Governing the coordination of care for older people: Comparing care agreements in Denmark and Norway

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Running head: Governing the coordination of care for older people
Key words: caregiving for older people, healthcare, integrated care, mandated coordination, national regulation, comparative research, Denmark, Norway
Accepted for publication 10 May 2017

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Abstract

Increasing specialisation and demands to decrease the length of hospital stays have important consequences for the integration of specialised health and local care services. Based on case studies of care agreements in Denmark and Norway, this article compares subnational governance strategies for coordinating care services for older people discharged from hospitals. The question is how, and to what degree, national government regulations have an impact on local service coordination strategies. The analysis reveals that the numerous subnational procedures for coordination are somewhat more itemised in Denmark, and that regional variation in care agreements is greater in Norway. The identified differences can partly be accounted for by national differences in regulation, which is tighter in Denmark than in Norway. The study suggests that despite decentralisation of responsibility, subnational procedures to facilitate coordination are heavily influenced by national government policy.

Introduction

Working across sectoral boundaries to increase coordination is a salient issue in modern welfare states (O'Flynn, 2014; Lægreid, Sarapuu, Rykkja, & Randama-Liiv, 2015). In relation eldercare, the focus is on coordinated care solutions at the interface between (specialised) healthcare and local care services. It is well documented that eldercare systems in almost all European countries are highly fragmented (Daly & Lewis, 1998; Ranci, 2002; Alaszewski, Billings & Coxon, 2004; Leichsenring, 2004). The interfaces are manifold: between users, between families and professionals, within and among providers and managers, and not least between the governmental levels that govern the different organisational dimensions of eldercare (e.g. planning, regulating, providing, and financing). Efforts to find integrated care solutions are therefore diverse, and increasingly so as new societal approaches to care for older people need to be devised to meet the challenges posed by aging societies all over

Europe (Dahl, Eskelinen, & Hansen, 2014; Leichsenring, 2004, 2011; Øverbye, Smith, Karjalainen, & Stremlow, 2010; Theobald, 2012; Ulmanen & Szebehely, 2015).

This resonates with current developments in healthcare systems, which stress the importance of coordinating services between specialist hospital services and local care services. Here, older people are a major concern, as illness tends to be concentrated in the last years of life (Blank & Burau, 2014: 28). Coordination is also high on the agenda in Nordic health policy (Martinussen & Magnussen, 2009). The present article focuses on recent healthcare reforms in Denmark (2007) and Norway (2012), each of which has introduced its own system of care agreements to coordinate care delivery between hospitals and municipalities, encompassing both health and social care services.

The challenge of developing sustainable mediating structures, incentives, and regulative arrangements among the actors at different governmental levels still remains, however, and that is the starting point for this article. The purpose of the article is to analyse how, and to what extent, regulation by the national governments in Denmark and Norway influences subnational procedures for the coordination of care services for older people. We first identify the differences and similarities between the national regulatory strategies across the two countries. We then compare and contrast the subnational procedures for coordinating services for older people discharged from hospitals, as specified in the respective care agreements. Hospital discharges were chosen because they represent critical cases of care service coordination (Henwood, 2006; Scott & Hawkins, 2008). The process is highly complex, as it involves different specialities within the hospital as well as care providers in community settings, and because coordination occurs over a very short period of time.

The literature on the coordination of care for older people is extensive, but is mainly concerned with services in community settings (see e.g. Glendinning, 2003; Glendinning, Dowling, & Powell, 2005; Leichsenring, 2004, 2011). Comparing the subnational

coordination of care services in relation to hospital discharge and its national regulation in Denmark and Norway is therefore relevant for many reasons. First, the care agreements are especially interesting as they originate from the healthcare system and have an explicit focus on coordination with hospitals (Romøren, Torjesen, & Landmark, 2011; Wadmann, Strandberg-Larsen, & Vrangbæk, 2009). Second, the cross-country comparison has allowed us to critically review the importance of national contexts, a factor that is widely acknowledged in single-country case studies (see e.g. Glendinng, 2003; Henwood, 2006; Rommetvedt, Opedal, Stigen, & Vrangbæk, 2014; Torjesen & Vabo, 2014; Vrangbæk, 2014). Both Denmark and Norway have recently introduced care agreements, but in different regulatory contexts. The two countries are characterised by a strong commitment to universalism *and* a strong tradition of local autonomy, but the latter is greater in Denmark than in Norway (Calltorp & Larivaara, 2009; Sellers & Lidström, 2007). In both countries the care agreements encompass national as well as regional and local levels.

The functioning of care agreements in Denmark and Norway has attracted considerable attention in the literature (e.g. Brekk & Kirchhoff, 2015; Rommetvedt, Opedal, Stigen, & Vrangbæk, 2014; Romøren, Torjesen, & Landmark, 2011; Vrangbæk, 2014; Wadmann, Strandberg-Larsen, & Vrangbæk, 2009). However, existing studies have typically covered the two countries separately, and are mostly empirically driven. Our study was guided by a theoretically-based framework for comparison, and deals directly with the relationship between national regulations and sub-national care agreements. This aspect of coordination is hardly touched upon in the existing literature.

The context for coordination in Norway and Denmark is characterised by tax-based national healthcare systems dominated by public provision, i.e., publicly owned hospitals and public employees in local care services (Schmid, Cacace, Götze, & Rothgang, 2010). Unlike insurance-based systems, such as the ideal-type private health insurance and social health

insurance systems represented by the United States and Germany, respectively (Giaimo & Manow, 1999), the actors involved are mainly *public purchasers* and, to varying degrees, *private providers*. Among the Nordic countries, the use of competition and market solutions in the care sector is most extensive in Finland and Sweden. Market elements have also been introduced in Denmark and Norway, represented, for instance, by the shift away from the inpatient to the outpatient sector in healthcare services, and in local governments' introduction of competitive tendering in the provision of local care services (e.g. Fotaki, 2011; Schmid, Cacace, Götze, & Rothgang, 2010; Szebehely & Meagher, 2013). Unlike many other countries with national healthcare systems, however, the share of private actors involved in care service provision in Denmark and Norway is minor. The law introduced in Denmark (in 2003), which made it mandatory for local governments to offer users of home care services a choice of providers, does not alter the fact that the main actors involved in the investigated care agreements are public.

The article proceeds as follows. We start by discussing the analytical framework structuring the study, including the operationalisations needed to ensure stringency in our analytical endeavour. We then account for our data and methods, followed by a presentation of the empirical findings. The article concludes with a discussion of the findings.

Analytical framework – regulating subnational procedures for mandated coordination

There is considerable variation in patterns of healthcare service decentralisation among West European countries (Bankauskaite, Dubois, & Saltman, 2007; Vabo, 2010). In the Nordic context, the coordination of care services for older people has a territorial dimension. Hospitals are typically run at the regional level, while local care services are operated by local governments. Care services include both health and social care but, more importantly, they

are the responsibility of local governments. Thus, coordination involves public actors at two levels of government. In both countries, these actors are local governments at one level; but at another level regional governments are responsible for running hospitals in Denmark, whilst hospitals in Norway are run by Regional Health Enterprises that are subordinated to central government. Older people discharged from hospitals typically need a broad range of local care services, and therefore specific procedures are needed to ensure coordination between hospitals and local governments. The latter is an important switchboard both in Denmark and Norway because so few relevant care services are provided by actors other than the municipalities themselves (Szebehely & Meagher, 2013).

National government instruments to regulate coordination of care services at subnational levels

In the present context, coordination is needed to overcome the well-known division of responsibility between actors providing care services (Glouberman & Mintzberg, 2001a,b; see also Reeves, van Soeren, MacMillan, & Zwarenstein, 2013). At the institutional level, hospitals and municipal care services must collaborate. At the service level, successful service delivery to patients depends on coordination among professionals. Care agreements emerge as expressions of collaborative intentions among institutions aiming to achieve coordinated – or integrated – service provision.

The literature proposes three basic coordination mechanisms (Bouckaert, Peters, & Verhoest, 2010, see also Rico, Saltman, & Boerma, 2003), which we used to assess the choices made by national governments in Denmark and Norway to impose mandatory contracts as a means to achieve coordination. The respective mechanisms draw on different types of coordination capacity: authority and power typically feature in *hierarchically-based* instruments for regulating coordination; bargaining is associated with *market-based*

incentives; and information, norms and mutual co-optation characterise *network-based* initiatives.

The care agreements introduced in Denmark and Norway are tools of government that impose coordination between regional actors and municipalities, and as such they are based on *hierarchy*. Although the actors involved are public, the administration of healthcare services predominantly relies on indirect lines of command and control. In Denmark, the national government can only encourage coordination between the regional and local governments, and the same applies to collaboration between the Regional Health Enterprises and local governments in Norway. When regulating regions (in Denmark) and municipalities (in both countries), national governments must respect subnational democracy and especially local government autonomy (Sellers & Lidström, 2007). National governments lack direct control over subnational actors and the potential success of mandatory coordination can therefore be questioned.

However, as stressed by Bouckaert, Peters, & Verhoest (2010), hierarchy can be used as an instrument of coordination in a more or less authoritative or strict way. Coordination based on hierarchy may range from the national government giving instructions to collaborate and forcing specific actions, to a more open mandate based on the regulation of procedures or encouragement through information, for example in non-binding guidelines.

Care agreements as contracts regulating hospital discharge

In order to identify the kind of coordination regulated in the care agreements, we drew on Mintzberg's (1979) distinction between six basic mechanisms used to coordinate work in organisations. *Mutual adjustment* involves two or more people simply adapting to each other as their work progresses. *Direct supervision* denotes coordination through directives issued to the persons involved in doing the work. Coordination may also be encouraged through four

kinds of *standardisation*, namely in relation to *work, outputs, skills* and *norms*. Only three of the six mechanisms – direct supervision, standardisation of outputs, and work – are coordinating mechanisms embedded in hierarchy or the use of authority. Skills and norms grounded in professional work typically involve complex judgements about care and cannot be controlled technocratically (Glouberman & Mintzberg, 2001b; see also Hasenfeld, 2010). Coordination based on skills and norms requires mutual adjustment, with employees responding to each other's needs and ideas. The care agreements represent a *contract* which aims to affect professional *work* by regulating the responsibilities of the involved actors.

Basic economic theories of contracting (Williamson, 1985; see also Argyres & Mayer, 2007) suggest that contractual partners will make considerable effort to identify contractual hazards and to incorporate safeguards into their contracts. Given the interdependency between specialised care in hospitals and local care of older people, detailed descriptions of the roles and responsibilities of the involved parties are pivotal to securing coordination. By determining roles and responsibilities, ambiguity is reduced and thereby also the scope for opportunistic actions.

Thus, from a theoretical perspective, itemisation emerges as an important means to reduce ambiguity. Indeed, empirical research suggests that successful coordination when discharging older people from hospitals requires a precise and common understanding of the boundaries between sectors (e.g. Henwood, 2006: 406; Vinge, 2014). Our core assumption, therefore, is that subnational coordination strategies, as expressed in the care agreements, need to be wholly operational in order to be successful. Thus, we investigated the relative degree of itemisation of the subnational regulations pertaining to care agreements in the two countries. As national governments may play an important role in establishing a common understanding, we also assessed the relative spatial variation in subnational strategies for

itemisation within each country to evaluate the relative strength of the respective national strategies.

Operationalisation of the analytical framework

The aim of this article are two-fold: first, to assess how tightly national governments regulate subnational coordination efforts; and second, to analyse variations in the itemisation of subnational procedures for coordinating care services. Table 1 below offers an overview of the analytical framework and the operationalisation of its individual components.

TABLE 1 APPROX HERE

The left-hand side of Table 1 captures the national regulatory regimes, and more specifically the instruments used by national governments as part of the care agreements to regulate the coordination of care services for older people discharged from hospitals at the subnational level. We distinguish between three substantive instruments of regulation, relating to the content, completion, and monitoring of care agreements. In accordance with the discussion above, we characterise the instruments in terms of their degree of *hierarchical standardisation* and then assess the relative specificity and bindingness in their respective provisions as regards the *content* (standardisation of work), *completion,* and *monitoring* (standardisation of output) of the health agreements. *Specificity* relates to the provisions' level of detail – whether they comprise general procedures or more specific content. *Bindingness* concerns the authority underpinning provisions – whether the instruments are authoritatively binding provisions or merely offer non-binding guidance.

The right-hand side of Table identifies different dimensions pertaining to the degree of *itemisation in the subnational procedures* for coordination offered by the care agreements. The dimensions are defined as the specific mechanisms underpinning the process of discharging older people from hospitals. In economic theories of contracting, the most

extensive contracts specify the terms for roles/responsibilities, decision/control rights, communication, contingency planning, and dispute resolution (e.g. Argyres & Mayer, 2007). Based on this, we related the mechanisms included in subnational procedures to the different stages of the transition of older people from hospital to the local care systems, including the transfer of information and securing mechanisms to ensure *communication* both with the patient and with health and care professionals in the municipality, *planning* of the patients' discharge from hospitals, and the *supervision* of agreements.

Data and methods

We chose a cross-country comparative design to systemically review the importance of national regulatory contexts for coordination. The specific comparison of Denmark and Norway has added value to the analysis for two reasons. First, the two countries differ in relation to the relative autonomy of their respective local governments. According to the literature on local government, local autonomy is greater in Denmark than in Norway (Goldsmith & Page, 2010; Sellers & Lidström, 2007). Second, the regions in Denmark represent an independent level of government, whereas the Regional Health Enterprises in Norway are owned by the national government and can be governed in more direct ways. These differences shape the regulatory contexts which influence subnational procedures for care service coordination between hospitals and the municipalities. These procedures were analysed in relation to two-fold variations in itemisation: the degree of itemisation and regional variations in itemisation.

The analysis focuses on care agreements that are regulated nationally and ratified between regional actors and the municipalities. In Denmark, distinct care agreements are made for older people under the five regional governments, and these represent the owners of hospitals as well as 98 local governments. In Norway, the relevant care agreement, which

encompasses all patient groups, covers the four Regional Health Enterprises that represent the national government in its role as hospital owner. The four Regional Health Enterprises have delegated responsibility for contracting care agreements to their 24 subordinated Health Enterprises, which in turn deal with 428 local governments that provide care locally. Our analysis covers two of the five regions in Denmark and four Health Enterprises (one from each Regional Health Enterprise) in Norway. The regions in Denmark and Health Enterprises in Norway were selected to include less densely populated areas (Northern Jutland Region/Helse Finnmark, Helse Nord-Trøndelag) as well as densely populated areas (Central Denmark Region/Helse Vestre Viken, Helse Stavanger). Based on this selection, we examined agreements in 30 out of 98 municipalities in Denmark (31%) and in 87 out of 428 municipalities in Norway (20%).

The substantive focus of our analysis of specific care agreements was on the discharge of older patients from hospitals to municipalities which offer both healthcare and social care services, as this group represents a particularly challenging case when it comes to coordination. The data gathering was concerned with identifying those sections of the care agreements dealing with the discharge of 'somatic patients'. The data come from the first wave of care agreements, which were established in the period between 2011 and 2014 in Denmark, and 2012 and 2014 in Norway. Before formal regulation was introduced in Norway in 2012, however, many hospitals and municipalities had reached some sort of agreement that formed the basis for the new and more standardised approach. The data concerning the national regulation of coordination in both countries include the relevant legislation as well as information on relevant directives and guidance available on the World Wide Web.

Empirical findings

National regulations for the coordination of care services at subnational levels

National governments in Denmark and Norway use a range of instruments to regulate the coordination of hospital discharge at regional and local levels; these differ in terms of their degree of hierarchical standardisation. See Table 2 below for an overview.

Table 2 approx. here

Concerning the first set of instruments, the regulation of the *contents of the care agreements*, Denmark is characterised by a higher degree of hierarchical standardisation than Norway. In both countries, the provisions are only moderately specific; although they are relatively detailed, they relate exclusively to the procedural milestones of hospital discharge and provide no minimum standards. For example, in Denmark, the provisions define the overall aims and objectives of the care agreements and sketch out the broad areas they have to cover. This is complemented by more detailed provisions that regulate when and how to provide information about a forthcoming discharge, as well as when and how to agree on individual patients' needs and their implications for service provision. In Norway, the act simply specifies that routines designed to secure coordination between hospitals and municipalities have to be agreed upon. The specification comes from the national guidelines, where it is recommended that the agreements describe, for example, the exchange of information and dialogue and routines for interaction with the general practitioner. As in Denmark, the guidelines recommend making specific agreements, for example for routines for hospital discharge notification and the need for technical aids and care services when patients move back to their municipality.

There are significant differences, however, regarding the authority underpinning the specific process regulations in the two countries, and the regulations have a more authoritative character in Denmark. In Denmark, the provisions are part of the Healthcare Act (*Sundhedsloven*) and the corresponding ministerial guidelines. The provisions are therefore

legally binding, and the regions/municipalities are compelled to follow them. In contrast, the provisions feature in non-binding guidelines in Norway.

However, there are also examples of highly specific formal regulations in Norway. When it comes to the coordinating bodies, patients have the right to a contact person and the collaborating service personnel are obliged to set up specific bodies to ensure organisational coordination. This contrasts somewhat with Denmark where the corresponding regulation only stipulates that arrangements must be made for a contact person to ensure communication between the hospital and the municipality. In addition, the provisions in Norway cover a broader range of substantive areas. For example, there are additional regulations concerning the information that should follow the patient (the contents of the discharge summary), the criteria for discharge, and the right to an individual plan for patients with particularly complex needs. Although some specific areas are legislated for in Norway, in Denmark the regulations are more binding in defining the core processes of cooperation between the two parties in following up care-needing patients once they are discharged from hospital.

Concerning the second set of instruments, regulating *the completion of care agreements*, Denmark is again characterised by a higher degree of hierarchical standardisation than Norway. The provisions are more specific in Denmark, being both detailed and content-related. The Board of Health checks that the individual care agreements have been completed, and also has to approve every single care agreement based on specific requirements about their structure, as outlined above. If the Board of Health decides not to approve a healthcare agreement, a revised document must be submitted for reassessment. The corresponding regulation in Norway only requires that the Directorate of Health should check the completion of agreements. In practice, however, the Ministry of Health has delegated responsibility for this to the Regional Health Enterprises, and the care agreements are systematically filed and made accessible to the public on the internet by each of the 24 Health Enterprises. The role of

the Directorate of Health is reduced to providing an integrated web presentation featuring links to all relevant web pages. The consequences for a hospital or municipality of not completing an agreement are not specified in the legislation.

The two countries vary also in terms of the third set of instruments *regulating the monitoring of care agreements*, with Denmark representing the higher degree of standardisation. In Denmark, the provisions require the Coordination Committee in each region to take responsibility for monitoring, and even to specify the procedures for how this should be done, including the membership and responsibilities of the committee together with the concrete mechanisms for monitoring. The requirements for revision of the health agreements, meanwhile, are less detailed and only state that adjustments should occur on a 'regular basis'. In Norway, the national provisions explicitly leave it to the Health Enterprises and municipalities to decide how to monitor the care agreements. Although the regulations are less binding in Norway than in Denmark, the degree of specification seems comparable. Norway's national guidelines recommend the establishment of suitable cooperating bodies and procedures, not only to make the agreements and implement the procedures agreed upon, but also to follow up and further develop the evolving practices. The act requires sub-central actors to revise the care agreements on a yearly basis, but without clarifying any expectations regarding the process required to ensure the necessary evaluation.

Based on the three sets of hierarchical instruments that national governments use to regulate the coordination of hospital discharge, Denmark is characterised by a higher degree of hierarchical standardisation than Norway. While the regulation of healthcare agreement content is specific in both countries, the provisions are more binding in Denmark than in Norway as they are part of the Healthcare Act. The difference between the two countries is even more pronounced when it comes to regulating the completion of agreements, where provisions in Denmark are both more specific and more binding. The Danish regulations for

monitoring care agreements also display stricter hierarchical standardisation than in Norway. While these regulations seem to be on the same level of specificity across the two countries, the Danish act gives an independent body the authority to monitor the implementation of agreements, and in the Norwegian case it is left to the contractual parties to decide what kind of arrangements to set up for this purpose.

Itemisation in subnational procedures for coordinating hospital discharge

Overall, the degree of itemisation of subnational procedures for regulating hospital discharge is somewhat greater in Denmark than in Norway. That is, the subnational procedures concerning information, planning, and supervision are slightly more itemised in Denmark, and we find the largest regional differences between care agreements in Norway. Table 3 below gives an overview of our findings.

Table 3 approx. here

Our investigation of regional variations included differences both between regions/Regional Health Enterprises and between the many municipalities with which the regional levels complete care agreements. However, the latter type of difference, between municipalities included in contracts with the same hospital, is insignificant in both countries and has therefore not been included in the following analysis.

In relation to *information* enabling coordination, the overall degree of specificity in the care agreements is high in both countries. Regional variation is low in Denmark, but we did find some variation in Norway. Concerning the exchange of information in connection with hospital discharge, the relative degree of specificity varies somewhat between different areas. Itemisation is high when it comes to information about a forthcoming discharge, whereas itemisation was moderate in relation to contact persons. The specificity of information exchange is particularly high in Denmark where there is, for example, detailed standardisation

of the dialogue between the municipality and the hospital. In Norway, rather than agreeing on what kind of information is to be exchanged, the emphasis is on specifying deadlines for when the municipalities must receive information about a patient's discharge from hospital. In contrast, there is little formalisation of the written documentation of oral information in Denmark compared with Norway. Contact persons are also given relatively little attention in the Danish care agreements, whereas their role is more or less specified in the Norwegian contracts. Here, all agreements state that oral information on the need for care services and the actual time of transfer of the patient to a nursing home or his/her own home must be confirmed by both parties and registered in the patient's medical record. Furthermore, two of the four Norwegian agreements state that the contact person in the local government must be registered as soon as the patient is admitted to the hospital.

Care agreements in both countries exhibit a relatively high degree of itemisation concerning the *requirements for written documentation* following the patient. This particularly applies to Denmark. In these care agreements, documentation is embedded in a common system of electronic communication, which includes a detailed plan for when and how to implement standards for 'good electronic patient pathways'. There is limited regional variation. Electronic transmission of information is preferred in Norway. The degree of specification somewhat less detailed than in Denmark, however, with all agreements referring to the term 'case summary' without specifying their contents. Yet regulation in this field is more formalised in Norway than in Denmark, where the focus is on the reciprocal documentation of the oral communication between involved parties – the hospitals, local governments as responsible service providers, and patients. We find insignificant regional variation in the agreements in Norway, as they refer to ministerial and mandatory guidance. All agreements state that written documentation must follow the patient, although there are

minor differences concerning whether or not the documentation should be both manual and electronic, and to whom the information should be sent.

In terms of *planning* as a means of coordination**,** the picture is more mixed when it comes to subnational itemisation in the care agreements, while the degree of regional variation is generally more pronounced in Norway than in Denmark. The regulations concerning *the specific medicine and technical aids that should follow the patient upon* discharge are highly specific in the Danish agreements and considerably less so in the Norwegian ones. For example, in relation to medical care, the Danish agreements describe precise procedures for how medicines should follow patients from the hospital, and they also define exact timeframes for the divided responsibilities. There are further distinctions between different types of medicines, different lengths of stay in hospitals, and different eventualities. Although specified in most Danish agreements, we find variations between regions when it comes to the length of the period in which medicines are provided by the hospital; and one of the agreements describe cooperation between hospital and municipalities in making use of welfare technology in cases where care-needing patients return to their own homes. In Norway, the agreements generally state that 'necessary medicines and medical aid' should follow the patient when discharged from hospital. There are regional variations in the agreements, however, in terms of whether hospitals are made responsible for ordering and/or ensuring that the necessary medical aid is installed so that patients can function well when moving back to their own homes.

When it comes to regulating the coordination of patient care, the Danish agreements are detailed, specifying, for example, particular meetings and who is to be contacted when. In Norway, the same level of detail is found in the individual plans referred to above. The agreements, therefore, are rather specific in both countries. In Denmark, however, the coordination of patient care covers all patients involved in hospital stays of more than 24

hours, whereas the corresponding provisions in Norway only covers patients with particularly complex needs. There are also differences in relation to the appointment of coordinators, with the level of specificity being low in Denmark and high in Norway, reflecting the existence of relevant legislation. In Denmark, there is some variation between regions in terms of the details of required home visits and the approach to ensuring an ongoing dialogue in the process of discharge from hospitals mentioned in the agreements, and whether specific coordinating teams are mentioned. In Norway, however, we find significant regional variation in the degree to which processes and means for the coordination of patient pathways that are legislated for, i.e., individual care plans and appointed coordinators are mentioned, agreed upon, and concretised in the care agreements.

In terms of the two core dimensions of planning discussed above, the degree of itemisation is somewhat higher in Denmark than in Norway. However, there are different kinds of variations in relation to the two remaining dimensions. The regulations concerning *the criteria for discharge from the hospital* to the municipality are more specific in Norway than in Denmark, as are those for *providing information to a patient's GP and family* about a planned discharge. The criteria for discharge referred to in the agreements are standardised in a mandatory ministerial guideline in Norway, which defines which health-related factors need to be assessed and documented by responsible health personnel. In all agreements, the relevant guidelines are cited, leaving no variation between regions. The Norwegian guidelines are specific about the criteria for when a patient is ready for discharge, stating, for example, that there should be a conclusion on the patient's diagnosis and that his/her level of everyday functioning should be determined. As for Denmark, the criteria seem to be somewhat less specific and the agreements more concerned with whether the local governments are able to provide sufficient health and social care services for the patient discharged from hospital.

There are a couple of examples of specifications in the agreements, in situations where patients may remain in hospital although they are regarded as ready for discharge.

Information to the family is not regulated in the Norwegian care agreements, but information to the GP is mentioned in general terms in three of the four cases, and the need to transfer discharge summaries is specified in two of the cases. Thus, here we find significant regional variations in the agreements in Norway. In Denmark, provision of information to the GP and the family is not covered in the care agreements.

The care agreements in both countries deal with follow-up *supervision* of the procedures to coordinate services, but the degree of itemisation is again higher in Denmark. Here, care agreements contain detailed procedures for supervision at regional and local levels, including the membership, remit, and activities of the respective committees and the exact indicators to be used. In Norway, the care agreements only identify the precise bodies responsible for supervision. Unlike in the case of information and planning, we find no regional variation in the agreements about supervision in either country.

Concluding discussion

The coordination of care for older people is a major concern in welfare states across Europe and thus raises the question of how to develop sustainable structures, incentives, and regulative arrangements to support integration across different government levels. Based on a comparative analysis of care agreements in Denmark and Norway in relation to hospital discharge, we asked in which ways, and to what degree, regulatory instruments at the national level influence subnational procedures for the coordination of care services for older people. The following four central findings emerged from our analysis.

First, the care agreements in both countries offer numerous procedures for coordinating care when older people are discharged from hospital. The procedures are broad

in scope and relate to the passing on of information, the planning of discharges, and the supervision of the agreements. Each of these three procedural areas includes several individual mechanisms. These can be highly distinct in terms of the degree to which they specify procedures. There are additional regional variations between care agreements in Denmark and Norway with regard to the substantive indicators of itemisation used within the individual stages of hospital discharge. Taken together, the care agreements in both countries offer an extensive and highly differentiated toolbox for coordinating the hospital discharge of older people.

Nevertheless, and second, the overall degree of itemising procedures for communication, planning, and supervision in the care agreements is somewhat higher in Denmark than in Norway. These differences in the degree of subnational itemisation particularly concern the core dimensions of planning hospital discharge and the procedures for supervising the agreements. This is significant, as we have referred theoretically and empirically to clear and specific requirements as a central factor for encouraging coordination.

Third, within this overall picture of country difference there is some, albeit limited, regional variation among the care agreements. The variation is greater in Norway than in Denmark. This may seem surprising, given that the regions responsible for hospitals in Denmark represent an independent level of government, while the Regional Health Enterprises running the hospitals in Norway are owned by the national government. At the same time, however, in both countries the care agreements are embedded in a complex context of multi-level governance which includes the national, regional, and local levels. The level of complexity is further exacerbated by sheer numbers: Norway has almost five times as many regional entities and more than four times as many municipalities as Denmark, which may partly explain the greater variation in procedures at the regional level in Norway.

Fourth, the analysis suggests that national regulation of hospital discharge coordination can at least partly explain why subnational procedures are characterised by greater specificity in Denmark. The shadow of hierarchy is more pronounced in Denmark than in Norway, as the regulatory instruments of the national government show a greater degree of hierarchical standardisation in the former than in the latter country. While the regulation of the contents of care agreements is specific in both countries, the provisions are more binding in Denmark than in Norway. The difference between the two countries is perhaps most evident when it comes to the regulation of the completion of agreements, where provisions in Denmark are both more specific and more binding, since they form part of the Healthcare Act. This powerfully confirms the findings from single-country studies of the coordination of care for older people. For example, Henwood (2006, p. 406) stressed that building and sustaining coordination occurs in an environment that is, to a large extent, shaped by central government. Similarly, Glendinning (2003, p. 139) emphasised that horizontal inter-organisational arrangements are profoundly influenced by the wider policy environment and not least by vertical relations with the national government. Furthermore, Mackie and Darvill (2016) have identified national policy as an important enabler of coordination at the subnational level. National regulation based on hierarchical standardisation can facilitate subnational coordination, but as the literature also stresses, this is no guarantee that coordination actually occurs at the regional and local levels (Mur-Veeman, van Raak, & Paulus, 2008; Øvretveit, Hansson, & Brommels, 2010; Petch, 2012). This calls for a multi-level approach to coordinating care for older people.

This study covered two of the four regions in Denmark and all the administrative health regions (Regional Health Enterprises) in Norway. The variation in care agreements found in our study is therefore representative of the two countries, although variation may be even larger than we have been able to detect. We posit that if we find differences in the

itemisation of subnational procedures for coordination in the formalised care agreements, such differences will certainly also exist in practice. Theoretically, there are indeed good reasons to believe that agreed procedures and actual practice will differ (Brunsson, 1989). Thus, the question of the degree to which practice corresponds to the formal care agreements should be further researched. For example, in the case of Denmark, there are many local case studies of specific organisational measures to strengthen the coordination of care services for older people (Burau, Doessing & Kuhlmann, forthcoming). However, more systematic assessments across municipalities as well as comparisons with other countries are lacking.

Finally, in our investigation of care agreements in Denmark and Norway we have focused exclusively on the conditions for coordination between public actors. As pointed out in the Introduction, different healthcare systems encompass, to a varying degree, private business and health insurance companies, which increases the complexity of coordination. Complexity is introduced, not only by the increased number of actors, but also by the problems raised by cooperation between private actors. The United Kingdom is a good example of this: Although based on the same national healthcare system as the Nordic countries, private provision of services is extensive and a multitude of public and independent actors are involved in local care provision (Fotaki, 2011; Porter, Mays, Shaw, Rosen, & Smith, 2013; Schmid, Cacace, Götze, & Rothgang, 2010). Obviously, in market-dominated systems, vertical integration between the levels of actors involved in patient care is pivotal in order to reduce problems of coordination, among other things (David, Rawley, & Polsky, 2013). According to the traditional zero-sum view of competition and collaboration, however, agencies may avoid collaboration with competitors even though partnering is necessary in order to deliver comprehensive and coordinated care services. Competition over new contracts, the hiring of qualified personnel, or the recruitment of new customers may hinder cooperation (Bunger, Collins-Camargo, McBeath, Chuang, Pérez-Jolles, & Wells, 2013). The

relevant literature on so-called coopetition calls for a reconceptualisation that transcends the competition-cooperation paradox. Multiple empirical studies indicate that coopetition may have significant advantages for outcomes such as innovation, knowledge sharing, economic performance, and service quality (e.g. Bengtsson, 2016; Chen, 2008, Peng, Pike, Yang & Roos, 2012). The coordination of care in countries dominated by private and social health insurance systems are in any case likely to face different challenges than in countries with national healthcare systems based on public provision. The type of national regulations investigated in this article might not be as relevant in such diverging contexts (see e.g. Rico, Saltman, & Boerma, 2003). There is a need for further research on how specific features of the healthcare system – from specialised services in hospitals to care services in communities – influence the kinds of coordination mechanisms chosen to encourage integrated care solutions, as well as the regulation of those mechanisms.

Aknowledgement

We are grateful to our research assistants, Benny Baagø and Andreas Henriksen Aarflot, for invaluable help. They collected and systematized the relevant information on national regulations and the great number of health agreements in Denmark and Norway respectively. Many thanks also for constructive comments from participants in the seminars where the paper have been presented.

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Table 1. Empirical operationalisation of the analytical framework.

Hierarchical instruments of national government – degree of hierarchical standardisation of coordination at regional and local government levels	**Care agreements as contracts regulating hospital discharge – degree of itemisation of coordination in subnational procedures**
(1) Regulating content of agreements * Relative specificity of provisions * Relative bindingness of provisions	**(1) Communication** * Exchange of information in connection with hospital discharge * Requirements for written documentation following patient
(2) Regulating completion of agreements * Relative specificity of provisions * Relative bindingness of provisions	**(2) Planning** * Regulations stipulating which medicine/technical aids must follow the patient from hospital * Regulations governing coordination of patient care/individual patient pathways * Criteria for discharge from hospital to municipal care services * Regulations covering information to GP/family about planned discharge
(3) Regulating monitoring of agreements * Relative specificity of provisions * Relative bindingness of provisions	**(3) Supervision** * Regulations concerning supervision of agreements

Table 2. National government hierarchical instruments – degree of hierarchical standardisation in the regulation of coordination at regional and local government levels.

Indicators for degree of hierarchical standardisation by national government	**Findings**
(1) Regulating content of agreements	*Highest degree of hierarchical standardisation in DK* * Relatively specific regulations in both countries * More binding regulations in DK than in NO
(2) Regulating completion of agreements	*Highest degree of hierarchical standardisation in DK* * More specific regulations in DK than in NO * More binding regulations in DK than in NO
(3) Regulating monitoring of agreements	*Highest degree of hierarchical standardisation in DK* * Relatively specific regulations in both countries * More binding regulations in DK than in NO

Table 3. Care agreements as contracts regulating hospital discharge – degree of itemisation of coordination in subnational procedures.

Indicators for aspects of itemisation at major stages of hospital discharge	**Findings**	
	Degree of itemisation	***Regional variation in itemisation***
(1) ***Communication***		
Exchange of information in connection with hospital discharge	High specificity of information exchange, particularly in DK No formalisation of written documentation of oral information in DK; considerable formalisation in NO High specificity concerning contact persons in NO; medium specificity in DK	No variation in DK; some variation in NO
Requirements for written documentation following patient	High specificity in both countries	Insignificant variation both in DK and NO
(2) ***Planning***		
Regulations covering the medicine/technical aids that must follow the patient from hospital	High specificity in Denmark; less so in NO	Some variation both in DK and NO
Regulations pertaining to the coordination of patient care/individual patient pathways	High specificity in both countries, but varies according to patient groups Low specificity concerning appointment of coordinators in DK; high specificity in NO	Some variation in DK; significant variation in NO
Criteria for discharge from hospital to municipal care services	High specificity in NO; low specificity in DK	Some variation in DK; none in NO
Regulations covering information to GP/family about planned discharge	Not covered in DK; covered in some agreements in NO with varying specificity	Significant variation in NO
(3) ***Supervision***		
Regulation concerning supervision of agreements	Covered by all agreements with relatively high specificity, especially in DK	No variation in either country