English summary

In this volume, we have described and discussed the development of the central civil health administration in Norway from 1983 to 1994, but have also put the story of this period into a longer time perspective. We have tried to show that this period is a transitional period.

First, we discuss the macro content of the transition: the struggle about the content and implementation of the overarching organizational reforms, and thus also the relationship between especially the Ministry of Social Affairs and the Directorate of Health. We then portray the leading man behind the drive to reorganize the central health administration, Permanent Secretary Jon Ola Norbom. We continue by looking at the micro reforms of the organizations, especially the Ministry and the Directorate. Following this discussion, we portray Mr. Norbom's chief "adversary," Director General of Health, Torbjørn Mork. We then go on to look at the functions of the central health administration, the "upstream functions" of health and disease surveillance and planning of new policies, then at the top functions of decision-making and the content of the policies and finally at the "downstream" functions of implementation, control and supervision. In the last part we also discuss the emergence of the new quality control and development policies. We close by discussing the theoretical and ethical considerations that have informed the study.

The transformation of the macro structure of the central health administration

In 1983 the former Ministry-based Directorate of Health, was moved out of the Ministry and established as a separate, more technically oriented directorate. At the same time the Ministry established a division for health affairs, headed by an "ordinary" division head ("ekspedisjonssjef"). The "old" Director General of Health was partly an independent directorate head, to wit in "professional matters," and subordinated to the minister in "political" matters. He did not report to the permanent secretary of the Ministry. He was himself a kind of permanent secretary, of health affairs, that is. The Ministry was in this way partly a bifurcated ministry – two ministries with one minister. This arrangement gave the Director General a very strong position, a position the then current director, Torbjørn Mork, like his predecessor, Karl Evang, knew how to exploit. They were both strong personalities.

The 1983 macro structure reform was part of a broader regime reform. A physician-led regime that we have called an *iatrocracy*, after the Greek words for physician, *iatros*, and rule, *krateín*, dominated the health care sector until the mid-1970s and early 1980s. Under this regime the medical chief had not only a strong position in the ministry, he also had a direct managerial line to the physician leaders at lower administrative and clinical and pre-clinical (public health) levels. Directly under him, the top physician had county physicians. Either directly, or through these middle-level physician leaders, he (and his directorate-based (medical) head of the physician office) had a line down to the state-appointed, locally based, district physicians. The latter managed local health affairs. The Director General also had a line, via his directorate-based hospital office (physician) head, down to the medical chiefs of the hospitals. He also had an important influence on who became hospital medical chiefs, and of course county and district physicians.

This regime began to crumble during the (second half of the) 1970s and first half of the 1980s. The "outsourcing" of the Directorate from the Ministry in 1983 was the most symbolic expression of this. However, the change of regime involved more than that "outsourcing." The outsourcing meant that the Director General lost his direct contact with his collegue leaders in the municipalities and hospitals, the district physicians and the managing chief physicians. The municipalities took over (most of) the primary health care system in 1984 and counties (most of) the hospitals and the specialist health care system in 1970 and 1976. The district physicians disappeared and so did the managing chief physicians. They were replaced by municipally appointed health directors and hospital directors appointed by the counties.

The new, emerging regime was at first a more "polycratic" regime, a regime characterized by a mixture of regime elements. It contained elements of a (lay) political regime – a democracy, of the legally based bureaucracy and, especially, of a utilitarian form of regime. The latter, also called goals-and-results oriented, was the most dynamic element in the reforms. Many observers soon began to describe it as representing a New Public Management. We may add, that the two latter forms of governance and management, inspired by legally trained people and economists, represented an attempt to replace lay-political or medical common sense-based management with a more professional and explicit form of management. The first round of reforms resulted, however, also in a strengthening of the lay-political element. This had a great effect on the "politics" of the health care administration reform in the 1983-1994 period; it delayed the utilitarian professionalization of the governance and management of the sector. Thus from the close of our period, new initiatives were taken to curb the current influence of elected politicians, especially at the lower levels of government and in the management of clinical health care. Hospitals were, from 2002, made into state-owned enterprises, managed by partly politically shielded managers. At the local level, many nursing homes became business-like entities. Many other, more freestanding health care providers became more or less tightly controlled contractors. This happened at about the same time as the hospitals were "nationalized" and made into companies. We should add, though, that it was not the intention of the reform-makers to loosen up the management of the health care system. They wanted to *strengthen* it, by making it more "objectively" results-oriented. Let us add, that at this time almost the whole medicines sector was privatized and commercialized, and thus subjected to an even more non-political and strict management.

Our period acquired much of its flavor from the attempts to introduce and implement the new form of management. At the central administration level, the Director General of Health, Torbjørn Mork, and many of his people, were strongly opposed to the reforms, not least the wing-clipping of the Directorate and its chief. The Director General was, however, also strongly critical of all the organizational reforms, especially the dismantling of the district physician system. Thus, when the Ministry was to implement the bifurcation reform at the top, he was anything but cooperative. Several sharp exchanges of opinions, especially between the Director General and the deputy Minister, the orchestrator of the outsourcing of the Directorate, and the head of the new health division in the Ministry, erupted. The leaders of the Ministry did much, starting in 1984 and continuing to the end of the 1980s, to try to allay the tensions, but to little avail. The permanent secretary, Jon Ola Norbom, felt that he had to do something about the tense situation, but failed in getting the Director General to accept the new state of affairs. The latter continued to air his dismay. Mr. Norbom, a cautious economist-diplomat, dubbed these years the period of "creaking" ("knirkeperioden"). In the summer of 1989 he decided, with the implicit support of the outgoing Minister, that something more surgical had to be done if the Minister and the Ministry was to be able to function properly again as a Minister. With the support of the new bourgeois Minister, and

with himself as chairperson, he prepared a "secret" proposal for a reformed central health administration (October 1990). The bourgeois government soon after collapsed and a new minority Labor government acceded to power, with Tove Veierød as Minister for Social Affairs. She gave Mr. Norbom the green light to go ahead with a study of how to reorganize the central administration. The latter presented the recommendations of his group on 19 August 1991. The group recommended splitting up the Directorate into several components and merging some of them with other, existing institutions. Norbom and his co-analysts also recommended placing the specialized health administration institutions under the direct command of the Ministry. These institutions were now under the direction of the Directorate of Health. They also recommended that the Ministry took over the superior function of supervision from the Directorate. In other words, the recommendations implied the centralization and "politicization" of the central health administration of the country.

The report from the Norbom group stirred up much political noise, but the Ministry went ahead with the planning of the reforms, but now with Mr. Norbom on the sidelines. As the chief target of the opposition against the reform plans, he could not also lead the work of turning his general policy proposals into concrete draft laws. In the course of the fall of 1991, it became clear that it might be difficult for the government to secure a parliamentary majority for the Norbom plan and its legislative concretizations. If the government was to get the plan, and the accompanying legislation, through parliament, it was dependent upon support from the bourgeois side. It quickly became clear that the right wing Progress party would go against the plan, as would the Socialist Left Party. As the fall turned into winter, it also became uncertain what the Conservatives would do. Some, including the previous minister, had already come out against the plan. However, the government decided, without overt enthusiasm, to follow the plan. As the Ministry worked with the plan and its accompanying bill during the winter, it became more and more uncertain whether the two middle parties, the Center party and the Christian People's party, would stick to their earlier commitment to reform. In the end, they turned against the proposed legislation, and plan. On the night between the 15th and 16th of June Parliament rejected the bill. The Minister, and in reality her Permanent Secretary as well, were humiliated. Not even the MPs of the party of the Minister stood up for her. The Prime Minister was absent from the floor of Parliament that night. A few months later, the Minister of Social Affairs threw in the towel and a new minister was appointed.

When Parliament rejected the government's, or the Minister's, plan, and thus "rescued" the Directorate from being dismantled, it also dictated that the Directorate of Health be redefined as a *supervisory* agency. The intention of the parliamentary majority was not to make the Directorate into a new type of institution, but that was eventually what happened. During the old regime, supervision had been a mostly collegial type of activity. Now it was to become more "modern," i.e. legalistic and professionalized. As the new supervisory agency, reorganized as such from 1994, began to realize what supervision implied, and the Ministry did likewise, it did not take long before at least a partial dismemberment of the Directorate was executed: The non-supervisory tasks were "outsourced" and made parts of a new Directorate of Health and Social Affairs (2002). The seeming "victory" Mr. Mork had won in 1992, turned out to be a Pyrrhic victory. However, he did not live to realize it. He died in the fall of 1992. The administrative leaders of the Ministry, humiliated in 1992, in effect took revenge on the Directorate a decade later.

The Ministry's Permanent Secretary: Jon Ola Norbom

In separate chapters, we have portrayed the two chief administrative "combatants," the Permanent Secretary, Jon Ola Norbom, and the Director General of Health, Torbjørn Mork.

The former was born in Bærum, a wealthy suburb of Oslo, in 1923. He had had a stint as Minister of Finance in 1972–73, but had otherwise had a professional and administrative career. He trained as an economist, and as a young man joined the Liberal party. In spite of his brief political experiences, his style was cautious and low-key. He was, by nature, more an administrator than a politician. The bourgeois government in 1983 asked him to take the position of Permanent Secretary. After some hesitation – he was well established as a GATT director in Geneva at the time – he accepted the invitation to apply for the position.

He was well respected in the Ministry and had a good relationship with all who served as ministers during his tenure as Permanent Secretary. When he and his commission had delivered its report on administrative reform in August of 1991, he refrained from going into confrontations with the Director General of Health. He had delivered his report and it was up to others, to wit the political leadership of the Ministry, and the administrative staff assigned to prepare the reform plan and the new legislation, to complete the work he had started. However, it was not easy for him to be just an observer, especially since he continued to be the main target of the opposition against what was seen as *his* plan. Turning 69 in December of 1992, he stepped down as Permanent Secretary, but remained for another year as special advisor in the Ministry – on the future financing of the welfare state.

The Internal Re/organizations of the Ministry's Health Division and of the Directorate

In 1983, the Ministry established a general division of health. However, the Directorate remained the quantitatively dominant central health administration agency. The Ministry was organized to handle strategic functions, including the preparation of long-term plans, the budget and legislation. Its head, Harald E. Hauge, a physician, managed the division in an ambitious way and soon began to challenge the position of the Director General of Health as the country's No. 1 public health physician. That contributed to the tension between the Ministry and the Directorate. However, his relationship with the Minister began to sour after the change of Minister (and government) in 1985. Nevertheless, the Ministry continued to expand in the area of health, fueled by the growing tension with the Directorate. In 1988, a public health unit was established. It was administratively but not strategically related to the division of health. That same year a Secretariat for modernization and efficiency development was also set up, more or less on the side of the division. Both of these units were a challenge to the Directorate, and a beginning of the introduction of a new and more ambitious Ministry as far as health was concerned. The new realities were formalized in 1992 and 1994. A Minister of health was appointed in the fall of 1992 and from 1994 the Ministry was called the Ministry of Social and Health Affairs.

The Directorate, which had been organized largely based on offices headed by health professionals, was in 1983 organized based on a mixture of principles. Most importantly, it

was organized based on politico-administrative premises, with one division for the municipal health care system and one for the county health care system. The pharmacy office continued as a partly pharmaceutically managed office, but was redubbed the Medicines division, reflecting the growing role of the industrialization of the medicines supply-chain. The old hygiene office also continued, as a public health division. Finally, the administrative office went on more or less as before, but its role gradually became stronger, as an NPM-administering and promoting division. From 1989, the two first divisions merged and a new division for health law was established. The last reform reflected the Directorate's movement in supervisory direction, but also the increasingly prominent role of legally trained personnel in the Directorate.

Mr. Mork did not have a clear philosophy about how to organize and manage the Directorate, though he did at first signal that he wanted to strengthen the office of the Director General. He gave in when the unions reacted negatively. When the Directorate reorganized from 1989, then, it did so more as a function of the distribution of power inside the organization and the recommendations of hired consultants, than of the strategic thoughts of the Director and the leadership group of the Directorate.

The Director General of Health, Torbjørn Mork

Torbjørn Mork, born in Odda on the West coast in 1928, was, of course, a physician. Mr. Mork was influenced by the traditional culture that still dominated the region where he grew up. He was a bright boy and chose medicine as his profession. After having gone through the post-graduate clinical program required to become authorized as a physician, he went into epidemiology and public health and earned a PhD from the London School of Hygiene and Tropical Medicine in 1960. As a youth, he had supported the Conservative party, but as a young physician he joined the Labor party. He was appointed Deputy Minister of Social Affairs in 1972. Later that year he succeeded Karl Evang as Director General of Health.

Like Mr. Evang Mr. Mork was a strong-willed and charismatic leader. During his first period, the years from 1972 to 1983, the attacks on the iatrocratic structures started to come, as we have seen. At first, Mr. Mork played along with the new way of seeing things, but from around 1977, he became increasingly critical of them. From the fall of 1977 he began to air his dissenting views. When the Directorate was outsourced in 1983, he almost became a health policy dissenter. However, even if he was highly critical of the most important structural reforms, and engaged in what almost became a war of attrition with his superiors in the Ministry, he accepted, but did not embrace, other parts of the new ideas for public management – like the ideas about public planning associated with the NPM program. He also, by emphasizing the growing role of his Directorate as a supervisory agency, unwittingly contributed to laying the premises for the dismantling of the old Directorate.

Torbjørn Mork, who had written his PhD thesis on the epidemiology of what was to be called COPD, was a heavy smoker and toward the end of the 1980s, the disease began to visibly affect him. However, it did not soften his fighting spirit. He fought almost to his last day, in the fall of 1992, to save his beloved Directorate. However, he also, and perhaps more – and more wholeheartedly, fought for all those who struggled in life. If anything, his social engagement became stronger as he grew older. He defended the weak and downtrodden with

the fervor of a high priest. Mr. Mork died in his study at home, alone, just before he turned 64. Mr. Norbom died in April 2020 in Suwanee, Georgia, at the home of his oldest daughter.

The Functions of the Central Health Administration

We have discussed the development of the functions of the health administration by taking as our point of departure what we have called the administrative (and political) cycle: Thus, we start by looking at the upstream need and supply development surveillance. Data about these provide the premises for the planning of the next cycle of policy development and execution. The function of planning provides the premises for the final, in principle political, or top, function of decision-making. We close by discussing the content of the downstream processes of implementation and control. Under the latter rubric, we look at both supervision and the new quality control and development policy.

We have shown how the ambitious, precise, goal and results oriented utilitarian management philosophy, accompanied, but also at times challenged, by the new ambitious form of legalism, increasingly have come to dominate health policy development, government and management, in Norway as in many other Western countries.

On the upstream side, this has led to increasing efforts especially to monitor the need situation. From about the middle of the 19th century, the Norwegian Bureau of Statistics and public health authorities began to monitor the vital statistics of the country. To some extent, they also collected data about certain diseases and, gradually, about certain groups of patients and the composition of the patients in various institutions. However, these data were often a bit dated. Hence, "qualitative" impressions, demands aired by health personnel and patients, at times through the mass media, played a significant role. In 1935 (psychoses), but especially from the 1950s, a number of patient and disease registers, but also a birth register, were established. From the 1980s, medical specialists of various sorts began to establish quality registers for various types of treatment. All these registers reflected the "utilitarian" development of medicine – i.e., its increasing precision and goal-orientation. However, they were organized in a way that also reflected the iatrocratic past. Separate institutions, often controlled by self-conscious physicians, managed these registers. They did not see themselves as part of a wider and well-coordinated *managerial* cycle, e.g. such that they collected data in a health policy goal-oriented way. Rather, they tended to communicate downward – with the professional communities. Attempts were made during the 1970s and 1980s to merge some of these registers under the National Institute of Public Health, and in that way to link them better to the *managerial* cycles. The attempts created a reform pressure, but did not result in concrete reforms during our period.

The Norbom commission pointed out how the registers could be more closely coordinated, but refrained from recommending direct mergers. The processes leading up to the 1994 reforms also failed to result in ambitious reforms. The merger reforms were in many respects delayed until the reorganization of the central health administration of 2002. That year a new law on patient registers also went into effect. Part of the reason for the delayed progress of the utilitarian planners and managers was the growing concern about data protection and privacy. The establishment of the Data Inspectorate in 1980, and the appointment in 1991 of a

commission to look into the privacy concerns raised by the registers, put the ambitious utilitarian planners on the defensive for a while, but only a short while. In 1997, an important new register, the Patient Register, was established. It was for ten years run by the research institution Sintef Health, and then taken over by the (new 2002) Directorate of Social and Health Affairs.

We should add that throughout our period the need metrics used, reflected more the views of health professionals than goals defined by the health policy authorities. We should also add that the data did show something that was becoming increasingly important: Since the 19th century, and a couple of decades into the 20th, acute diseases dominated the clinic and infectious diseases the pre-clinic (the public health work). Child mortality was high and people had five to six children. After World War II, improved living conditions, the success of public health work and a more effective clinic resulted in a shifting of the bulk of the need from acute pathology striking children and young people to chronic pathology burdening older people. People had only two children and they all survived into adulthood. This began during our period to create tensions between the clinic and the pre-clinic. Health services research and clinical epidemiology – they both emerged during the 1960s and 1970s – began to question the health effects of clinical work, and recommended to shift resources to the public health arena. Much was done from the mid-1970s, and especially through the 1980s and early 1990s to give "health for all" more attention, but with modest effects. Acute illness continued to trump potential illness.

On the supply side, the volume of information gradually became larger and more policy relevant. The main information gathering and providing institutions were the statistical bureau, Sintef (Samdata) and the Public Health Institute. However, the information they collected and disseminated was only related to the various types of resources, like personnel, institutions, (some) technology, economy, beds etc. There was no real monitoring of the development of the content of knowledge and its accompanying technology. That monitoring took place in the old-fashioned way: Central administrators, especially in the Directorate, tried to keep track of the development, by reading journals, participating at conferences and seminars and keeping in contact with key researchers and clinicians. The Directorate also used various medical specialists as advisors. As medicine began to become more precise and rules-based – that is, to become "evidence-based" – it became more relevant to manage clinical (and pre-clinical) practice with the aid of guidelines and the electronic recording of (pre-) clinical practice (that was now beginning to become more extensive). The Norbom committee talked about the need for a "competence policy." However, the suggestions of the committee were premature. A center for knowledge administration was only established in 2004, in the wake of the extensive administrative reforms of 2002. The model was the British National Institute for Clinical Excellence (NICE), established in 1999.

Before our period, much of the planning was based on traditional reports prepared by experts and representatives of key stakeholders and analyses carried out in the Directorate or the Ministry. These reports and analyses took as their point of departure in data about need and supply and partly in policy discussions where various stakeholders frequently played a role. However, during our period, the planning became somewhat more systematic; i.e. more based on precise data and on explicit goals. This became clearer from 1991 and especially 1992, when the government emphasized that ministries should formulate their policy documents in a goal-oriented way, and align their sectorial policies with the national and state budgets. As part of this more integrated policy a new measure was introduced, the so-called assignment (or commission) letter. To follow up this form of goal-oriented management, the government

introduced a system of top manager contracts. It contained a bonus element. However, practice was less strictly utilitarian than the policy declarations and even the new managerial techniques could lead one to think, even toward the end of our period. Old-fashioned politics and politicking continued to play a role. The new goal-and-results oriented institutional planning ("virksomhetsplanlegging") that was introduced around 1990 became more an expression of a planning exercise than of creating templates for policy execution.

From a goal-oriented perspective, policy execution should be a relatively "mechanical" undertaking. Control should be a "simple" and precise activity. However, just like the relations between the various functions on the upstream side were loose in our period, so where the relations between the downstream functions. One reason for this was that the state was becoming normatively over-ambitious (equal access, high quality, cost control/efficiency). By becoming so, it forced decision-makers at lower levels to determine many real priorities. Another reason, which just as much had to do with strategies as goals, was that much decision-making authority rested with the municipalities and counties. A third reason was that the state's own administrative system was loosely "coupled." As we have seen, even the two primary "heads" of the health care system, the Ministry and the Directorate, were at loggerheads throughout our period. There were also skirmishes between the Directorate and some of the administrative level three institutions. A fourth reason was that at clinical levels, much remained of the old professional, especially medical, autonomy. Here we should add though, that as this autonomy came under attack, from above by county and municipal authorities and from below by professionally ambitious nurses, much political noise erupted.

Yet, at the same time, the new, more interventional legislation and more goal-oriented form of planning and management began to reshape the downstream processes. The new legislation came first, from 1969-70, the utilitarian management later, from the mid- and late-1980s. After the division of the Directorate in 1983, the Ministry took control of much of the key administration of the most important laws. It remained for the Directorate to take care of the more technical and less value-laden part of the administration of the legislation. From time to time, the Directorate complained about this. The Directorate became more preoccupied with the development and administration of the new institutional plans from 1989. From 1991-92 both the Ministry, the Directorate and other central health administration agencies began to adapt to the new NPM-inspired directives.

From 1983, the Directorate became partly an agency for policy implementation, in practice for the detailed administration of laws and regulations, and partly an agency for control and supervision, including for the handling of complaints (from patients). As we have noted, the latter tasks came to occupy an increasing part of the portfolio of the Directorate. It became an inspectorate from 1994, and solely that from 2002.

At first, it handled its control and supervision functions in a semi-traditional, or pedagogical and collegial, way. Gradually it became a more modern, professional and legalistic supervisory agency. However, it did not become only a professional such agency. It retained some of its "political," or activist, role: Its role was limited to health concerns; it could largely disregard economic concerns. Hence, it was from time to time tempted to criticize care providers for letting economic constraints cause harm to citizens (patients). As we have seen, the Director General liked to see himself as a kind of watchdog for patients, especially "vulnerable" people (patients), at times to the chagrin of politicians responsible for the relevant services.

However, the Directorate was not even responsible for supervising all direct and indirect care or public health work. It was especially concerned about services. The commodity side of the "equation" was often, in whole or part, the responsibility of specialized technical agencies, with the exception of the clinical use of these services. This was the case with radiation hygiene, the supervision of electro-medical equipment and medical materials. From 1994, Norway's entry into the European Economic Area led to the enactment in 1994 of a law about medical equipment (generally). Through this law, Norway had to abide by European regulations. The law meant that the cultural influence of the commercial world on the health *services* sector became stronger. After the Norbom-processes, a process of outsourcing of the control with medicines started. In 2001, the Directorate lost the rest of its oversight of pharmacies and the pharmaceutical sector. The new, merged Norwegian Medicines Agency assumed control of the entire drug supply chain. Before this happened, both the wholesale and most of the retail sale of pharmaceutical products had been privatized and commercialized. Again, the (semi-)commercial encircling of the health *services* sector took a new turn. On the public health side, some of the same happened with the control of food production, sale and consumption. There had always been a tension between the industrially oriented food chain policy and the food control and food advice policy and practice. The first law on food control from 1933 did not "solve" those tensions. The same is largely the case with the next, from 1978, even if it was a law on *coordinated* food control. Coordination is more explicit in the law on food production and food safety that came in 2003. However, the new law was (to be) administered by a new agency, The Norwegian Food Safety Authority, administratively organized under the Ministry of Agriculture and Food.

Commodities of relevance to health and health care, then, came increasingly under the control of agencies set up outside the health services sector during and in the wake of our period. As we have noted, this made the health care service sector, but also public health work, more open to the commercial concerns of the producers, marketers and sellers of medical materials, drugs and food. However, it also meant that the services part of the health sector particularly became more dependent upon commodities of all sorts. With that dependence, came also an increasing dependence on what we might call the commodity culture.

As part of the conversion of the Directorate from a combined strategic and managerial agency into a more technical and administrative, i.e. downstream, control agency, it also became more of a supervisory agency. Indeed, it almost ended up as the latter. It had always been also a supervisory agency, but in "the old days," it had been so in a mostly pedagogical and paternalistically collegial way. The relations between supervisors or inspectors and care providers and public health officers were "internal" and educative. Now they were to become more "external" and "judgmental." In the old days, relations between supervisors and care providers were often related to care provision and were reactive. Now they were also to become expressly preventive and proactive: In the new Law on Health Supervision, enacted in 1984, *internal control* became the watchword for the new form of supervision and inspection. The more reactive activity of complaints handling did not disappear, though. Indeed, it became more extensive. However, it assumed a more juridical function: The supervisors became more formal investigators and, almost, judges. New legislation had now also extended the legal foundation for the complaints handling. Important laws were the Hospital Act (1969), the Law on Municipal Health Care (1982), the Damage Compensation Act (1969), the Product Control Act (1976), a number of health personnel laws – in 1999 replaced by a general Health Personnel Act, and the later Law on Patient Rights (1999). Of some importance was also the so-called *culpa* norm and the Criminal Code (1902). The

catchword for the assessment of complaints was and is the relatively new legal concept of acceptability (non-malpractice – "forsvarlighet").

The supervision and inspection law reflected aspects of the past, in that, in its *travaux préparatoires*, it emphasized that the inspection ought to be pedagogical rather than disaffirming. In addition, the law did not contain a provision for the issuance of regulations. The Directorate prepared such regulations in 1990-91, but the Ministry put the foot down. This was just a few months before the Ministry was to present its own proposal for the reorganization of the central health administration. Regulations about internal control for the health and social sectors specifically only came in 2003.

In the years following the enactment of the inspection law, site visits were relatively few, and mostly confined to the primary care sector, the part of the whole sector with which the county physicians were most familiar. These visits were mostly pedagogical and relatively "friendly." Gradually they became more, though not much standardized. Toward the end of the 1980s, county physicians also started to visit hospitals. With the transition to the 1990s, the county physicians began to request standardization help from the Directorate. By now, their inspections had also become more "external" and critical. At this time, the Directorate also began to earmark certain sectors for special, nation-wide inspections, but was slow to introduce templates for these inspections or for supervision and inspection in general. The Norbom-processes occupied too much of its attention at this time. The real professionalization of the "preventive" supervision and inspection activities only came after the reorganizations precipitated by the Norbom-processes.

The right of patients to submit complaints against personnel or institutions, either directly to them or to the inspection authorities, was based on common practice, not on formal provisions. The procedures for handling complaints also followed common practice. However, this practice became more standardized during our period, and especially from 1989 when the new department of health law was established in the Directorate. In addition, patients could, and can, report personnel or institutions to the police (under the criminal code) or file damage claims against them. Since 1989, patients could also submit demands for economic compensations for injuries sustained during treatment by personnel and institutions to a special public organization, called The Norwegian System of Patient Injury Compensation. Under this arrangement, compensations were and are awarded on "objective" grounds. The mass media also played an increasing role as a complaint channel during the period we are looking at. As another sign of a new era, counties began to appoint patient ombudspersons during the 1980s.

The number of formal, and probably also informal, complaints, increased during our period. We do not have complete information about the number of complaints submitted to the inspection authorities, but a study done at the end of the 1980s showed that the volume of complaints received by 13 of 19 county physicians increased by 48 percent from 1987 to 1989. Complaints received by the Directorate of Health went up by 15 percent from 1984 to 1988 and by another 18 percent by 1995. However, the complaint volume remained negligible relative to the total number of clinical consultations in this period.

The county physicians first handled complaints submitted to the inspection authorities. They sent the cases to the Directorate for possible formal reactions. The Directorate could then issue a warning or a rebuke to the personnel or institution in question. The Directorate regarded these reactions as statements of opinion, not as formal legal reactions. That view was

challenged in a complex complaints case that ran through the 1990s. The case concerned a group of anesthesiologists at a central hospital who had used the relatively new, but quick acting anesthetic, Diprivan, on two small children. Both children died. The hospital reported the incidents to the Directorate and the parents of one of the children submitted a complaint. The Directorate gave warnings to some of the (senior) physicians involved and rebukes to others. The parents of one of the patients who died also filed damage claims against the physicians, the hospital and the producer of the medicine used. The physicians, with support from the hospital, pursued the case and, through a number of court rounds partly prevailed. The parents won in the first court round, but lost in the later ones.

The courts found that the warnings and rebukes were formal, legal decisions. This was humiliating to the Directorate, which had adopted a view that was more iatrocratic than an expression of the new, more professional understanding of what supervision implied. The courts found that the Directorate, in many cases, had applied the law wrongly, but by doing so, and by reclassifying the reactions, contributed to pushing the Directorate further in a legalistic understanding of what its role as a supervisory authority meant. It took at least the rest of 1990s for the Directorate to redefine itself – as a modern, supervisory agency.

Quality Assurance – the New Downstream Function

Quality reached health care as an almost irresistible wave in the second half of the 1980s. It had its roots in the manufacturing industry, but now spread to all parts of the services sector. Quality originally referred to characteristics of a commodity or service. It has come to mean (high) scores on these characteristics. Gradually the reference characteristics became more all-encompassing. Thus, in health care they soon also included access. In other words, quality became the summary word for the goals of health care. Management, then, became (total) quality management.

The quality management apologists understood their goals or values in two ways. One group understood them as minimum criteria or targets. That was the ISO and the consultancy and accounting firms' way of defining them. They needed threshold criteria because they aimed at *certifying* institutions, the latter to earn money doing so. The two American quality apostles, W. Edwards Deming and Joseph M. Juran tried to add something to this: quality *development*. They claimed that the ISO approach just led to "good enough" quality. The ambition should be constant improvement. That meant that management needed to be not a controlling activity but a mobilizing one: Managing ought to be to inspire executives and operatives constantly to be looking for better ways of doing things. If they were to be doing that, they had to be given sufficient autonomy and trust. Theirs was a humanistic management perspective.

The Directorate, in an uneasy cooperation with the Ministry, launched a plan for general quality development in the health care system in 1995. The plan was relatively general, and even if it contained the word "development," it was in practice primarily a quality control plan. Quality control rhymed better with "acceptability" control than did quality development. The plan could have given the Directorate another leg to stand on, but it pointed in the direction of strategy development and execution and therefore did not fit well with the Directorate's (Inspectorate's) turn to supervision and inspection. Quality concerns did not catch much of the attention of the leaders of the Directorate (Inspectorate); neither did it

fascinate people in the Ministry. The result was that it fell by the wayside. In 2002, the new Directorate took over the remnants of the quality initiative.

At the semi-clinical level the hospitals, encouraged by the superior policy institutions, and aided by the Norske Veritas (now the DNV GL Group), launched a program for training quality advisers in the hospitals. This initiative enjoyed some success: A quality community emerged in the hospitals, one that to some extent made the more slow-moving people in the Directorate (Inspectorate) a bit jealous. However, this initiative, it came to encompass also the municipal services from 1998, did not really permeate the clinical community, especially not the medical community.

We should also mention that the associations of some of the professions, especially the medical one, developed its own quality programs. The medical association's program, run by some quality development enthusiasts, had some success, for some time.

The quality wave hit health care in the late 1990s. It stirred up some interest through the first half of the 1990s. However, gradually it became part of the more general policy and management development in health care. It lost its special appeal and did not, and could not give the Directorate (Inspectorate) a new mission.