way it may well be that Danish leaders are more frustrated or cynical in relation to their understanding of possibilities to affect the professionals' motivation. Recent decades' strong focus on and relatively large success in keeping to budget limitations has apparently remained primarily the business of the economic-administrative management chain, and thereby hospital leadership. The health professionals are still perceived by hospital leaders as internally and professionally motivated and perhaps partially opponents in relation to the requirement of keeping to budget limitations.

The relatively high ratings of economy as a motivation factor in Norway certainly reflect that economic management indicators an attempts to achieve better budget discipline, more effective functional distribution between units within Norwegian health concerns and attempts to make savings have become part and parcel of Norwegian hospital leaders' daily life. The economic focus attached to leadership has been prominent, and it is in this area much of the Norwegian conflict lies today. When one in Norway introduced sole leadership at all hospital levels combined with the concern model, this also represented an attempt to found a stronger degree of economic management at all hospital levels. One director of a Norwegian health concern expresses, amongst other things, this concerning these conditions in an interview during the spring of 2003:

*“One effect of the reform comes as a consequence of the accounting law. Namely that it forces forward a much greater degree of economic consciousness about what is happening in hospitals.”*

Based on this, and from what one has otherwise been able to observe and experience, keeping to budget limitations has probably become more important in Norway. The lack of economic management has historically speaking represented a problem. There has up through the years been little attention paid to economy (Berg 1981). The medical profession and the health professional leadership have previously stood forth as more or less anti-capitalist, independent of economic conditions, and have had a mandate from within a system in which expert status counts for most, is rewarded and sanctioned within the profession; through a consecutive and diffuse management system of culture, norms and networks, i.e. “the logic of appropriateness” (Berg 1987, March and Olsen 1989, Vareide 2002). When the annual large budget deficits appear, these have always been paid off through extra funding allocations – either by Parliament or the National Insurance System. The problem of economic deficits was especially large through the last half of the 1990’s in the final phase of the county management regime in Norway – this, amongst other things, brought up the topic of a new activity-based financing system in an attempt to reduce the growth (Lian 2003). The concern reform considered as a management reform can be seen, against this background, as an attempt to gain control of the growth in expenditure.<sup>1</sup> A Norwegian director gives the following description and interpretation of the concern reform in an interview during the spring of 2003:

*“ Broadly speaking it is here a case of a legal responsibility reform, a leadership reform and a financial and economic reform. I believe the hospital reform or concern reform has had two outcomes. One is that it has made leadership in hospitals visible at all levels in the production chain and it has accelerated the need to foster hospital leadership at all levels.”*

Focus on economic management indicators are also translated into practice and seem to affect leaders’ focus at all levels in the Norwegian context of activity. Introduction of sole leadership in hospitals can be understood as a new step in the realisation of this idea. Leaders of result units are given the full result responsibility in as far as they have to meet the objectives sanctioned at a higher level in the organisation. When shared forms of leadership are under pressure, this can be understood as an expression of the current ideology putting equal signs between sole leadership and leadership as result responsibility (Torjesen and Gammelsæter 2004).

One Norwegian head of department with so-called “sole responsibility” tells here of his experience at the start of 2004:

*“We should not just get rid of waiting lists and help patients who are desperate and waiting in the queue, but budget control is important and this is what we do. Every month I check all sides of the budget. We get this type of budget control every month in which we have to examine every single post and look at what we have of deficits on medicine, overtime, extra shifts etc. All this is important. It is baked into us leaders. There is then enormous pressure on*

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<sup>1</sup> The actual growth in expenditure in general hospitals in Norway increased strongly from 1995 to 1997, with an annual growth of over 7%. The growth during these years is, however, especially connected to salary increases in the sector. The growth is also based on a considerable increase in resource input. There was amongst other things a strong growth in the number of work years (about 12000) from 1990 to 2000 (NOU 2003:1).

*the economy, also on the income side. This concerns input-managed financing by which we, with the help of correct coding of registered patients, can increase our income ability enormously. This is not always fun to do. There is pressure put on economic management and acquiring income which can sometimes make life very difficult.”*

The above quote probably bears witness to the pressure being greater after the reform. Most local health concerns today fight to hold the economic saving requirements imposed on them by the regions.

It is at the same time interesting that professional/expert commitment ranks highest and is nearly the same in both countries. Motivation and commitment from the profession itself does seem to be the dominant driving force in both countries. Even if introduction of the leadership dimension means greater independence from the professional aspect in Norway, and economic aspects affect leaders' management focus, the health professional commitment is still given large significance as a factor for motivation of the personell. It looks as though Norwegian leaders try to combine or balance professional and economic considerations. In the same Norwegian study, the majority of Norwegian leaders, 63% agree with the assertion “that leadership can be considered to be an independent subject unconnected to health subjects”. The leaders have, however, not completely freed themselves from professional considerations. The vast majority of Norwegian leaders (72%) attach great importance to independent professional standards as a value for carrying out daily work, and many leaders still have clinical work, in that every third leader(34%) still keeps up clinical practice in combination with leadership tasks.<sup>2</sup> Leaders live then in the area of tension between health professional considerations and more independent leadership that is unconnected to profession. A head of department in Norway illustrates this tension in the following way:

*“ My role embraces all possible dilemmas and contradictions. It is obvious if one becomes too clearly a purely administrative person who only moves by way of laws and regulations, one loses respect. Because the profession and leadership of this profession covers everything, one has to find a suitable balance between professional development and administrative development.”*

The quote gives the impression that hospital managers can be considered as negotiators between different values and value systems, i.e. that they integrate a set of ideas belonging to medicine a set of ideals belonging to leadership (Llewelyn 2001). Experience shows that it is not necessarily neutral professional leadership we are talking about (Benzen 2003), and that leaders to a larger extent uncover their professional identities. Surprisingly great importance is attached to professional commitment amongst Norwegian hospital managers as well as in Denmark with respect to motivating employees. The context of activity may have provided favourable conditions for the entry of a new and stronger leadership logic in Norway. This can however be tackled consecutively, through hospital managers putting on different hats dependent of time and place. A health leader in Norway says amongst other things this, as regards balancing different requirements and considerations:

*“ The popular decisions are not really hard to make. With unpopular decisions, on the other hand, if one is going to cut down or reduce services, it is obvious that it may be difficult to make such decisions and in the next moment become part of the group of experts. But some*

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<sup>2</sup> Amongst Norwegian leaders we have data for (N=133) in which every fourth head of clinic and top leader report working with clinical tasks and 45 % of heads of department.

*manage this. It works in a way if one manages to separate the roles. In a way change hats and say that: we have now finished that discussion.”*

One can also imagine leaders preserving their professional identity because they have invested a large part of their lives and careers in this, and it looks as though nurses to a greater extent than doctors choose leadership as a special career. A Norwegian leader with background as a doctor gives the following explanation of why medical professional identity is so strongly represented amongst leaders who are doctors of medicine:

*“I think that leaders who are doctors still have a strong professional identity because they will experience it as much worse to be squeezed between overriding management considerations and professional considerations than nurses and experience stronger problems finding out where their loyalty lies, or who they should take account of. Nurses choose this as a career and put their profession and the clinic behind them. Doctors would like to return to a job practicing medicine as a doctor. Usually one has used up about 11-12 years becoming a specialist. Nurses usually haven't done this.”*

Hospital managers are carriers and negotiators of changing considerations and requirements; they identify themselves both with the leadership group in the activities concerned (69%), and with employees in their own clinic (62%). They stand forth, on the one hand, as professionally neutral as well as being loyal to the superior management signals, i.e. hierarchical management, “responsibility” and “accountability”. This balancing act seems to be a central part of the world leaders have to tackle through the activity reform and the leadership reform. In another Norwegian study (Lægreid, Stigen and Opedal 2003), top leadership in the local and regional health concerns reckon the regional boards to be competent and capable of making decisions. There also seems to be good co-operation between the boards and the administrative leadership.

Danish leaders' evaluation of county and democratically elected management boards more or less corresponds to this (Vrangbæk 2003), but the above table perhaps indicates that Danish leaders consider health professional autonomy in relation to the leadership function to be even stronger than the Norwegian, or alternatively that Norwegian leaders are more optimistic about establishing other types of motivation factors than the health professional ones. The experience of separateness between different management chains is also pronounced in the Danish situation, in spite of a long tradition of focusing on economic parameters. The leadership role is strengthened by various points (economy, information management, establishment of monitoring systems in relation to clinical activity), but the bottom line still is that hospital managers, experience the staff's primary motivation as being connected to health professional logic and recognition. The leadership's recognition means less than their colleagues' recognition, and personal financial incitements play a relatively inferior role.

A good relationship to users is for hospital managers an ongoing important motivation factor in relation to the staff, and ranks as nr.3 in both countries. It is tempting to interpret the figures in the light of a general NPM trend which leaders seemed to have snapped up and identify themselves with. In Norway, the focus on users has been greater during recent years, amongst other things because of patient rights jurisdiction. When the Law establishing Health Concerns arrived (Government proposition 66 (2000-2001), one of the purposes was to strengthen the users' position and establish a “quasi” type of market for the allocation of health services, free choice of hospitals etc. (Østergren 2003, Vrangbæk and Østergren forthcoming). Later this has been institutionalised and legalised in the Law of Patient Rights.

The idea itself and the law concerning sole leadership dates back to the NOU-1997:1 “The Patient first”. In this document professional leadership was for the first time promoted as an answer to a more patient friendly health service. In an attempt to renew the contract between the citizens and the public, the “Supermarket Aspect” has gained ground within the NPM-inspired reform wave generally washing over the Western world. (Pollit 2000), but this trend has at the same time received local “field” versions (Røvik 1998), in that one in central health political documents has tried to mark a time change both in profession and leadership. The patient is now to come first:

*“The patient’s needs are the basis for all treatment and at the centre of all care. This is to characterise the development, practice and leadership of all health institutions. Health personell must first and foremost be recognised for and encouraged to make more efforts for patients’ wellbeing.”* (NOU 1997.2.9).

Whether this is loose rhetoric or has been put into practice is difficult to give an unequivocal answer to. Leaders do seem, however, to try and commit themselves to the ideas concerning greater patient focus. Even if a good relationship to users emerges as important for staff motivation and is ranked highly in both countries, user participation as an impulse to change, perhaps rather paradoxically, is given rather little importance in Norway with only 22%, (see the table beneath), whereas this represents a considerable change impulse according to Danish leaders. We can again interpret this based on the public criticism of Norwegian health concerns’ seclusion in their decision-making processes e.g. concerning localisation and functional distribution. Many of the decisions to create more functional and effective running through closures and fusions of units have been met with popular resistance. Introduction of the concern reform has ushered in a new age for torch-lit demonstrations in many Norwegian local communities. In some towns there have been more people out on the streets than during the freedom days of 1945. Evaluation of and research into the Norwegian reform has shown more or less lacking support and local political resistance (Lægreid, Stigen and Opedal 2003). The user organisations have strived to gain access to central decision arenas, and user participation does not seem to have replaced previous local political representative systems. The hospital reform in Norway can, based on this, have created a representative or communicative vacuum between activity and users. Today communication appears to a greater extent to occur through signals from quasi-market systems, e.g. in the form of free hospital choice.

A good relationship to superior authorities scores surprisingly poorly in both countries as a factor for motivating the staff. Again this is about the leadership’s interpretation of their staff’s motivation factors. The result again reflects then a conception of the health professionals in the eyes of hospital managers being relatively cut off from the political-administrative management chain. Their mode of function and legitimacy is built on internal professional criteria sooner than their ability or will to please external professional requirements.

### **Change impulses**

Based on the NPM trend and the discussion of autonomisation of hospital management, one could expect that hospital managers in both Norway and Denmark attach relatively little importance to political signals and requirements from administrative authorities and relatively greater importance to leadership and users as change impulses. Sociological new-institutional theory would lead us to expect that leaders to a relatively large extent point to “sister organisations” as sources of inspiration for changes.

**Change impulses: Which of the factors mentioned below have in your opinion contributed to triggering and forming changes in your unit?**

	<b>Denmark</b>	<b>Norway</b>
Political signals (e.g. changed priorities, new legislation etc.)	87	75
Influencing users (e.g. new user chains, more demanding users, active user organisations)	87	29
Requirements from superior administrative authority	81	75
Leadership (e.g. new leadership, new leadership methods etc. )	80	83
Technological advances	77	71
Inspiration from “sister organisations” (producing similar services)	60	32
Pressure from the media (e.g. poor mention or unfavourable focus on the organisation/unit and its tasks)	59	19
Internal problems (e.g. chronic bad financing, ageing staff, poor image)	44	52
	N= 46-47	56-58

*Reply category: “Especially important role” + “important role”. Other reply options were “not so important a role”, “unimportant” and “don’t know”.*

**Possible interpretations**

Political independence as a change impulse appears to have been attached importance to amongst leaders in both countries. This impulse is ranked highest or second highest as an important change impulse in both countries. The administrative authorities’ requirements also hold a strong position. In Norway the irony is here that the health reform, that was partially meant to depoliticise the sector locally, created a situation that is more politically charged than ever before. The health minister and the department constantly have to tell local communities and Parliament (in minority) what is going on in relation to the reform, and have on several occasions during the last couple of years changed management decisions taken in health concerns.

Nevertheless, leadership seems to rank highly in Norway and leaders attach great importance to themselves. Given the leadership reform, and that it is here leaders who answer, this is not so remarkable. But if we take into account the strong emphasis on leadership through decentralisation and new framework conditions, and the great belief in this in Norway at present – it looks as though this belief has gained a strong footing, i.e. that leaders stand forth as the new co-ordinating elite with respect to hospitals and that local politicians in the old counties have disappeared out of the picture. Based on own data, emphasis on leadership as a change impulse is made clear, 70% of Norwegian leaders agree with the statement that they have great influence (autonomy) when all is said and done, 63% consider leaders to have gained more power and influence after the transfer to sole leadership in Norway.

In light of the previous table concerning staff motivation, it is remarkable that Norwegian hospital managers attach relatively little importance to users as a change impulse (here we refer to the above discussion). Furthermore, it is strange that relatively little emphasis is placed on inspiration from sister organisations compared to Denmark. This supports the above interpretation that Norwegian hospital managers, to a greater extent than their Danish counterparts, see the organisation as autonomous in relation to external factors which may influence the situation.

Another difference is that Danish leaders, to a much larger degree than Norwegian, have experienced media pressure as an independent change factor. This could support the conceptions of a more consistent politicisation of the health system in Denmark, and a relative screening of Norwegian hospital organisations up until now.

## Value orientation

Based on the NPM discussion and general management political tendencies as illustrated in Beck Jørgensen (ed.) 2003, one could expect that values being connected to user needs, productivity, change and innovation, as well as career opportunities would have a relatively high standing for modern public hospital managers. On the other hand, one could expect that democratic principles such as political managability, public insight, user democracy, and consideration paid to public opinion would stand up relatively weaker than previously. Something similar could be the case for broad public values such as legal security, general societal responsibility, equal rights and continuity, as long as the hospital manager to a greater extent is oriented towards the organisation's strategic location in a dynamic market and in an interplay with users. Finally, one could expect that network values would have a relatively high standing.

As shown in the table, these expectations are fulfilled to a certain extent. The results are discussed more closely below.

## Value orientation

	Denmark	Norway
Independent professional standards	80	20
Individual user needs	78	31
Productivity	61	50
Change, innovation	57	30
General societal responsibility	49	36
Transparency for the public	45	21
Equality	44	21
Legal security	35	33
Career opportunities	26	12
Political managability	24	38
Horizontal movement, network development	20	9
Continuity	18	12
Concern for public opinion	15	12
Enhancing user democracy	13	9
Balancing interests	11	18
	N=45-46	N=55-58

Note: reply in the first category: "basic, we can be associated with this."

## Possible interpretations

The four first values in the Danish column present a picture of professional, user-oriented, ready-for-change and productive organisations. It looks in other words as if NPM oriented values in interplay with professionally oriented rank highly with Danish hospital managers, whereas traditional democratic and public sector values end up further down the list. It is different with Norwegian leaders, for whom the productivity value tops the list, but this is combined with "political managability", "general societal responsibility" and "legal security" as values immediately following on. It seems, in other words, somewhat paradoxical that the Norwegian leaders' value profile is relatively more oriented towards traditional public sector values than their Danish counterparts' profile. The Norwegian reform has seemingly not eroded the traditional public sector values (yet). On the other hand Norwegian leaders attach little importance to the value of network development. Norwegian hospital managers are apparently more oriented towards hierarchical relations and individual productivity, than to relations to external co-operational organisations and users.

## Discussion

Initially we put forward a thesis that the leadership function in both countries in their self understanding is affected by the NPM mode of thought, but that the impact may be different as a result of differences in the path of reform. We argued moreover, that hospital managers in both countries are stretched between different overlapping management chains, that are not necessarily to the same extent characterised by new management ideas. We studied four main themes in order to shed light on these questions.

With respect to the leaders' comprehension of *changes in hospitals' placement in relation to the outside world* we found out that Danish leaders along most of the dimensions indicate a greater degree of change than Norwegian leaders. The exception to this is the change in formal status, which is not so surprising given the Norwegian reform. Danish leaders feel to a much higher degree than Norwegian leaders that it is a question of "increased participation in networks" and "increased competence in relation to closest superior authority." The first provides a picture of Norwegian hospitals that "close themselves up", but that despite the change in formal status do not necessarily feel that they have gained greater competence in relation to superior authorities. This is surprising seen in relation to the reform's intentions. Generally speaking one might well conclude that the Norwegian reform has created more formal autonomy, but that far from all Norwegian hospital managers experience increased competence with relation to the closest superior authority. Furthermore, that Norwegian leaders are more oriented towards political administrative management relations than networks across organisations.

*Leaders' understanding of what motivates the staff* was the next theme. Here the main conclusions were that the leaders in both countries understand profession-related motivation factors to be predominant (health professional commitment, development on the job, colleagues' recognition, a good relationship to users and social factors at work). Further down the list come factors such as the leadership's recognition, keeping to budget limits and a good relationship to superior authorities. These results can be interpreted in the light of the first presented ideas concerning overlapping, but partially separate management chains, in which leaders to a large extent experience that the staff orientates itself towards an expert professional management logic instead of an economic-administrative logic. – However, there are interesting differences between the countries, in that Norwegian leaders seem to be more optimistic than their Danish counterparts with regard to the importance of traditional motivation factors such as "the leadership's recognition, "commitment to the organisation's role/mission" and focus on "keeping to budget limits". One interpretation may be that Danish leaders have longer experience with this type of reform, whereas the Norwegian reform has relatively recently been introduced.

The third theme was hospital managers' understanding of *change impulses and dynamics*. Here it was remarkable that leaders in both countries still consider political signals and requirements from superior administrative authorities to be primary change impulses. Danish leaders especially, point in addition to user influence, whereas this, rather surprisingly only to a limited extent, applies for Norwegian leaders. Both Danish and Norwegian leaders attach great importance to leadership as a change impulse. One has, in other words, a clear understanding that leadership does make a difference, and that one as leader oneself has an opportunity to influence, within the framework, that is given from the political-administrative system. Much more importance is attached to inspiration from sister organisations in Denmark than in Norway. This can be collated to the above-mentioned tendency for Danish

leaders to a greater extent than Norwegian to be oriented towards network development. Altogether this indicates that Norwegian hospital managers consider their organisations to be more secluded and autonomous units than their Danish counterparts, or that one in one's leadership orientation especially focuses upwards towards political-administrative authorities and inwards towards one's own organisation, but to a limited degree outwards towards networks, sister organisations and users.

The fourth theme was hospital managers' *value orientation*. Here emphasis in both countries is put on productivity, reflecting the generally strong focus on the economy dimension over the last decades in both countries. Apart from this there are interesting differences in that Danish hospital managers to a relatively higher degree than their Norwegian colleagues emphasise professional standards, user orientation and change readiness. The Norwegian leaders place a lot of emphasis on traditional public sector values (political managability, societal responsibility, legal security) compared with the Danish leaders. In relation to sets of values Danish leaders emerge as more NPM oriented than Norwegian leaders.

What broadly-based conclusions can then be drawn from these observations?

It seems as though both Danish and Norwegian leaders stand in a field of tension between, on the one hand NPM- related conceptions concerning greater autonomy and business requirements, and on the other hand a continuing strong anchoring in general public sector values and orientation towards administrative and political authorities. A third dimension in the field of tension is the professional logic, at any rate in relation to the staff's commitment. Differences in the two countries's profile can, however, also be ascertained. Norwegian leaders seem, surprisingly enough, to place relatively more emphasis on traditional public sector values. Norwegian leaders are, moreover, to a lesser extent than their Danish counterparts against establishing external and horizontal networks. Neither did user orientation surprisingly play a dominating part as a change impulse or in relation to value orientation in Norway.

The differences are not quite so clear as one could expect bearing in mind the Norwegian reform, and in some cases the differences go in the opposite direction of expectations. This can perhaps be due to the time factor. The Norwegian reforms are relatively recent. Before 2002 one had lived a more secluded existence than Danish hospitals with regard to rationalisation requirements, NPM instruments and structural adaptation. The reform's effects are first now beginning to make an impact.

Another type of explanation is that the structural reforms carried out despite all the commotion and attention have actually had a limited impact in relation to the practical reality of leadership of public hospitals. There probably is a certain increase in the surrounding complexity and uncertainty, and a definite objective of greater autonomy, but basically, public hospitals' primary points of orientation are still the political/administrative hierarchy and the expert/professional production chains, supplemented by users and networks in Denmark.

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