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Review/Comparative article

Implementing cancer patient pathways in Scandinavia how structuring might affect the acceptance of a politically imposed reform

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ABSTRACT

Through political decisions all three Scandinavian countries implemented national reforms in cancer care introducing cancer patient pathways. Though resistance from the professional community is common to top-down initiatives, we recognized positive receptions of this reform in all three countries and professionals immediately contributed in implementing the core measures. The implementation of a similar reform in three countries with a similar health care system created a unique opportunity to look for shared characteristics. Combining analytical framework of institutional theory and research on policy implementation, we identified common patterns of structuring of the initial implementation: The hierarchical processes were combined with supplementary structures located both within and outside the formal management hierarchy. Some had a permanent character while others were more project-like or even resembled social movements. These hybrid structures made it possible for actors from high up in the hierarchy to communicate directly to actors at the operational hospital level. Across the cases, we also identified structural components acting together with the traditional command-control; negotiation, consensus and counseling. However, variations in the presence of these did not seem to have significant impact on processes causing decisions and acceptance. These variations may, however, influence the long-term practice and outcome of cancer-care pathway-reform. Knowledge from our study should be considered when orchestrating future health care reforms and especially top-down politically initiated reforms.

1. Introduction

In the three Scandinavian countries, cancer care was elevated to the national political agenda around the turn of the century, first in Norway and Denmark and then in Sweden. National cancer strategies were launched, and several measures were introduced including prevention, screening, education, quality registers, centralization and clinical trials. Nevertheless, challenges remained, and the situation reached a state of urgency. The problem in each of the three countries was unacceptable waiting times. The common answer was to launch a reform introducing cancer patient pathways (CPP) as a national standard for the sequence of procedures in all major cancer diagnoses and standards for patient waiting times from referral to the start of treatment. The implementation of CPPs implies an ambitious change directed by the Ministry of Health in a complex field with different levels and logics: a change of attitude, behavior, and system management at the hospital floor level and at the political and higher administrative levels.

In health care, resistance to reforms and change initiated from above is widespread. The presence and dynamic connected to this was treated both theoretically and empirically by Alford in his book from 1975 [1] and several years later by the work of Kellogg [2]. As illustrated in a literature review by Appelbaum and Wohl [3], numerous papers have then been published discussing how to overcome resistance to intended reforms and changes in health care. However, in the cases we studied the reforms seemed to receive acceptance and even commitment and the core formal measures were fast established and filled with activity. This observation inspired our main research questions: How can we explain that this top-down reform at least in the early launching and initial implementation phase were well received and that the measures was rapidly effectuated? Can we identify common structural features facilitating the process and thus contributing to the out-

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come? And on the contrary, are there simultaneously any structural differences that may lead to divergent practice and outcome of the reform?

Several scholars have published comparative case studies investigating the influence of the different European models of health care on the implementation of reforms and changes in health care practice. Overall, studies have concluded that health care structures matter [4–7] and some key features include degree of centralization; degree of professional independence; and impact of top-down governance, including how health care funding is institutionalized. These studies, however, compare a wider variety of health care systems than is found in the three Scandinavian countries, which all have Beveridge-type health care system. In our cases, by combining observations from a fairly similar reform in similar health care system we are given an opportunity to identify what could be structural features that were crucial for the perceived success. Simultaneously, with such a stability in variance we might also recognize structuring mechanisms that could contribute to different tracks and outcomes of the reform process. More specifically we focus on the interplay between ordinary hierarchical bureaucratic structures, matrix structures across institutional borders, and project-based structures established as part of the reform processes. We try to identify which structural elements are present in all three countries, which elements vary and elaborate on how these similarities and variations influence implementation process and thus the outcome of the reform by creating space for agency and interaction between the institutional logics and levels at play.

1.1. Analytical references

How the structuring of politically initiated changes influence the dynamic of the implementation process in complex organizational systems and across hierarchical layers has been an important topic for organizational studies in both sociology and political science. Two traditions relevant for this case are the study of policy implementation and of organizational institutionalism. In the current study, we build upon the cross-fertilization of these two approaches. We are inspired by Baret [8], who concludes in her review based on 20 years of implementation research by calling for renewed emphasis on cross-disciplinary work. We follow this trajectory by identifying relevant related concepts and models in research in these two mentioned traditions. We argue that the combined heritage will strengthen the application of them in our analysis. We also recognize that other recent studies of policy implementation in health care fruitfully embark upon a combination of institutional theory and other traditions [9–11].

The works of Phillip Selznick [12] and of Pressman and Wildavsky [13] are particularly influential in organizational institutionalism and policy implementation respectively. Both books deal with the process of translating a political reform from the national level to the local level, although the reforms they discuss probably are more complex than implementing CPPs. The questions addressed in these works and the findings, concepts and models developed by their research have relevance to the current study. Across the two traditions there is a corresponding vocabulary partly expressed in different ways. Building on these corresponding concepts, we constructed a model of core concepts constituting a platform for analyzing our data and further developing the model.

1.2. The direction of change

Studies of both institutional change and policy implementation are concerned with the direction and mechanisms of change. The starting point for the tradition of institutionalism is embedded institutional mechanisms to resist change and to remain control, authority and legitimacy [14]. For policy implementation research on the other hand, the starting point is the limitation to reach out with comprehensive information from the position of the policy maker and the limited ability to identify internal resistance from groups at ground level [15–19]. Both traditions acknowledge the limitations of planned, rational processes initiated from a central core position in the institutional field [20] or a top hierarchical level [18]. To make change within reach and explain a possibly successful change initiative, contributions from both traditions describe cases that combine and orchestrate synergies from top-down and bottom-up. These processes are dependent on two elements: One is room for improvisation, adaption, and exploration at the organizational level. The other is translation between the political-administrative top to the bottom, or from the field level to the practice level [16, 20–24].

The presence of several competing institutional logics has served as a background for several studies of institutional change. Institutional logics was introduced by Friedland and Alford [25] defined as cultural beliefs and roles determining how practice and structures are assessed. In early implementation research, Hjern and Porter [26] identified different rationalities influencing the implementation process. Institutional logics have been presented as both the source of change and the carrier of the change process. Different logics or rationalities might have different sources, originating from the field or central level, the practice or street-level or outside the field or the periphery. One logic might be dominant and challenged by others. In studies of change initiatives in health care, logics have been explained as an analytical tool, especially in the institutional tradition in general [27–30] and in integrated care specifically [31,32] but also in implementation research [33,34].

1.3. Agency and entrepreneurship

Agency and entrepreneurship do not have obvious important position as driving forces of change in either strongly institutionalized fields or hierarchal bureaucracies [35]. Beckert [36] argues that entrepreneurship and strategic agency may be present in persons expressing personal authority and not just administrating the change process through bureaucratic authority. Similarly, an important observation in studies on institutional entrepreneurship [37,38] is that entrepreneurship is possible because the entrepreneurs have a legitimate role in several of the affected interest groups. This could be an expression of combining structural and normative legitimacy [39]. The entrepreneurs have space to move between different organizational fields or levels and they have the ability to transfer and translate ideas across borders [40]. In his research on implementation, Sabatier [17] discusses the tensions between top-down and bottom-up. He introduces the role of policy brokers similar to what Sabatier and Mazmanian [41] calls the role of so-called fixers. They describe a role with legitimacy to intervene and access to available resources independent of level. Alternatively, the bridging of levels may be accomplished by managers [20]. Olakivi and Niska [42] argue that some actors may simultaneously influence and be influenced by two logics indicating a hybridity practice. Institutional entrepreneurship may not be a question of heroic action but expressing activity by backstage organizers and facilitators [43] imposed by actors spatially dispersed in the organizational field [44].

1.4. Emerging structures

Agency and entrepreneurship might not just be performed through individual actors and entrepreneurs but also through collective action. This can be accomplished through phenomena like social networks and social movements. Both represent a possible

way of cross-circuiting institutional and hierarchical levels and organizational borders. They may act as carriers of new impulses or alternative logics from one level or field to another. Social networks have been studied in relation to both policy implementation [4, 45–47] and institutional change [48]. Similar to networks, social movements might be a means of avoiding the traditional trappings of bureaucracy [49] and failures of hierarchical coordination [50]. Social movements might also create processes within institutions [2,51] or constitute a phase of a change process [10]. Both social networks and social movements express themselves through social relations and structures. Strategic networking is therefore seen as an important policy implementation activity [52,53]. Meeting arenas [43] that function both as a free space for possible alternative practice and discourse and a forum for cognitive and emotional framing [54,55], connecting individuals and the movement and thus specific logics, are central to social movements.

Network structures and arenas that emerge as temporary structures connected to social movements illustrate the role of structures in policy implementation and institutional change. Not only emergent structures but also general and specific formal structures have been a subject of research in both traditions. Though Pressman and Wildavsky [13] in their study of implementation clearly questioned the building of organizational constructions circuiting the ordinary lines of bureaucracy, Hjern and Porter [26] as early followers encouraged looking for less formal and more matrix-shaped structures when investigating implementation processes in multi-organizational clusters. More recently, Peters [33] underlined the need for structural arrangements facilitating coordination and Lindquist [56] discussed the emergence of special units to support implementation. In organizational institutionalism, formal structures and change are approached through studying the phenomenon of institutional infrastructure [14] and hybridity constructions [57,58]. In both traditions, there is an acknowledgement of attempts to orchestrate change through processes of discourse and bargaining [18,33]. The participating individuals and groups represent the involved perspectives, rationalities and logics.

1.5. Coordination mechanisms

How might differences in structural arrangements influence the rules of discourse and degree of bargaining? How will the structural context of interplay between logics affect the room for agency? Some studies from the institutional tradition have addressed these questions. Reay and Hinings [59] describe how the relation between competing logics is managed through collaboration; the different logics accept the presence of and contributions from the other logics in certain defined parts of the organizational field. They show how medical decisions are separated from administrative decisions., Nevertheless, there is informal contact creating joint definition and exploration of experimental sites. A second contribution to the discussion, which describes a more complex interplay between institutional logics, is offered by Andersson and Liff [60]. They describe a rivalry between professional and managerial logics based on co-optation mechanisms. Building on Selznickś [12] concept of co-option and using a case study from psychiatric care they show how strategies and measures developed from one logic and its interest group at an individual actor level are integrated into another logic. The coexistence of institutional logics in health care happens through finely grained mechanisms, providing a dynamic, interactive explanation. According to Andersson and Liff [60], co-optation in health care is both a power strategy and a cooperative strategy, not to mention an attempt from one group to increase its legitimacy in health care on a general level. This connects to a conclusion made by Mur-Veeman et al [5] that policy implementation in the case of integrated care depends on the institutional constellation present influencing the interaction of actors involved.

The two mechanisms described above, collaboration and co-optation, raise the question whether there is a connection between the mode of coexistence between institutional logics and the structural framing of the implementation process and the organizational field in which the reform is going to be implemented. According to Thorntorn and Ocasio [61], a crucial dimension of the structural framing is the type of coordination between actors. They describe the phenomenon of structural overlap as an organizational arrangement influencing the interaction of logics. Hanlon et al [47] refer to two mechanisms structuring the relation between the present logics in a case study for policy implementation in health care. One is consultation, collaboration and relationship building which is in sharp contrast to the mechanisms of command and control. However, the former is not free of tension but represent another way of dealing with it. In the policy implementation literature, organizational process of implementation aiming to bridge gaps contain mechanisms of both negotiation and consensus building, as well as the use of force [62] or, in the words of Hjern and Porter [26], negotiation, consent and persuasion. In a recent work, Tuohy [63] synthesizes how the structuring processes of logics are constituted of control and influence. In her analysis, the three instruments of control are hierarchy, through command, the market, through exchange, and peer control, through persuasion, and the instruments of influence are state, private and professions. While the relevance of Touhy's work to our study can be disputed, as there is no obvious market element in the health care system in Scandinavia, negotiation is a mechanism that is still highly relevant to the analysis of health care reforms.

2. Materials and methods

The empirical scope of this study is the CPP reform in cancer care enacted in three Scandinavian countries. Each reform constitutes a case. The timeframe we have given attention in the cases is the process from the political decision through the initial phase of orchestrating implementation and until the reform measures reached hospital floor level. We then focus on the structuring of these processes from the ministries of health and through the involved parts and levels of the health care system. In studying these cases we did not follow the implementation down to the practical deployment on local health care.

Each country's reform process is considered as a case limited geographically and in time and constituted by a complex configurations of events and structures [64]. Choosing cases can be done according to several principles. One of these is most similar cases [65] where most of both the context variables and independent variables are the same. But if one or a few independent variables differ it is appropriate to study the specific effect of the few independent variables that varies across cases. Choosing most similar cases is then appropriate to explain variance in dependent variable. In this case however, with small variation in outcome we argue that to use similar cases are suitable to search for more general explanations for the rare outcome. Two other principles of case selection are choosing either a deviant case or an extreme case [66]. Such cases are suited for studying outcome of an independent variable that diverge from the majority of cases. With the unique outcome of our cases we also may categorize them as a deviant case.

In line with other case studies and studies of organizational institutionalism and implementation studies [19,61,67–69], our empirical data consists of both documents and interviews. During the data collection process, cross-fertilization between the two sources allowed us to identify additional relevant documents and additional informants.

The documents used as data-source were all publicly available on relevant organizations' web sites. Together they constitute the official documents for the political or administrative reform process [70]. Such documents cover the official analyses, rationale and measures of the problem at hand and also represent opinions about the reform [71]. Other documents, such as public presentations given by key players during the process and published research papers, served as secondary sources. The information, arguments, and opinions expressed in the documents were a reference for the content of the interviews, as well as a data source for the analyses of each of the process phases.

The informants were recruited through purposive snowball sampling [72]. The selection criteria were that they had to have a key position in conducting the implementation of the CPP reform or at some crucial events during the process. The informants were regarded as institutional actors [71] representing their organization. Thus, the positions of the interviewees during the time frame of the investigation correspond to the active organizational entities in each country. In total, we conducted 26 interviews, nine each from Denmark and Sweden, and eight from Norway. The median length of the interviews was one hour. The roles of the informants varied: Four represented health ministries, ten national coordinating units, six patient organizations, and five regional/hospital managements; two were researchers. In the Danish case, time had elapsed between the events studied and the interviews. However, to reduce time errors we referred to documents written at the time of the process as a reference during the interviews.

In line with an abductive approach, we carried out semi-structured interviews with open-ended questions, allowing flexibility in the conversation and in the issues addressed [73–75]. We developed an interview guide based on the time line of the process adjusted according to country and interviewee profiles. Analysis of the data material started during the initial reading of core documents and continued during the interviews and the process of transcribing and coding. We used a multi-step coding process [73]. First, we organized quotes based on topics introduced explicitly by the interviewers. Second, we started searching for similarities and differences across the three cases. During the analysis, we followed an iterative approach [76,77] between the data material, inductively based analysis, and analytical frames based on literature from the two research traditions to identify significant elements across the three cases we compared [78]. We identified a model comprising structural elements and dynamics and applied this model to the analysis of our data material. The comparative element made it possible to trace what seem to be more general patterns and to explain the variance in how reform processes were orchestrated [21].

3. Results

The movements that elevated cancer to the national public political agenda in the three Scandinavian countries started during the 1990s. In Norway, an expert group delivered the first national report on challenges in cancer care, along with a plan for improvement, in 1996; this was followed by political decisions to put more resources into cancer care [79,80]. Denmark launched its first national cancer plan in 2000 [81]. The discussion in Sweden started not long thereafter, and a governmental commission was designated in 2007, resulting in a national cancer strategy being approved in 2009 [82]. The national reports were all comprehensive, addressing topics like prevention, screening, education, quality motivated centralization, quality registers, palliative care and clinical trials, in addition to increased investment. However, the combination of the modest improvement, scientifically based potential for more progress, the seriousness of delayed diagnoses and the strong increase in incidence resulted in public expectations not being met. The core of the problem was identified as unacceptable waiting times. Expressed in this context of urgency the political answer in all three countries was to introduce CPP.

Several of our informants observed that a characteristic of this reform was the strong top-level engagement, which was positively received in the medical and care community at the ground level. This kind of top-down implementation can be high-risk, and as one Norwegian interviewee said, "Trying to change practice at the hospital floor level through the Ministry of Health will always be a risky business. Several attempts have been made to accomplish this, even using laws, but in vain." Several informants considered that the process, though challenging, was a success: "This was probably one of the few initiatives from above that was well received from below." The process even built on local engagement from floor level as summarized by a Norwegian and a Danish informant.

The central experience from this reform process was the involvement of everyone connected to it. It is all about the transformation of the central initiative to practice change at the ground level.

The engagement of the politicians and central officials was crucial to establishing the reform. However, the implementation of the reform was not politically driven. I do question whether it is possible at all to command health care professionals. I think it is almost impossible. They might manage to motivate the professionals, for example by making resources available.

Two papers describing the reform processes in Denmark and Sweden [83,84] confirm this description.

3.1. Key variations in general organizational structures

According to the OECD classification of health care systems, and more sophisticated classification [85], the Scandinavian health care systems are in the same category. Every citizen has the right to access to what is considered as necessary and standard health care, both acute and elective. The financing is provided by governmental budgets. Public authorities own and run the majority of the hospitals

Despite these similarities, however, there are differences between the three countries in the way health care is structured. These differences might affect how cancer care reform is implemented. The following is a summary of some major structural aspects of the three national cases: When the government wants to intervene, in Norway there is a direct executive line from the Minister of Health to the hospital CEOs. This is apparent in the financing, the ownership, and the governance structure. In contrast, the Swedish model is more decentralized to the county level, and national governance and coordination is to some degree taken care of by a membership organization, the Swedish Association of Local Authorities and Regions (SKL), and is dependent on negotiations between SKL and the Ministry of Health [86]. The Danish model falls somewhere in between the more centralized Norwegian model and the more decentralized Swedish model. In Denmark, the fact that the country is divided into only five health regions, and the regions' financial dependence on the government results in a more centralized system than in Sweden. In all three countries, there is a national health agency with assignments issued by the Ministry of Health. However, the ability of these agencies to influence hospital governance is impacted by the relation between national government and hospitals. Here, some cancer specific entities played a crucial role.

3.2. Cancer-specific structures as a playground for implementation

In all three countries, the measures put in place as a part of the national cancer strategy included organizational initiatives. Two

novel types of organizational structures were established to facilitate further change and improvement in cancer care. The first was a national coordinating structure. These structures varied between the countries, but shared common unique organizational characteristics for cancer care. In Denmark, the National Cancer Board was created. This was a body appointed by the National Health Authority. In Norway, the Health Directorate created a position as strategy director for cancer care. In Sweden, Regional Cancer Centers (RCC) was established with a national coordinating committee under the umbrella of SKL [87,88]. The Swedish RCC was constituted as an association between regional entities but changed through a kind of political bargaining process in which both the Ministry of Health and the counties were active. The RCCs were based on an existing coordinating regional structure for quality cancer registers. This regional organization was not directly aligned with an existing administrative structure level of government and was based on the principle of independent counties, which functioned as the basic unit of hospital governance. This structure of on-task cancer-specific coordination implied a larger degree of local variation in the construction and function of each RCC.

The other novel cancer-specific structure was national multidisciplinary groups covering each major cancer diagnosis. These groups recruited members from each specialized medical society involved in diagnosing or treating patients. The first task of the multidisciplinary groups was to produce a unified nation-wide action program comprising guidelines for diagnostics and treatment. In Norway and Sweden, the representatives were appointed by the Health Directorate and by the SKL, respectively, which also approved the programs. In contrast, in Denmark, the multidisciplinary groups were independent, professional non-governmental associations.

3.3. New specific structures launched as part of the CPP reform

When the CPP reform was launched in each country it worked its way from the ministries of health through the administrative apparatus. Here we can identify both similarities and differences in how the implementation processes were orchestrated in the three countries. The first major distinction is how the reform was transformed from the government and the ministry of health to the executive level in the hospitals. In Norway, an informant explained how the line of hierarchy influenced the process:

The order to implement the CPPs was given through a traditional governance protocol delivered from the minister to the regional health authorities. From that point on, the issue was high on the agenda at the governance meetings between the ministry and the regional health authorities. From the very beginning, waiting time measures were presented at the meeting.

In Denmark and Sweden, the administrative split between the state and the hospital owners implied that the execution of the reform was dependent on negotiations [89]. The first agreement between the administrative levels was of uttermost importance as it defined the future structure for the annual negotiations.

The newly established cancer-specific organizational constructions played a major role in orchestrating the implementation of the CPP reform [83,84]. One example is the multidisciplinary national cancer groups that were established in all three countries. A Danish informant confirmed that “the existence of these groups after the political initiative was launched was of major importance for the implementation.” Although these multidisciplinary groups were created at the national level, they were made up of senior hospital clinicians who championed bottom-up processed at their hospitals. A Danish informant expressed it this way: “When the national multidisciplinary cancer groups started their work on designing the CPPs it was a terrific example of the medical community at work.”

The recently established cancer-specific national coordinating entities were also given a core role in the implementation process in each country. In all three countries they had a formal role in designing the national processes and were in a position of influence but without executive power. In Denmark, the National Cancer Board was appointed during the process of designing the first national cancer plan in the late 1990s. In the implementation of the CPP reform, the board served as a coordinating national council. Above this entity, a national Cancer Task Force was established with only top regional leaders and leaders from the Ministry of Health and the Danish Health Authority and administrated by the latter. According to an informant, “the newly established national task force gave us an arena which guaranteed involvement of administrative levels that otherwise might have caused major problems in the implementation process.” The Cancer Task Force approved the standardized pathway description delivered by the multi-disciplinary groups, and the idea was that this process balanced several perspectives:

We had to create a model for developing the CCPs that combined what were medically best practice and optimal logistics and feasibility. Therefore, the CPP proposal went through a two-step decision process to make sure that both perspectives were taken into consideration.

In Norway, the position of strategy director for cancer in the Health Directorate was an organizational asset:

“The cancer strategy director, with his extensive national network in the oncology community, played a crucial role in orchestrating the implementation, acting as a link between the several groups and levels that we were dependent on.”

In addition, a specific project manager was appointed in the Norwegian Health Directorate.

In Sweden, the national coordinating group of the six RCCs was in charge of the CPP implementation. As one informant expressed, “We would not have been able to manage this reform if we did not have the small national coordinating unit. With the meetings in our joint national committees of RCC leaders, we managed to drive the process together.” In 2009, the regional RCCs were created as bodies with the mission to implement the national cancer strategy, and the CPP reform was a main task for the RCCs when it was launched in 2014. These regional boards had executive power, the capacity for administrative coordination, and access to relevant competences to support this type of change. By 2015, some of them had already engaged cancer-specific regional process leaders and started working on patient process improvements.

In all three countries, project-like structures emerged on several levels during the implementation. The design and selection of CPP templates for each diagnosis were organized like projects. Communication about the mission and CPP tools was accomplished through campaigns like conferences and meetings. Supportive groups, resource groups, and task forces were established at both the national and regional levels.

To access the executive hospital level, the national health agencies were ordered to support the processes. However, their roles varied. The Norwegian Health Directorate actively organized and supported the designing of the CPP prototypes and the operative implementation. The Danish Health Authority played a major part in organizing the CPP design process and chaired a national implementation plan during the first years. In contrast, the Swedish National Health Board’s role was to annually evaluate the reform process and facilitate process learning at a national level. Though the health ministries were not hands-on when the executive processes, they were all close to the process with regular contact with national health agencies and the hospital owners.

In addition to creating the project-like structures and activating new and previously established cancer-specific organizational entities, the hierarchical line of governance also played a part in

orchestrating the implementation. However, several informants, including a Danish and a Norwegian informant, underlined that this was not a one-way, top-down governance process:

We had to involve representatives from the hospitals in the process from the beginning. If we had not, they would not have listened to an order from above, just a new fancy idea from the top bureaucrats in Copenhagen.

Those regions that approached the implementation task with a humble attitude towards the local hospital levels were probably the most successful. Their attitude was, we are dependent on each other, this is innovation, and we have to accomplish it together.

In the Swedish case, there was clearly hierarchical governance working on the county level. However, the RCCs must be distinguished from this:

Since the national and regional RCC networks are working close to the hierarchical executive line, we might look like a hierarchy ourselves. But we were not. The heads of the RCCs have to be aware of that and conduct themselves accordingly.

The organizational picture in orchestrating the reform was then a mixture of project-like constructions, social movement like events, emerging new cancer-specific structures and traditional line management. Although this kind of mixture can create an oppertunity space for managing implementation, at the same time it might create tension and obstacles. One tension that might arise is between ordinary line management, on the one hand, and the specific cancer configurations and project-like processes on the other. With reference to the Swedish RCC structures, an informant stated,

Accomplishing this reform process without being a direct part of the hierarchical line organization was an advantage. Of course, both hospital CEOs and process managers might be frustrated along the reform journey. These two positions have to be in dialogue.

With reference to the multidisciplinary groups, a Danish informant expressed the crosscutting problem like this:

The actual driving forces for filling the CPP form with content came from outside of the ordinary line of hierarchy—that is, from the crucial role of the actually not governmentally appointed multidisciplinary groups of professionals who also linked the national and local levels together.

3.4. Structures defining the space and rules for agency

The organizational construction created room for entrepreneurial leadership. It gave some actors a unique opportunity to move up and down between the levels of the health care system during the initial implementation process. Some key positions in each country were filled with people that seemed to seize this opportunity. They were able to exploit the possibility of entrepreneurship in part because of the space offered by the situation to move more freely, both horizontally and vertically, within the organizational structures. These actors were insiders from the medical community. A majority of them had long experience from health care and hospitals, in both clinical and managerial positions, from different administrative levels in health care, and from the organizational fields of hospitals, health bureaucracy and research. This provided the process with both the prerequisite for building legitimacy and skills for entrepreneurship. Altogether, this was a set of complex arrangements being aimed at building trust around roles representing different interests and rules for performance.

It was really a challenge to build the trust and mutual acceptance roles between the RCCs, the counties and the hospitals. The RCCs had to communicate their services in a way that built trust and created interest at the counties and hospitals in adopting their ideas and asking for their services. The RCC construction provided an arena to create new experiences.

Properties of the structures defined rules of interaction in the process. We have described the diversity on the specific national constructions of formal hierarchy and lines of direct command. The orchestration of the implementation processes is summarized in in Fig. 1

Fig. 1

Other process features include the degree of consensus [84] and the active facilitation of counseling and knowledge management [83]. In Sweden, the national and regional coordination mechanisms were dependent on consensus-based processes; this also appeared to be the case for the national Danish cancer task force. In all three countries, the process in the multidisciplinary cancer groups was also dependent on reaching consensus.

The group that was in charge of designing the CPP was invited to a two days seminar at a hotel. They got a rough draft as a starting point for their discussions. The rule of the game was that the participants had to agree on a final document before leaving.

Informants in Norway cited the facilitation of local processes through counseling as an important activity of the resource groups established at the national and regional levels. In Sweden, the core of the RCC, in addition to being a forum for regional consensus, was a counseling and reference unit facilitating support and providing knowledge for the counties and hospitals in their region. The role of process facilitator might be seen as a special form of counseling:

The RCCs had no direct power. They did not have money. They were not in charge of health care. However, they were facilitating the process that happened to be of uttermost importance.

This statement also reflects the general view of core actors in the implementation in all three countries that this was a tremendously successful process. We summarize the mechanisms at work in Table 1.

An obvious difference in the immediate output of the orchestrating process was that the CPP implementation in Sweden got two billion SEK in direct governmental support released as a part of the national negotiations that end up launching the reform. In Denmark, too, additional financial allocations were available and granted as a result of the negotiations between the government and the Danish regions. In Norway, according to the instructions provided by the government to the regional health authorities, the reform was supposed to be implemented without any extra support.

4. Discussion

Our aim in studying the implementation of this reform was to explain why this reform in the early launching phase was well received in hospitals and among professionals and that the measures were rapidly effectuated. To elaborate analytical tools for this, our starting points was the classical works of Selznick [12] and of Pressman and Wildavsky [13] both studying policy implementation initiated nationally but realized locally. In both studies they noticed that a basic challenge is that the level of initial decisions is far from reality and that implementation is challenged by difficulties to predict and control process and outcome. In these processes they describes tensions and dilemmas between different perspectives being present and discuss the experience of alternative organizational solutions to ordinary bureaucratic administrative lines. In our study we connect to the issues they put on the agenda and not least the research legacy following their foot-steps contributing to still more sophisticated insights and analytical elements in respectively in policy implementation research [14] and organizational institutionalism [15,18]. We searched for connections between specific structures and processes present and the room for agency and coordination mechanisms in an implementation where several institutional logics were involved. The challenge was across

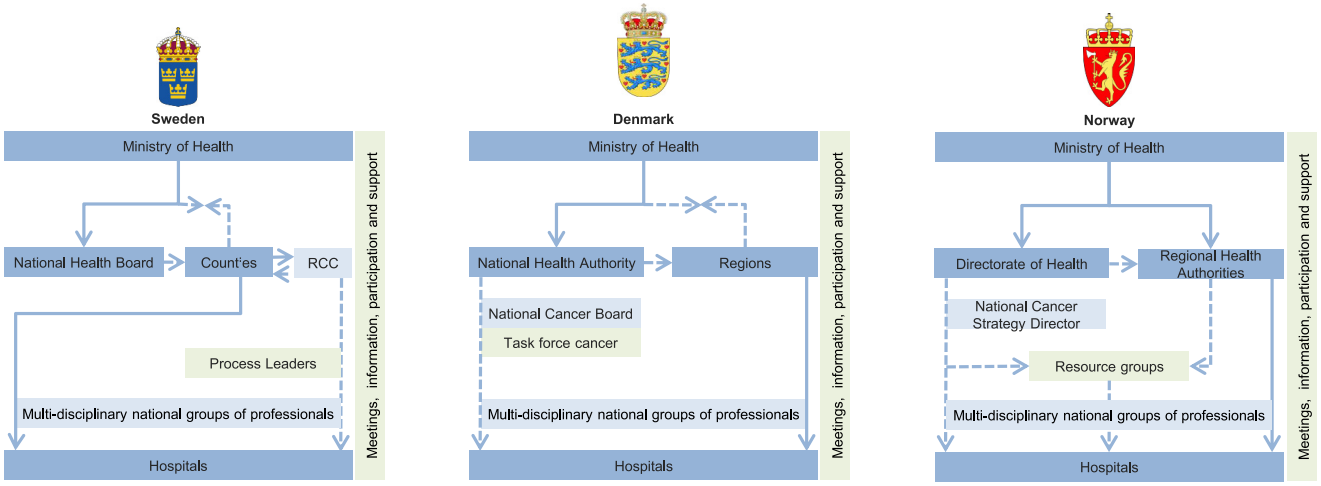

Fig. 1. Orchestration of the implementation processes. Hierarchical multi-layer governance structures, specific cancer related organizational bodies.

Table 1
Structures of organizing implementation.

	Denmark	Norway	Sweden
Hierarchical line of commandment	Accomplished from each region towards hospital management line	Accomplished from the Ministry of Health via the Regional Health Authority to hospital management line	Accomplished from the level of county government towards hospital management line
Negotiations	Between the Ministry of Health and the Danish regions.	No direct negotiation arena during the process.	Between the Ministry of Health and SKL.
Consensus processes	Inside the Danish Regions, in the National Cancer Advisory Board, in the national Task Force and in the multi-disciplinary groups.	In the multidisciplinary groups.	In the RCCs on national and regional level and in the multidisciplinary groups.
Consultation and advisory activities	Performed through regional administration and through experienced hospitals.	Performed through resource groups on the national, regional and local hospital levels.	Performed though the project leaders and the diagnosis-based process managers.

the immediate mixtures of multifaceted structuring elements to identify common structuring features that may explain similarities in outcome and at the same time be aware of crucial structuring differences between the cases that at least in the long run might lead to divergent outcomes.

As described in literature [26,62] in all three countries, there was a mixture of elements characterizing the context structuring the implementation. These had to do with the general design of the health care system, the novel cancer-specific organizational constructions, and the structuring of the implementation process. In all three cases, the general structuring of health care implied that administrative lines of command were in action. However, these were present to a different degree and on different levels. In Norway, the hospitals are organized in regional health trusts and the Minister of Health was able to impose direct instructions at the hospital floor level through the regional trust. In Denmark and Sweden, there was no direct line between the Ministry of Health and the regional and county level respectively. Thus the implementation of a national health policy decided by the national government was dependent on negotiations and agreements.

In all three countries, specific organizational entities established both before and during the reform were active tools in the implementation. These were on two institutional levels: first, the national coordinating bodies like the National Cancer Board and Task Force in Denmark, the cancer strategy director in Norway and the RCC-S in Sweden. Second, the diagnosis-based national multidisciplinary groups were active in all three countries. The ability to decide and deliver in all three countries was based on consensus within the groups. These consensus processes included peer groups or representatives from units not directly hierarchically related. Thirdly, we observed a structuring of the initial implementation phase. This had clear project-like features. Process managers, project leaders, resource groups and task forces were among the instruments borrowed from the project management toolkit. They arranged large meetings to address marketing and mobilization and for the purpose of dialogue. These events potentially influenced the normative engagement of the involved organizations and added to the process a type of organizational behavior resembling social movements [49,51] in a time where learning from social movements was lifted as a promising tool in executing change in huge health care systems [90] . Both the specific cancer-related entities and the project-like structures facilitated the development of networks. As previously discussed in literature [52,53] these networks created an infrastructure and had the potential to connect the process to local proponents. During these processes, another mechanism was active, namely counseling and advisory activities. This was particularly seen in the Swedish case with the RCCs reaching out to support the implementation process in the hospitals.

The structuring of the implementation process has clear consequences in terms of the room that exists for agency through what Segato and Masella [9] calls participatory communication which they argue correspond to satisfactory implementation. For the politicians in charge, rapid progress was crucial. At the same time, they faced a severe obstacle in the organizational distance between themselves and the operative level in hospitals where change was supposed to happen. Even in Norway, where there was a direct line of command, there was an understanding that the CPP reform could not be imposed through that channel alone. Additional organizational constructions and mechanisms came to the

rescue. The arenas shaped and the networks created by linking key persons from different entities and levels facilitated communication and movement in the total institutional field that were not legitimate according to the ordinary hierarchical governance structure. This opportunity for connection across the field had strong impact and created a space for agency and entrepreneurship for key actors who filled different roles simultaneously and over time. These actors had held positions in several areas of the organizational field that gave them cultural capital, providing them with both the legitimacy and the skills to act in several areas of the institutional field [17,20,37] and combining structural and normative legitimacy [39] or even downplaying their impersonal source of authority [47]. The emergent structures made it possible for actors to travel geographically and make contacts across levels and also to employ colleagues and identify different roles as a platform for action at local level. In all three countries, these key actors took advantage of the space for agency in a way that actively defined the implementation process and acted as institutional entrepreneurs [38] or policy brokers [17].

This entrepreneurship emerged because the reform was launched in a situation of urgency. Pace counts and the presence of alternative structures for action - both top-down and bottom-up - facilitates fast communication and mutual adjustments between levels and interests. This may be prevailing to reach proclaimed targets. However, this room can be perceived as a threat to the decision makers, and handling this tension is crucial for reform implementation.

In addition to the discussed structuring features creating similar kind of mechanisms stimulating participation and acceptance across institutional levels and logics we also identified some structuring elements that regulates the collaborations in significantly different ways. This is connected to structures expressing different coordination mechanism along these values: command, negotiations, consensus, and counseling. They are close to the categories of instruments of influence developed by Tuohy [63] regarding policy development and implementation, namely hierarchy, mutual agreement, and persuasion. These different ways of exerting influence and power were all present in all three countries. The point here is however, that the presence and influence of the interaction mechanisms varied between the countries when comparing how they emerged through the general structuring of health care, cancer-specific structures and novel entities for the implementation process.

The mechanism structuring the coordination process regulates the performance of this coexistence in different ways. In general, top-down processes are most strongly facilitated by hierarchical line management. Negotiations between levels will encourage dialogue about targets and how to reach them and enhance deals related to distribution of influence and the execution across the organizational field. Consensus processes assume that agreement can be reached and are dependent on who defines the rules for the process. Counseling, especially at local levels, presupposes that local adaption of measures is possible and is also to empowering this level. While this combination of mechanisms has the potential to enhance fruitful coexistence and synergies during simultaneous processes from above and below, it can also create unfruitful tensions. In the cases in question, we can recognize both of these effects. This is in line with the general arguments of Bretton et al. [91].

Both the national cancer-related coordinating units and the project arrangement involved representatives from administration and management, medical professionals, and patients. They represent each an institutional logic [27,30,33,34]: the economic administrative, medical, and patient-oriented that guided the structuring of the implementation. Thus, one could argue that the four above mentioned mechanisms regulating the decisions and the content of process and structure also regulate the dynamics between these core logics. They could be interpreted as contractual arrangements [9]. The collaborative pragmatic coexistence of several logics [92] is encouraged by structures building on dialogue and negotiation. The co-optive coexistence [60] of logics is promoted by hierarchical governance based structures. Hanlon et al argue [47] that implementation of health care reforms being dependent on changing behavior in the professional community should chose to structure their processes through collaborative partnership, consultation and dialogue. The three cases can be summarized as follows: The Norwegian model with government owned hospitals has a direct executive line from the political top level to the hospital floor level. However, the implementing cancer care reform was supplemented by structures based on dialogue and counseling, both during the process of designing the CPPs and during the local implementation. The Danish model was based initially on representatives with distinct positions engaging in consensus processes at the national level through the National Cancer Task Force, the National Cancer Board, and national multidisciplinary groups. The carriers of different logics met, and the outcome was a blend of processes mobilizing the three logics. Implementation also had an element of negotiation in the interface between the national and the regional level. Later in the process, however, it was based on hierarchical governance. The Swedish process was first based on negotiation between state and counties. Then, implementation was carried out through a process involving dialogue between and counseling from the national to the local level with the aim of reaching consensus. The study of Granström et al [93] illustrates the performance of the regional counseling roles in Swedish health care acting as a hybrid connecting top-down and bottom-up processes.

Combining the concepts elaborated from the two research traditions we draw upon can be presented as in Fig. 2

Fig. 2

4.1. Limitations and general validity

What we have done through our case studies is to identify how certain combined mechanisms and structures of implementation that might play a decisive role in designing the processes of creating a perceived positive outcome of implementation. Our findings encompasses both similarities across the three national cases and those that might make a difference in process dynamics and possibly in outcome. The discussion on more general validity of these findings then is a discussion on under which circumstances the mechanisms and structures we identified might contribute to understand process and outcome in other cases of health care reform implementations processes. This raises two issues: First, do the results from studying reforms in these three countries have extended validity to every country and any kind of health care system? A core argument for the study-design was three cases with stable and similar context variables of health care system. However, inspired by the discussion on classifications of health care systems presented by Freeman and Frisina [78] we claim that the assessment of the breadth in external validity should be based on which traits of health care system are relevant for the issues treated and not necessarily on a general established classification form. As Freeman and Frisina [78] point out the latter classifications are mainly based on financing and transfer rather than on delivery and regulation of health care services. Because of this and the prevalence of hybrid health care systems [78,94], the classical classification is not fit for capturing the current evolvement of complexities in health care delivery. Since we are dealing with implementation of governmentally decided health care policy a relevant framing of validity might be health care systems where hospitals to a large extent are subjects to public governance. We argue that the patterns we have described across our three national cases

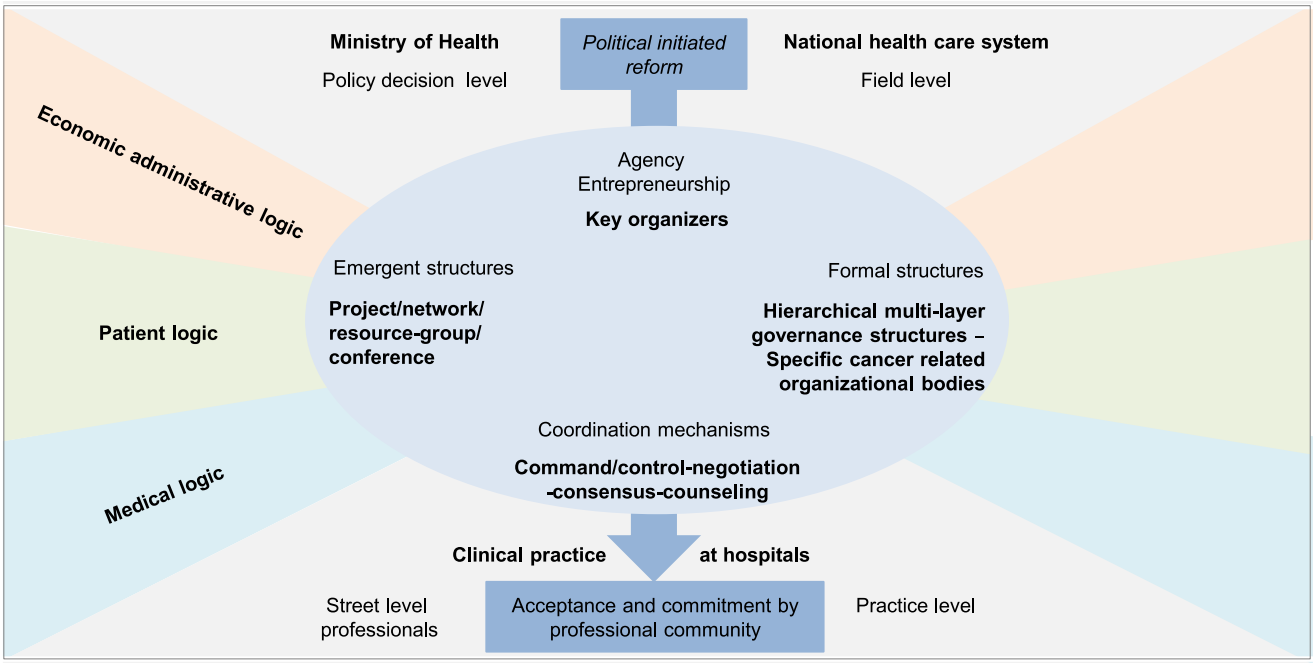

Fig. 2. Concepts in use explaining the implementation process. Concepts from policy implementation and organizational institutionalism elaborated and combined supporting explanation of the perceived acceptance of the reform.

then should be relevant also in explaining processes and outcomes of reform implementation in a broad group of countries characterized by this.

Second, can we anticipate that the lessons from this study are valid to all kind of health care reforms? To decide the limits of validity related to this dimension we must identify which category of health care reform this reform belong to. We argue that the core of the particular type of reform we studied can be categorized in line with classical studies of Selznick [12] and Pressman and Wildavsky [13] and later studies in their traditions, as a reform that presupposes advanced change on several levels of health care system, covering both attitudes, behavior and supportive systems. The implementation is dependent on competent and professional labor force and of complex cooperation across organizational borders. We do not claim our findings to be valid in the case of a health care reform whose primary concern is not directly targeting care like a privatization reform, change in financial logic, the ownership structure or changing the technological platform of health care.

5. Conclusion

We studied a politically initiated reform in cancer care launching measures characterized by being a complex intervention aiming at changing behavior on several levels in the health care system. We recognized that such ambitions are often received with local resistance and hesitation especially from the medical community. However, in all three countries where a similar reform was put on the agenda, support and even enthusiasm were reported from the professional community and the explicit measures were rapidly put into practice. We searched for explanation by drawing on analytical tools both from institutional research and research on policy implementation with special attention to present and emerging structures. In spite of variations in the specific way they were expressed we found that the ordinary hierarchical processes in all three cases were combined with supplementary structures on several levels. These structures were simultaneously present inside and outside the formal management hierarchy and served as interaction-arenas for institutional logics present. Some had a permanent character while others were more project-like or even resembled social movements. These hybrid structures made it possible for actors from high up in the hierarchy to communicate directly to actors at the operational hospital level. The advantage of these combined structures allowing for collaborative partnership and dialogue is that they foster compliance by expressing acceptance of different institutional logics present and fostering arenas for dialogue between them. Simultaneously they create a shortcut between levels and groups of actors allowing for unprecedented pace in the process. Based on these findings recognized in all three countries and reform processes, we will encourage searching for a proper design of accomplishing implementation through a combination of ordinary line management and situational created hybrid structures.

Across the cases, we also identified some structural variations generating a crucial mixture of these mechanisms: command-control, negotiation, consensus and counseling. They do not seem to overrule the structural elements causing acceptance, but they might have an impact on the long-term practice and outcome of cancer-care pathway-reform. From this we will, in line with Watson [95], encourage attention to the design of the institutional environment in future preparation for and research on this type of policy initiated reform implementation.

Declaration of Competing Interest

None.

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