

**States Under Pressure:
Institutional Adaptation to New Policy Challenges**

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Abstract

Governments' approach to policy making and implementation depends not only on the preferences of the party or parties in power, but also on the institutional capacity of the state to formulate and deliver policy and to do so effectively. Governments may therefore need to find new means of addressing emergent policy challenges that involve institutional adaptation and innovation. This paper uses national time-series databases of state institutions for Norway and Ireland to analyse shifts in the structure of state institutions that have taken place in response to new policy challenges. We take two substantive policy areas in which significant new demands on state capacity have been experienced – health care, and immigration. The comparative research design enables us to probe the reasons for similarity and contrast in state responses in the two countries.

We note that the proliferation of new agencies in both countries appears to be consistent with New Public Management principles of organizational specialization and increased agency autonomy, with a view to improving organizational efficiency. We also note a subsequent trend toward attempted consolidation and reintegration of state agencies. This is spurred by a new concern with policy coordination that would appear to be consistent with post-New Public Management reassertion of political oversight and increasing financial controls over agency functioning.

However, we find that this common trend is explained by rather different political imperatives in the two countries. The new situation in each country diverges significantly from the status quo ante; the political drivers are rather different; and the ensuing capacity of the state to formulate and deliver effective policy in each country shows a marked contrast.

Introduction

Governments' approach to policy making and implementation depends not only on the preferences of the party or parties in power, but also on the institutional capacity of the state to formulate and deliver policy and to do so effectively. The comparative study of political institutions is a well developed field of inquiry. Until recently, however, public management research has been relatively underdeveloped in respect of cross-national comparative institutional analysis. Following early work by Olsen and Peters, there has been a gradual appreciation in the number of texts providing examination of public administration characteristics and reforms of recent years across states (Chandler 2000; Olsen and Peters 1996; Ongaro 2010; Pollitt and Bouckaert 2004).

This paper uses national time-series databases of state institutions for Norway and Ireland to analyse shifts in the structure of state institutions that have taken place in response to new policy challenges. We analyse two substantive policy areas in which significant new demands on state capacity have been experienced. The first is health care, and specifically the organization of the most expensive part of health care, the management of the hospital system. The second is immigration. The comparative research design enables us to probe the reasons for similarity and contrast in state responses in the two countries.

Our approach is informed by Mahoney and Thelen's conceptualization of institutional change as centred on the inherited structure of policy provision and routinized practices around this, and the interactions between policy actors within this context (Mahoney and Thelen 2010). Our focus is on the change in the organizational structures of the state itself through which policy is made and delivered, where there is much scope for exploring the dynamics of change comparatively (Hall 2010, pp.219-20). This paper represents an initial exercise in profiling institutional change comparatively. Further work will explore more systematically the clusters of actors involved in each policy area, how these contributed to shaping the nature and direction of organizational change, and what the implications have been for the institutional context of policy in each country.

We begin by looking at the politico-administrative institutional contexts in the two states, then outline some features of the two policy issues under discussion. We profile shifts in the institutional management of each policy over time, with a view to analysing both the political

imperative and interest coalitions driving change, and the implications of organizational change for state capacity to function efficiently and effectively.

Case study selection: Norway and Ireland

The purpose of this study is to analyse changes in the institutional apparatus through which policy is made and delivered in two critical policy areas: one located in welfare state provision (health care), the other spanning labour market and citizenship policy (immigration). Both policy issues are politically sensitive: healthcare because of rising domestic demand and sensitivity over quality of service, especially in access to acute hospital care; and immigration because of growing domestic sensitivity to boundary-maintenance in the context of freer population flows.

We seek to deepen existing organization theory by locating it explicitly in the context of party political competition and shifting social coalitions to which elected officials seek to cater. We therefore expect to find some tension between competing principles animating the choice of strategy in designing institutional management of these issues.

Creating new specialized bodies to deal with key policy issues could follow from two rather different preoccupations on the part of government. One has to do with maximizing efficiency, consistent with the precepts of New Public Management. The other concerns the political sensitivity of issues, and governments' wish to insulate themselves from direct responsibility for decision-making as well as to ensure their proposals are not easily reversed by future administrations. We would expect there to be some variation in the tendency to do this depending on the partisan composition of government. When governments seek to increase efficiencies, we might expect more decentralization and agencification. Equally, when governments seek to create some distance from a sensitive policy issue, we might expect more decentralization and agencification. The motivation for organizational change cannot simply be read off from the form of the change undertaken.

We recognize that governments also seek to ensure the coherence of policy design and implementation, and that diversified or independent bodies can make policy coordination difficult. This would lead us to expect a tendency for government to seek to centralize and simplify the institutional configuration of policy. Post-New Public Management theory posits that after a certain point of agencification has been reached, the imperatives to reassert both

political and financial control from the centre become increasingly felt, and a move toward reassertion of central authority can be expected. Similarly, we also posit that if an issue becomes contentious in public debate, the symbolic politics of reassertion of control can be advantageous, and that the quest for partisan advantage may motivate the desire to be perceived to be taking increased political responsibility for an issue. Therefore where recentralization of political control is discerned, the motivation similarly needs to be explored carefully and inferences drawn from formal change alone must be treated with caution.

We also recognize that our two policy areas are likely to be politically sensitive in different ways and to different electoral constituencies. Access to health care is a more central issue for parties of the left. Control over immigration has more typically been associated with parties of the right. Therefore the partisan complexion of government may affect the preference for agencification or recentralization of control over issues, and might mean that in any one country, the two issues might display different organizational logics.

The selection of Norway and Ireland provides us with a model case of paired comparison. Both countries are unitary parliamentary democracies of between four and five million inhabitants. Though Norway is not an EU member, its affiliation with the EU is substantial and on many policy areas Norway aligns itself with European norms.

The two countries are however ‘most different’ on the variables that interest us most: political partisanship and interactions between government and opposition in parliament, and the structure of public administration and the balance between central and local administration.

Legislative politics

The consensus-based Norwegian political system stands in contrast to the more majoritarian form of democratic politics practiced in Ireland, and the ideological spectrum in their party systems offers a marked contrast. The Irish party political system is one in which the conventional left-right is only weakly present. While smaller parties can readily be identifiable in a comparative European context as Social Democratic (the Labour Party), liberal (the Progressive Democratic Party or PDs, which functioned between 1986 and 2009), or Green, the two largest parties, Fianna Fáil and Fine Gael, cluster on the centre-right and are virtually indistinguishable in policy terms (Laver 1992; Laver and Benoit 2003). The

origins of the party system are found not in conventional European cleavage politics, but in the history of nationalist separatist politics early in the lifetime of the independent state. The two largest parties function as catch-all parties; and the trend toward coalition government strengthens the bias toward a broad-based policy stance and avoidance of overt ideological partisanship.

The ideological spectrum of Norwegian politics conforms to the ‘Scandinavian’ five-party model (Müller and Strøm 2000). It is characterized by a strong Left dominated by the Labour Party which has formed most governments since the end of WWII, but also a small socialist party which has more recently been in governing coalitions with the Labour Party. A small agrarian party with Green credentials, the Centre Party, is on the centre left. On the Right, a moderately sized Conservative party has been joined recently by a far-right Progressive Party. The ideological centre is occupied by a number of smaller parties including the Liberals and the Christian People’s Party.

While both countries practice ministerial responsibility to parliament, the unicameral Norwegian *Storting* is better equipped to perform ex-post parliamentary scrutiny of the administration than the bicameral Irish *Oireachtas*. Norwegian governments normally engage detailed negotiations with opposition parties to maximize parliamentary consensus for policy changes, whereas in Ireland the adversarial approach adopted in the lower house, Dáil Éireann, enables government to block or ignore almost all forms of political opposition to its policies (Döring 2004; Strøm 2000).

Administrative traditions

There are important differences in respect of state politico-administrative institutional features. Ireland belongs to the Anglo-Saxon family of public interest administrative systems based on the common law tradition. It shares many features in common with the Whitehall system of administration, in which the civil service is explicitly non-political and civil servants are precluded from joining political parties (Rhodes, Wanna and Weller 2009). The core units of administrative organization are government departments, of which there are normally fifteen, each headed by a government minister. The Irish bureaucracy also consists of a considerable number and variety of agencies and public service organizations, which are

subject to a variety of accountability and reporting arrangements (MacCarthaigh and Scott 2009; Verhoest et al. 2010.)

Norwegian public administration is not exclusively characterized by either public interest or civil law Rechtsstaat traditions, but displays elements of both. The civil service is non-partisan and there has traditionally been considerable emphasis on trust and cooperation in the relationship between politicians and administrative leaders (Christensen and Læg Reid 2005). The main units of organization are Ministries; these control a number of different types of state agencies, with considerable emphasis placed on the form of affiliation of these agencies to central political authorities, with reference to legal status or form of ownership. In terms of relative size, Norwegian Ministries employ about 4000 people while the central agencies have approximately 12000 staff. Ministries resemble secretariats for the political leadership and are heavily involved in policy formulation, whereas the implementation occurs through state agencies. In contrast, and excluding health, security and education services, Irish ministerial departments accounted for over three-quarters of the civil service workforce, with the remaining civil servants working in a variety of state agencies.

Therefore, although state agencies have an established presence in both states, their status and role varies considerably. The majority of Norwegian agencies are established through legislation, that is, by royal decree or ministerial act. Periods of expansion and contraction in the number of agencies employed by the central state are regular and normally follow administrative reform programmes. Recent administrative reforms in Norway have largely focused on the internal structure and organization of central government, including its function and tasks, work procedures, decision-making, and steering structures. The relationship between agencies and Ministries has been central to this. Norwegian central agencies, called 'directorates', normally have tasks related to exercising public authority or policy formulation, while other ordinary civil service organizations normally have tasks related to service delivery. Civil service organizations with extended authority have formally been delegated autonomy, primarily managerial autonomy, beyond the standard regulations, and government administrative enterprises have even more formal autonomy (Roness 2007).

In Ireland, in the absence of an established legal framework for the classification of agency types in Irish administrative law, as well as the circumstances surrounding the creation of

many agencies, it is not easy to comprehensively categorize Irish agencies. In fact a defining characteristic of Irish state agencies is the ad-hoc nature of their emergence, staffing arrangements, and relationship to parent departments (Clancy and Murphy 2006; Hardiman and Scott 2009; McGauran, Verhoest and Humphreys 2005). As well as variety in legal type, they enjoy a range of forms of public authority, including independent commissions, advisory bodies, Tribunals, statutory and non-statutory corporations, and companies limited by state guarantee. They also perform a wide variety of tasks, including service delivery, regulatory functions, research or contracting for services, across a multitude of policy arenas such as agriculture, environment, social welfare, and so on. The dominant trend has been one of gradual acceleration in the number of state agencies created over the last ninety years, with a peak being reached in 2007, and a process of uncoordinated de-agencification beginning after this (Verhoest, Rubecksen and MacCarthaigh 2009).

Sub-national government

Drawing on Hesse and Sharp's typology, Ireland may be seen as one of the most centralized states in the EU. Irish local government displays many of the features of ideal-type Anglo-American systems, including limited discretion and weak financial independence (Hesse and Sharpe 1991). Indeed, Irish local government is more akin to a system of local administration than a separate tier of democratic governance (OECD 2008). In contrast, the Norwegian system of local government is North European in type, and though local government is not formally recognised in the constitution, it is an integral part of the 'living' constitution. It has a strong political function of local democracy, general functional competences and high degrees of policy-making autonomy and financial independence. Thus while both states are characterized as unitary in form, in practice authority is more dispersed in Norway than within Ireland.

Profiling two policy issues: health care and immigration

Health care: spending profiles

The Norwegian welfare state falls into the Nordic welfare model with a strong emphasis on universality of service provision. In contrast, Ireland has a liberal welfare regime, featuring a more extensive reliance on means-tested access to services (Esping-Andersen 1990). Many citizens purchase basic services from the market. Yet private access is considerably less

expensive than in other liberal welfare regimes, since in addition to the subsidies provided by tax reliefs, the state often pays for basic infrastructure and current expenditures on which private provision builds (McCashin 2004; O'Connell and Rottman 1992; O Riain and O'Connell 2000).

Spending patterns are difficult to compare consistently, given the variation in how sectoral spending is estimated. Very rapid GDP growth, which Ireland experienced during the 1990s and 2000s, will depress the trend in relative spending. And GDP is often considered a rather misleading indicator of national disposable income, given the large presence of foreign-owned firms in Ireland and the extent of repatriated profits that ensue, a phenomenon that is inseparable from Ireland's FDI-led development model. Figure 1 nevertheless gives an estimation of the relative size of total directly publicly funded social spending in Norway and Ireland.

Figure 1. Social welfare spending as a percentage of GDP, Norway and Ireland

In 2009, Norway spent 8.9% of GDP on health, about the OECD average, while Ireland ranked lower at 7.6%. But GDP is likely to be somewhat misleading as a denominator for the reasons noted above, and may understate the 'welfare effort' on health care that each country makes, relative to the disposable income. Figure 2 therefore shows health spending as a proportion of net national income, showing also the relative proportions of private and public spending committed to health care.

Figure 2. Total expenditure on health as a percentage of Net National Income (2006)

Somewhat surprisingly, we find that Ireland and Norway look much more alike on this measure, although Ireland features rather more reliance on private spending. This may overstate the similarity of infrastructural provision and quality of service available in the two countries though. Both public and private spending on health care in Ireland grew very rapidly during the 1990s and 2000s, but much of this is attributable to catch-up spending consequent upon the sharp fiscal contraction enforced during the 1980s (Tussing and Wren 2006; Wren 2003). The reversal of health spending, particularly in current health spending (which mostly goes to front-line medical services) is profiled in Figure 3 below.

Figure 3. Current spending on health in Ireland 2000-2010

Immigration patterns

The wealthier OECD countries all experienced net inward flow of migrants during the 2000s. As Figure 4 shows, the Irish labour force showed a marked increase in the proportion of foreign-born workers; in Norway the increase was less marked.

Figure 4. Foreign-born labour force as a percentage of the total labour force, 1997-2007

The composition of the workforce reflects those who may be in competition with the existing workforce for jobs, which might be one factor that tends to make immigration a politically sensitive topic. These immigrants might be made up disproportionately of younger, single people; or there might be a deeper population transfer under way with entire families moving. The composition of the workforce does not capture the movement of people who may not be eligible to work because they are refugees or asylum-seekers, whose legal entitlement to residence and workforce participation may differ from other categories of immigrants. Total foreign-born population movements were a good deal higher in Ireland than in Norway over the period in question, as Figure 5 shows.

Figure 5. Inflows of foreign-born population, 1998-2007

The relative proportion of those who applied for refugee or asylum-seeker status is seen in Figure 6 below, along with a profile of the nationality of origin of non-nationals.

Figure 6. Asylum seekers by country of origin, 2008

This is indicative of the different profile of foreign-born populations in the two countries. Ireland experienced a massive inflow of economic migration during its high-growth years, mostly from Eastern Europe, and particularly people from Poland and Latvia. In contrast, Norway has had a steadier commitment to international humanitarian policies of receiving refugees and asylum-seekers.

Organizational Change: Health Care and Hospitals Policy

Ireland

The Irish health services employ a variety of institutional forms for service delivery at both national and sub-national levels. Until the mid-20th century, core health and other social

services in Ireland were largely delivered through religious organizations and in particular the Catholic Church, and state funding was provided to these organizations. The state kept central registers of doctors, dentists, nurses and midwives and had some regulatory control over hospitals through the Hospitals Commission, but the remaining ancillary health services provided by the state in its early decades, following independence in 1922, were managed by local government in Ireland. The 1947 Health Act provided statutory recognition for local authorities as health authorities, and a new Department of Health was created that year. A national health agency was also set up under the Act, the National Health Council, which first met in 1948 to advise the government on health issues.

Through the 1950s and 1960s, the state slowly began to take a more direct role in providing aspects of health care. Under the Health (Corporate Bodies) Act 1961, the state was able to establish statutory corporations to perform health functions by passing statutory instruments. This legislation greatly simplified the process of setting up agencies, and opened the door to the creation of bodies such as the Blood Transfusion Service Board, the Mass-Radiography Board, and the National Rehabilitation Board. The state also set up a health insurance company in 1957, the Voluntary Health Insurance Board (VHI), which held a monopoly on the Irish health insurance market until the 1990s. The early process of agency creation was therefore a consequence not of devolution of power from the centre, but of the growing acquisition of responsibility for health care by the state.

Under the Health Act 1970, locally-run health services were consolidated into eight regional Health Boards (which included local politicians on their governing authorities), reorganized into eleven in 1999. The Act also provided enhanced central structures, creating Comhairle na nOspidéal, a regulatory body to manage appointments in the hospitals. Shortly thereafter the Hospital Bodies Administrative Bureau was created to provide administrative services to the Health Boards.

The 1990s saw another wave of agency creation for various health-related purposes. Advisory bodies, such as the National Ambulance Advisory Council and the Consultative Council on Hepatitis C, were created to address policy areas of concern. Agencies for preventive health care, such as the Food Safety Authority of Ireland, the National Breast Screening Board and the Office for Health Gain, also became a prominent feature of the Irish

health care system. This trend toward specialist agency formation continued through the early 2000s.

But the structure of health planning and of acute healthcare provision was proving very unwieldy and difficult to integrate into a coherent planning structure. A major departure from the pattern of agency proliferation was the Health Act of 2004 which resulted in the merger of seventeen agencies, including the regional health boards, into one ‘super-agency’ with over 100,000 staff called the Health Services Executive, under the aegis of the (renamed) Department of Health and Children. The HSE’s remit was very broad. It covered not only health but also social services and it is the largest organization of its kind in the EU.

The centralization of healthcare organization was intended to facilitate the implementation of far-reaching rationalization plans for healthcare delivery. Among these were the strategy for primary care, to bring the largely self-employed family doctors into a planning framework; the national cancer strategy, to rationalize delivery systems into centres of excellence; and the associated hospitals reorganization plan, to centralize acute treatment into a small number of high-quality centres with large-volume throughput, which implied the corresponding downgrading of acute services in smaller regional hospitals. These plans secured the approval of expert opinion and were most actively driven by PD Minister for Health Mary Harney. But they proved extremely difficult to implement in practice. In particular, the hospitals rationalization plan ran counter to local communities’ suspicions that their acute services would be removed before sufficient capacity had been created elsewhere, and by dissatisfaction at the removal of local facilities to more remote locations. Moreover, the PDs also favoured intensifying the role of the private sector in hospital management, which proved controversial when periodic crises flared over poor access to adequate hospital-based diagnostic and treatment services for those totally reliant on the public system. Single-issue ‘hospitals’ candidates, standing for election to dramatize their communities’ issues, became a regular feature of the Irish political landscape.

The centralization of health services was reversed somewhat in 2009 by a decision to create regional structures within the HSE itself; this can be understood as a form of vertical de-specialization. Meanwhile, new financial sanctions were introduced to try to induce hospitals themselves to rationalize their management systems and improve efficiencies: a public

management resource very much associated with New Public Management. On the other hand, though, much dissatisfaction continued over the inefficiencies of the HSE itself. Very little administrative rationalization had followed the merger of the health boards into the HSE, with much duplication of function and increased complexity of reporting responsibilities, and no reduction in personnel numbers. Getting to grips with this was made more difficult by unclear lines of demarcation between the responsibilities of the Minister for Health and those of the Director of the HSE. Post-NPM centralization of policy capabilities and rationalization of structures has encountered numerous obstacles.

There have been other changes in the agency landscape within health services, and these can largely be understood, as before, as late responses to the under-governance and under-institutionalization of the health care system. To some degree, new agencies were an obvious answer to issues of regulation and oversight, but the circumstances of their establishment were once again often associated with crisis-management, such as the adverse publicity generated by the revelation of poor standards in HSE-approved nursing homes. In 2007, the Health Information and Quality Authority was created as a statutory authority. It integrated and expanded the functions of two agencies: the Social Services Inspectorate, established in 1999 as a non-statutory, non-departmental Body, and the Irish Health Services Accreditation Board, established in 2002 as a statutory corporation. For the first time, wide-ranging statutory inspection powers were put in place for all public hospitals as well as nursing homes and other facilities – though their remit did not extend to the small but growing sector of for-profit private hospitals. In 2009 and 2010, several more agencies, such as the National Cancer Screening Service Board and the Crisis Pregnancy Agency, were absorbed into the HSE as part of the Health (Miscellaneous Provisions) Act 2009. The pattern of formation and suppression of agencies in Ireland is summarized in Figure 7 below.

Figure 7. Health agencies in Ireland, 1985-2010

Norway

In 2002 responsibility for Norwegian hospitals was transferred from the counties to the central government. The reform centralized the ownership function, and the Ministry of Health was given the main responsibility, aided in administrative and oversight functions by two subordinate agencies. The reform also implied a new management system, which was

described as a decentralized enterprise model. Five regional health enterprises with separate professional boards were established, comprising thirty-three local health enterprises overseeing 250 health institutions of different types.

The official goals of the reform were to enhance coordination and utilize resources more efficiently through better control of the financial situation of the hospitals. The reform process was in many ways an entrepreneurial political effort by the responsible minister within the Labour minority government, who initiated and established the reforms. A change of administration however, meant that centre-right coalition inherited the responsibility to implement the reforms. The hospital reform involved a number of elements that one might associate with New Public Management. The hospitals were removed from the ordinary public administration and transformed into enterprises which were supposed to have greater managerial autonomy. This feature was combined with a DRG system, a complicated kind of 'money-follows-the patient' system, which via an incentive system for the treatment of patients transformed both administrative actors and doctors in hospitals into strategic actors (Christensen, Lægreid and Stigen 2006).

The hospital reform programme in Norway also has some distinct re-centralizing elements. The most important one is that the central government, represented by the minister of health, took over the ownership function and established an ownership division in the ministry. This ownership function is, however, very much enacted through a performance-management system of the sort associate with NPM, where central targets are set, resources provided and results reported from regional and local enterprises. Another aspect of this centralization is that the ministry has more legitimacy when it has to take drastic measures and is able to put aside the ordinary performance system, for example if there is a major crisis going on in the hospitals (Christensen et al. 2006).

A small part of the hospital reform was reversed when the new Red-Green government came to power in 2005, because it brought politicians back onto the boards of hospitals. The removal of politicians from the boards had originally been seen as important, because it symbolized keeping politicians at bay, just as in Ireland. But this was not so easily accomplished. Members of the so-called professional boards, after the reform, had a lot of political and other experience from the public sector (Hegrenes 2005).

Summing up, the hospital reform introduced a rather complex combination of centralization, decentralization and commercialization into its formal structure and displayed features of both NPM and post-NPM reforms (Læg Reid, Opedal and Stigen 2005). Overall it tilted the steering of the hospitals more in the direction of centralization, creating more legitimacy for tough measures when necessary, but this was balanced out by the increased managerial autonomy of the hospitals. In times of crisis there is a tendency for blame to be directed towards the political leadership. Overall the reform created more bureaucracy, more control and more reporting in the hospitals, thus reducing time the doctors otherwise spent attending to patients.

Organizational Change: Immigration

Ireland

Immigration does not fall entirely within the remit of any one department. While the Department of Justice and Law Reform has the most responsibility for immigration issues, both at department level and as the parent body of all relevant agencies, the Department of Enterprise, Trade and Innovation, and the Department of Community, Equality and the Gaeltacht, also have significant roles in regard to immigration.

The Department of Justice, Equality and Law Reform has long had primary responsibility for citizenship acquisition and for granting permission to non-EU nationals to remain in Ireland. They shared responsibility for refugee issues with the Department of Foreign Affairs, who were responsible for ‘programme’ refugees who came to Ireland as part of government agreements. The Department of Justice, Equality and Law Reform also was responsible for integration issues, which were centred in the Office of the Minister of State for Integration, a subordinate position created in July 2007. In May 2010, legislation was passed to move this office as well as other Equality policy units to the former Department of Community, Rural and Gaeltacht Affairs, which could be viewed as a downgrading of these issues in the context of economic crisis.

The Department of Enterprise, Trade and Innovation is the department with responsibility for issuing employment permits to migrants from non-EU/EEA states. Its Labour Force Development Division has responsibility for determining which categories of immigrants will be permitted to work and what conditions to place upon their employment. Ireland, along

with Britain, opened its labour market to the first wave of Eastern European member states of the EU. Ireland was at that time experiencing very rapid growth and had labour market shortages and fully-fledged housing boom, so the new influx of often young people with good skills was readily absorbed. More controversial was the system of work permits for non-EU nationals, overseen by the Department, issued to the employer and not to the employee. This became controversial in the light of scandals to do with exploitative labour conditions, especially among domestic workers, and agricultural employees. But the source of organizational change was a series scandal of a different kind. In 2005, Irish Ferries became embroiled in a dispute over sacking their Irish crew members in favour of cheaper Latvian labour. In 2006, agency workers employed by a Turkish company were found to be working on Irish construction projects in poor working conditions and at low pay rates. Labour protection became a deal-breaker in tripartite pay talks when the trade union movement insisted on a large expansion of the Labour Inspectorate of the Department of Enterprise, Trade and Employment, and tougher powers of investigation and sanction. This did not involve any major organizational innovation of an NPM sort though.

The formalization of immigration policy was driven first by issues to do with refugee status. The first agency created to deal with immigration issues was the Refugee Agency, a non-Statutory non-departmental body founded in 1991. In 2001, this was merged with a unit of the Department of Justice, Equality and Law Reform called the Directorate for Asylum Support Services, to form the Reception and Integration Agency. The Directorate of Asylum Support Services had been created in 1999, taking responsibility for the accommodation of asylum seekers from the Eastern Health Board. The newly founded Reception and Integration Agency dealt with a broad range of asylum seeker and refugee concerns.

During the 1990s, as economic growth took off, applications from refugee and asylum-seekers began to increase rapidly. Public debate became to air the view that in at least some cases, legal provisions were being stretched by people who were in reality economic migrants. Two bodies were set up as a result of the Refugee Act 1996. In 1996, the Office of the Refugee Applications Commissioner, a statutory office holder, was created. In 2000, a Refugee Appeals Tribunal, a statutory tribunal with responsibility for adjudicating appeals against the decisions of the Refugee Applications Commissioner, was established. The intention was to distance decision-making from political processes. But ultimately the

Minister for Justice could exercise discretion, and in some high-profile cases of imminent deportation, where local communities had gathered round a long-standing resident, popular pressure induced the Minister to overturn these decisions. Political distancing and blame-avoidance are periodically trumped by the strong localist bias in Irish political life.

In the late 1990s and early 2000s, there was a new focus on integration issues in light of rapidly increasing immigration rates. This led to the creation of several new agencies. In 1998, an expert body on racism and interculturalism, the National Consultative Committee on Racism and Interculturalism, was created. This company limited by guarantee had a board representing various non-government organizations, and it served mainly in an advisory capacity. In 2001, following a two-year pilot project offering English courses to refugees under the auspices of Trinity College Dublin, the Refugee Language Support Unit (RLSU) became Integrate Ireland Language and Training Ltd, a company limited by guarantee. Both organizations were disbanded in 2008 as part of a budgetary rationalization scheme to address the government's growing financial concerns. Thus the early attempts to generate a coherent policy on the integration of 'new citizens' were summarily abandoned under budgetary pressures, and not primarily on account of considerations of policy effectiveness or efficiency.

Applications for refugee status proved slow to process and many candidates complained of the inadequate linguistic and legal supports available to them. Failed applicants proved difficult to deport, because of a 1998 constitutional provision – part of the Northern Ireland peace settlement – that stated that anyone born on the island of Ireland would be deemed an Irish citizen. This 'birthright' citizenship provision had the unintended consequence of facilitating appeals against deportation by asylum-seekers whose children had been born in Ireland. The PD Minister for Justice Michael MacDowell spearheaded a constitutional referendum in 2004 to close down this provision; it was approved by a significant majority. The numbers of applications for refugee or asylum-seeker status fell off appreciably in the subsequent years, particularly from Nigeria, which had been the single largest source of applications previously.

In 2005, the Irish Naturalization and Immigration Service was created as an executive agency within the Department of Justice and Law Reform. It was envisaged as a 'one stop shop' for

immigration matters, introducing a post-NPM ‘joined-up government’ approach to immigration issues. It performs administrative functions on behalf of the Department of Justice and Law reform, as well as providing information on aspects of immigration handled by other departments. By 2009 it had almost 700 staff. The Garda National Immigration Bureau, a unit of the Garda Síochána, also plays a significant role in immigration, providing border control services as well as a front-line processing unit for issuing permission to remain. It also has responsibility for deportations and is active in human trafficking investigations.

The profile of Irish immigration agencies is summarized in Figure 8 below.

Figure 8. Immigration agencies in Ireland

Norway

In 2001 a major reform of the central immigration administration took place in Norway. All responsibility for this policy field was gathered under the Ministry of Local Government and Regional Affairs, moving the regulatory role away from the Ministry of Justice and Police. The Norwegian Directorate of Immigration (NDI), established in 1988, was given more formal autonomy, and a new body was established with a lot of formal autonomy – the Immigration Appeals Board (IAB). A broad coalition supported the reform; only the Progressive Party and the Conservative Party opposed it, claiming that it implied less political steering of a controversial political field. The main motives behind the reform were to ease the capacity problems and burdens of the central political and administrative executive by hiving-off immigration cases, and it also involved a blame-avoidance component (Christensen, Lægreid and Norman 2007). After the reorganization, the political executives could no longer interfere in ordinary individual cases. Steering was to be done from a distance, via general policy directives, thus furthering professional autonomy.

Rather ironically, when the new Conservative-Centre government came to power in 2001 and was supposed to implement the reform, the minister in charge was the leader of the Conservative Party who had previously opposed the reform. It soon became clear that the minister was not satisfied with a situation where she carried responsibility for many immigration cases but had her hands relatively tied in handling them (cf. Brunsson 1989).

She therefore launched another, smaller-scale reorganization process. The aim of the process was to exert more control over the immigration administration. The minister actually supported institutional autonomy and structural devolution in most other policy areas, but not concerning immigration, illustrating the salience of the issue.

The new measures – giving more general policy instructions from the ministry, having more formal routines for informing the ministry and having a new large board inside IAB for handling ‘positive’ decisions – went into effect in 2005. But they were accompanied by other, partly contradictory changes. The immigration division in the ministry was split into two, a regulatory and an integration part, and this change was also reflected in the NDI, which also split into two parts, one agency for regulation and one for integration and inclusion. The immigration units were moved to a new Ministry of Labour and Social Inclusion. Under the Red-Green government that came to power in 2005 and was re-elected in 2009, control measures have been tightened still further: directives and reporting/informing have become more formalized, but without any major reorganization. One reason was a crisis that arose in connection with the NDI’s handling of quite a number of cases from Iraq without informing the ministry (Christensen et al. 2007). Most recently, following a ministerial reshuffle, responsibility for regulation and control of immigration has been moved back to the Ministry of Justice and Police, while the integration/inclusion role has been moved to the Ministry of Children, Equality and Social Inclusion. Also, a public commission has been initiated with a view to identify ways of strengthening ministerial control of the immigration appeals organization, the IAB.

The 2001 reform was very much in NPM mode, while the later reorganizations were more post-NPM in character, even if further division and fragmentation means this claim is not entirely consistent. In 2001 it was argued that the modern way of handling individual immigration cases was to hive them off from the ministry and engage in a kind of strategic steering. The argument that politicians should stay away from handling single cases had a distinctive NPM flavor. The ministers behind the subsequent reorganizations in 2004–2005 and 2006–2007 were both motivated by post-NPM factors and control aspects. But in addition, given that they would eventually get the blame anyway, it was deemed better to try to regain political control over the cases. So Brunsson’s (1989) observation that leaders lose influence and information but keep formal responsibility when devolution is happening, can

help provide an explanation for the attempts by the minister to reintegrate and try to take more control, rather than increasing autonomy as had been done in 2001.

But overall, immigration in Norway shows a marked NPM-oriented reform in the direction of the structural devolution of power, which is difficult to reverse. The reform as such was very complex and had some ambiguous elements. Later efforts at reorganization and attempts at reasserting control do not seem to have reversed the main features of the first reform, so the message here is definitely a balance in favour of autonomy. Constant reorganization flows from efforts to balance political-administrative control and institutional/professional autonomy. But this makes the structure increasingly complex. The main effect is that the political executive is struggling to control the implementation of laws and rules pertaining to immigration policy, even though it has increased its frame-steering.

Explaining organizational change

The two issue areas of health care reform and hospital management, and immigration, are managed in rather different institutional contexts in Norway and Ireland, as noted in Section One above. Some similarities in the way they have been managed are apparent: during the 1990s, reform objectives were dealt with in both countries and across both issue areas through distinctly NPM-like means, with the creation of new agencies, and the devolution of autonomy and budgetary responsibilities down the line. Subsequently, we see a broad trend toward reassertion of central control, and attempts to secure greater budgetary discipline from the centre, consistent with the notion that post-NPM priorities of policy coordination come to the fore.

But these easy similarities belie deeper contrasts at work, and different political imperatives that structure the organizational evolution of policy in the two countries; contrasts that are also apparent across policy sectors as well. Figure 9 profiles the varying salience of health care reform and immigration policy to governments of different partisan composition over time. (These characterizations are, for now, heuristic, but opinion poll and manifesto data can shed more light on shifts in government priority-setting). This reveals some distinct contrasts in the perceived political importance of issues for governments.

Figure 9. Political salience of issues to governments in Norway and Ireland, 1980-2010

But issue salience does not necessarily offer much guidance as to how exactly a government is going to respond. The most marked ideological contrasts in Ireland are between the centre-left 'Rainbow Coalition' of 1994-1997, and the Fianna Fáil-dominated coalitions that have held power since 1997. While Norway has had a majority coalition government since 2005, prior to this it experienced a series of changes in government composition, normally featuring minority governments. Although shifts across the ideological spectrum in Norway are more apparent than most government changes in Ireland, the need to govern with parliamentary consent is stronger in Norway than in Ireland.

However, while Irish agency creation has at times features explicit elements of NPM thinking, much of the policy innovation in each of the two areas under consideration has been driven by a largely ad hoc approach to institutional innovation (OECD 2008). Health care and hospitals policy were developing from a low base of organization and a slow extension in the responsibilities of the state. Immigration was a relatively new policy issue in a country that had long experienced net outward migration and for which the experience of full employment was quite unusual. Thus the apparent emergence of post-NPM thinking might perhaps better be understood as attempts to create some policy coherence in an under-institutionalized policy environment.

Similarly, the Norwegian experience does not conform neatly to the broad arc of NPM to post-NPM development in either policy area. Norway's longer and stronger traditions of local governance and local management of service delivery made it institutionally more receptive to the devolution of responsibilities for the integration element of immigration policy, but control of immigration policy remained at central government level. And the recentralization of hospitals management, and of some aspects of immigration policy, did not overturn the structural shifts that had already been implemented.

Figure 10 summarizes the main elements of explanation in our two policy areas and in the two countries.

Figure 10. Comparing change cross-nationally

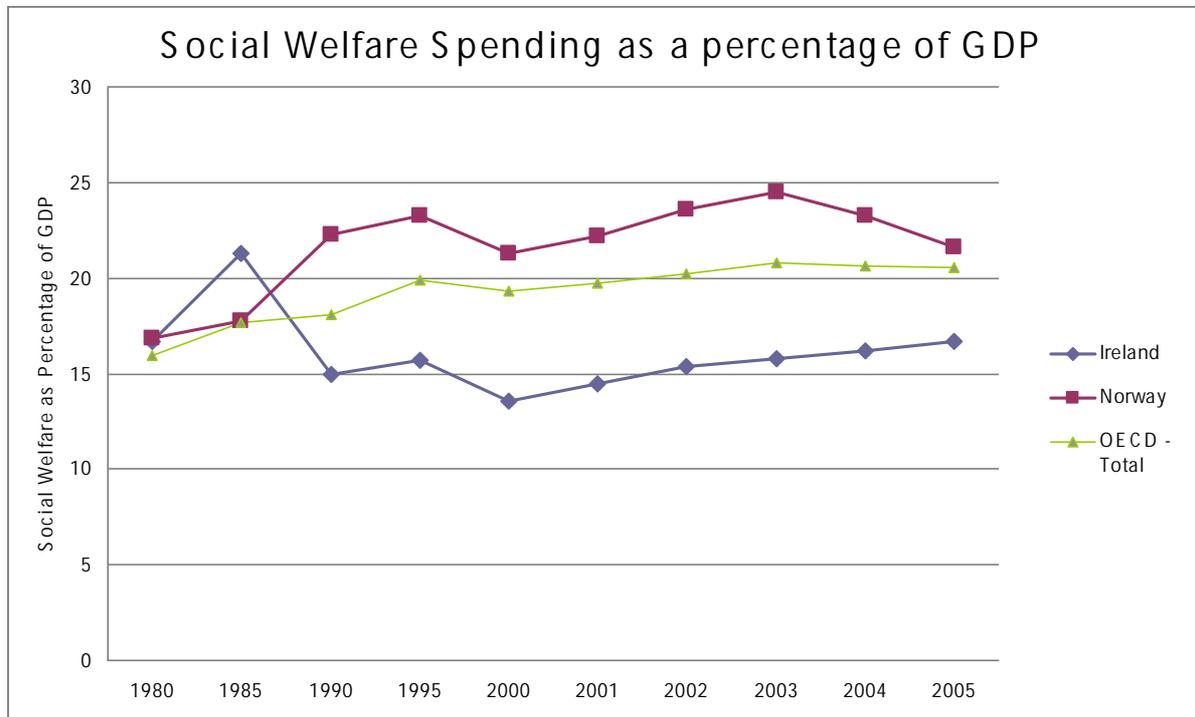
Conclusion

This pairwise comparison of countries and policy areas, drawing on institutional databases in both countries, enables us to trace in greater detail than hitherto the organizational responses of modern states to new policy challenges. We have four broad variables of interest:

- the influence of New Public Management business-model ideas about efficiency, delegation, and budgetary targets;
- the role of post-New Public Management ideas about policy coordination, political control, democratic accountability, and financial centralization;
- the role of government partisanship in shaping the degree of interest they take in specific issues;
- and the perceived value of creating political distance or blame-shifting mechanisms in place to insulate politicians from controversial decisions.

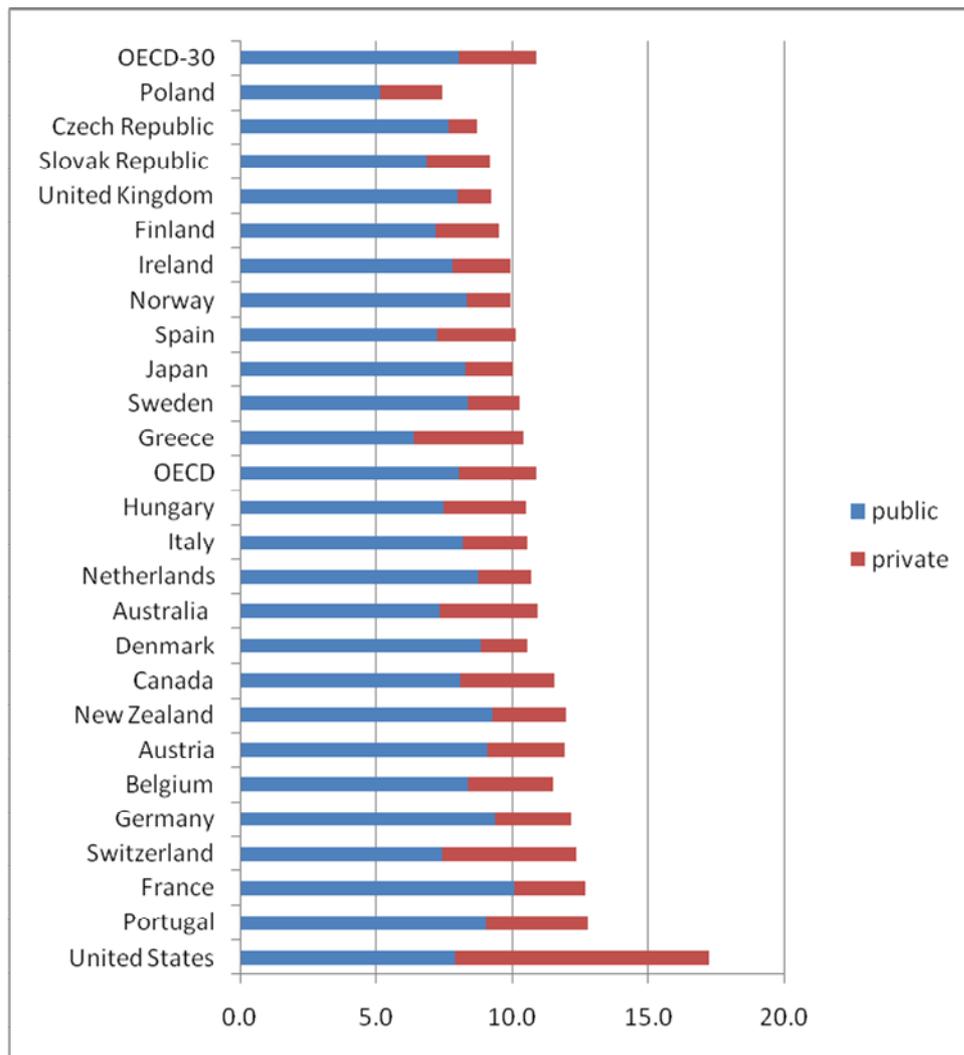
What we have found is that each of these themes plays out against a backdrop of institutional structures, policy inheritance, and unpredictable controversy, which complicates the profile of the political response. In the Irish case, two such influences stand out. The first is the lower level of institutionalization of policy making and implementation from which things start out, compared with Norway. The second is the much more fluid capacity of governments, notwithstanding their stronger executive powers, to create new agencies, compared with Norway, and their relatively freedom in doing so. While overt ideological debate is not much in evidence in Ireland over the size, obligations, and resourcing of public services, it is also clear that public dissatisfaction with public services was mounting over time. In Norway, in contrast, it may be argued that there is more institutional stability in the overall configuration of public policy, its reach, and the scope of entitlement notwithstanding the changes documented here. New agencies are more tightly rule-bound. The experimentation with business models in hospital reform did not fundamentally alter the structure of provision, though there is more evidence of the use of performance indicators and control measures. And immigration policy remained subject to a more consistent programme of eligibility, reception, assessment, and integration, than in Ireland.

Figure 1. Social welfare spending as a percentage of GDP, Norway and Ireland



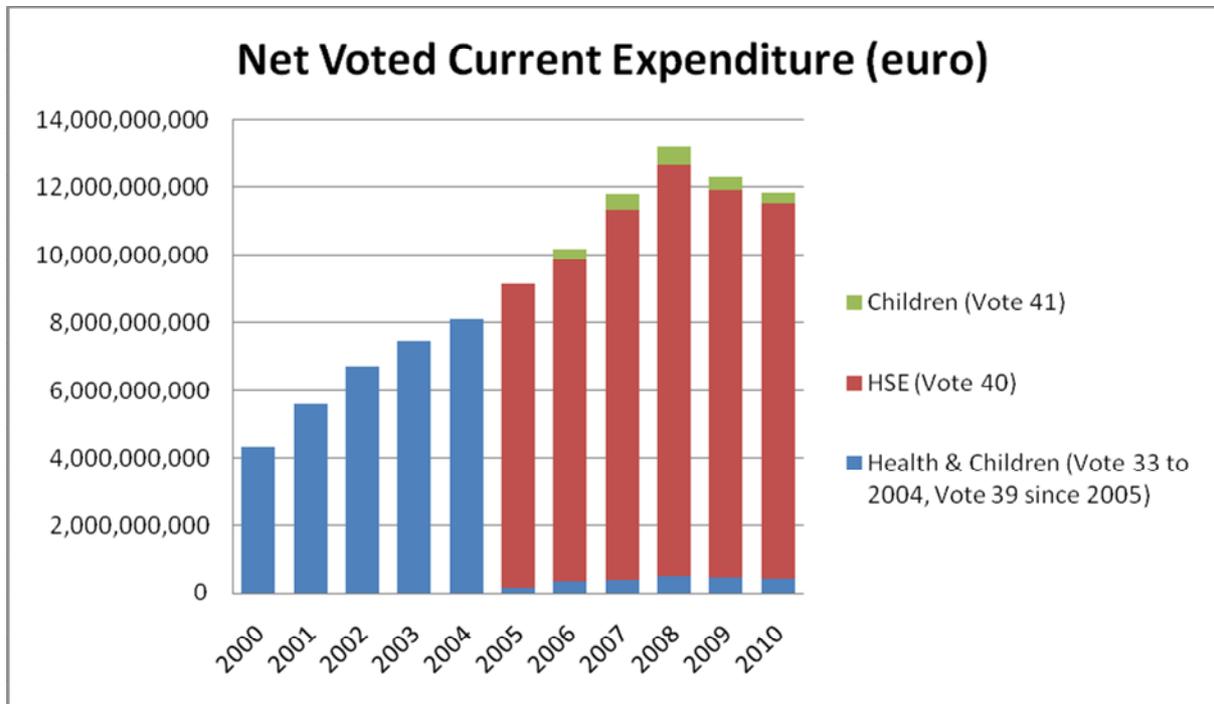
Source: OECDStat. Accessed 21 April 2010

Figure 2. Total expenditure on health as a percentage of Net National Income (2006)



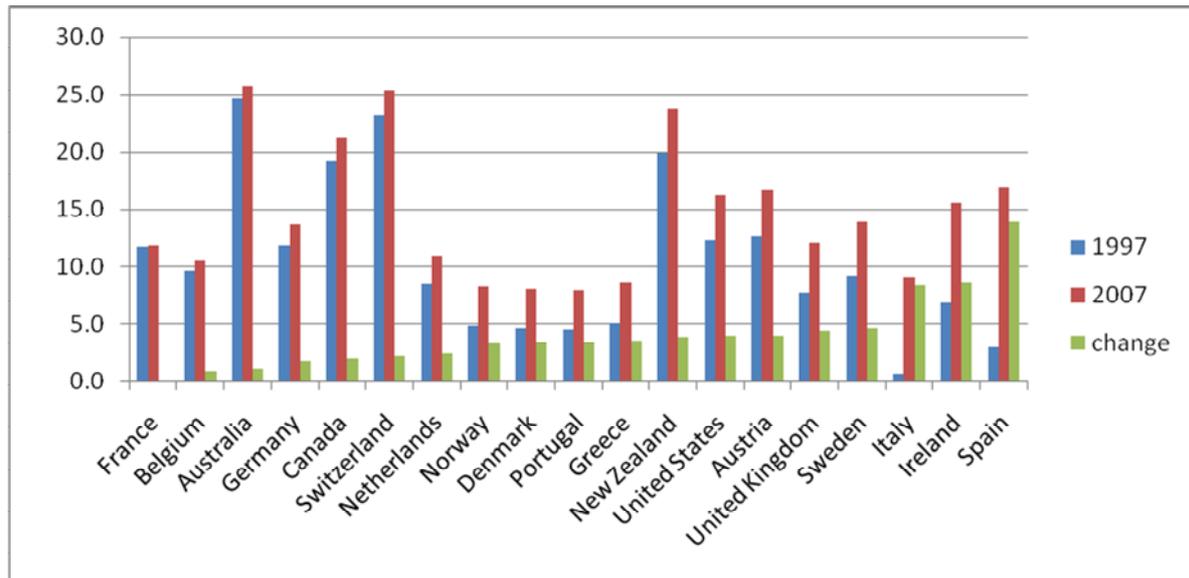
Source: SourceOECD *Society At a Glance 2009: Health Indicators* (accessed 1 June 2010)

Figure 3. Current spending on health in Ireland 2000-2010



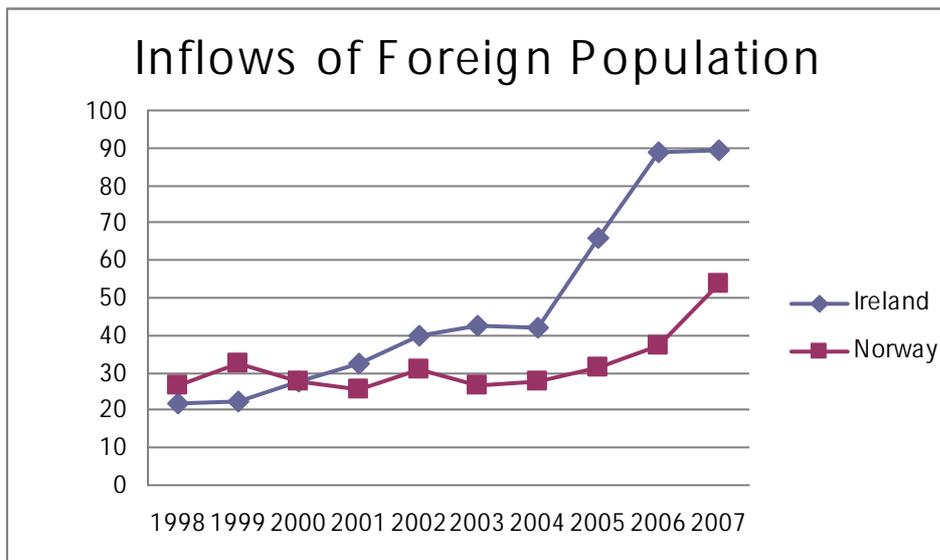
Source: Irish National Accounts data and Dáil Debates,

Figure 4. Foreign-born labour force as a percentage of the total labour force



Source: OECD Labour Force Statistics. Accessed 1 June 2010

Figure 5. Inflows of foreign-born population, 1998-2007



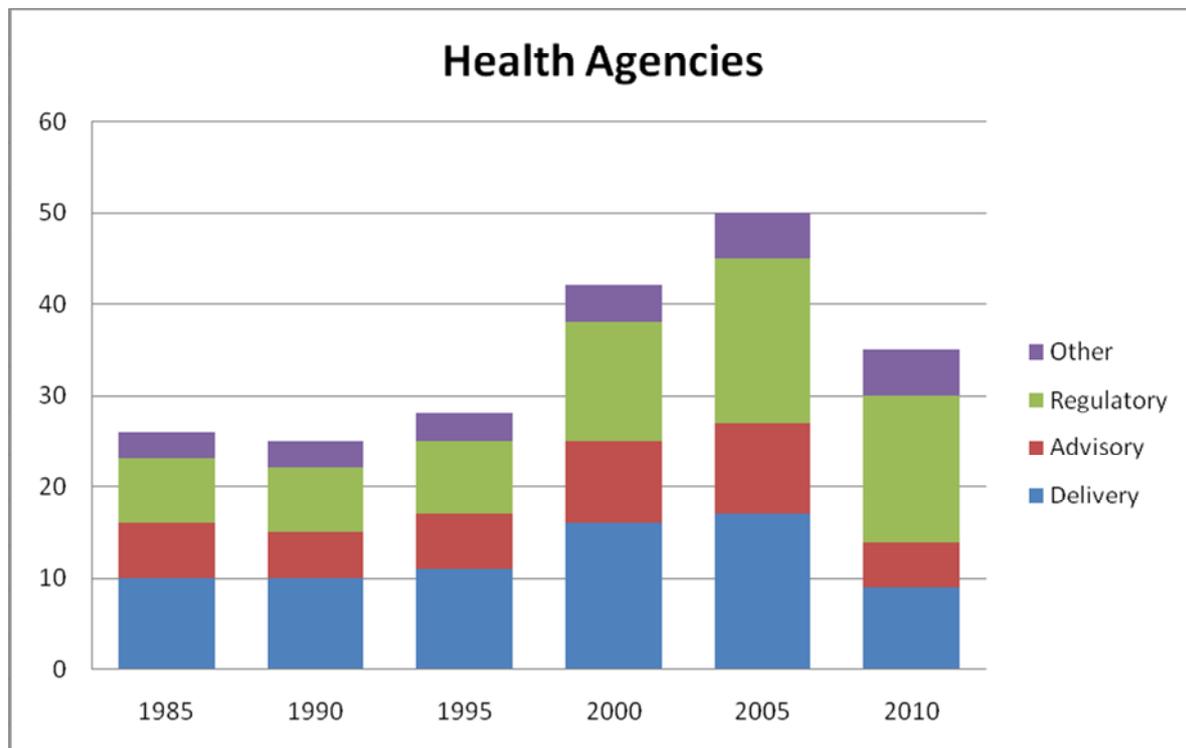
Source: OECD.Stat. Accessed 21 April 2010

Figure 6. Asylum seekers by country of origin, 2008

COUNTRY OF ORIGIN	DESTINATION COUNTRY	
	IRELAND	NORWAY
Afghanistan	79	1363
Bangladesh	45	8
China	180	81
Colombia	-	9
Congo	172	107
Eritrea	78	1799
Georgia	180	19
Iran	65	720
Iraq	203	3137
Nigeria	1008	436
Pakistan	237	38
Russian Federation	30	1078
Serbia	41	675
Somalia	141	1293
Somalia	11	342
Syria	17	115
Turkey	5	82
Zimbabwe	114	17

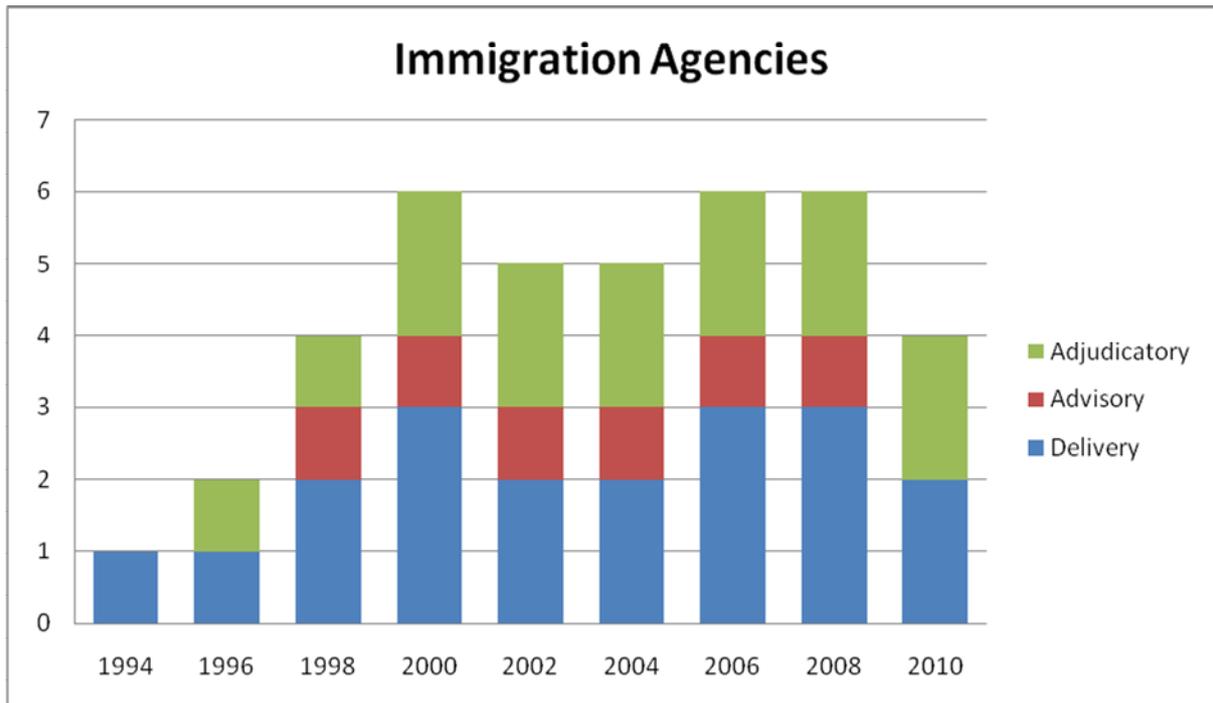
Source: (United Nations High Commission for Refugees 2009, Table 7)

Figure 7. Health agencies in Ireland, 1985-2010



Source: Mapping the Irish State database

Figure 8. Immigration agencies in Ireland



Source: Mapping the Irish State database

Figure 9. Issue salience of issues to governments in Norway and Ireland, 1980-2000

NORWAY				IRELAND			
	<i>Government</i>	<i>Health</i>	<i>Immigration</i>		<i>Government</i>	<i>Health</i>	<i>Immigration</i>
1981	Conservative	Low	Low	1981	Fine Gael-Labour	Medium	Low
1985	Conservative, Centre, CD	Low	Low	1982	Fianna Fáil	Medium	Low
1986	Labour	High	Low	1983	Fine Gael-Labour	Medium	Low
1989	Conservative, Centre, CD	Low	Low	1987	Fianna Fáil	High	Low
1990	Labour	High	Low	1989	Fianna Fáil, PD	High	Low
1993	Labour	High	Low	1992	Fianna Fáil, Labour	High	Medium
1997	Centre, CD, Liberal	Low	Low	1994	Fine Gael, Labour, DL	High	Medium
2000	Labour	High	High	1997	Fianna Fáil, PD	High	Medium
2001	Conservative, CD, Liberal (& Progress)	Low	Medium	2002	Fianna Fáil, PD	High	High
2005	Labour, Socialist, Centre (Red-Green)	High	High	2007	Fianna Fáil, Green, PD	High	High
2009	Labour, Socialist, Centre (Red-Green)	High	High				

Figure 10. Comparing change cross-nationally

NORWAY	Background and motives	NPM features	Post-NPM features	Main focus of (re)balancing	Perceived and potential effects
Immigration	Fewer executive capacity problems through structural evolution Blame-avoidance	IAB and NDI typical strong structural devolution	More central directives More formalization of procedures and Information	Relatively more autonomy	Political executives struggle to control policy practice, but still get the blame
Hospitals	Strengthen control in general and increase spending control	Decentralization to commercial health enterprises DRG system	Centralization and increased ministerial control Politicians back at the boards	Relatively more central control	More central control and getting the blame for negative effects; local autonomy

IRELAND	Background and motives	NPM features	Post-NPM features	Main focus of (re)balancing	Perceived and potential effects
Immigration	New policy challenge post-1990, slow institutional adaptation Transfer to new legal framework	Devolution of immigration related issues to variety of agencies	Closure of some advisory/information immigration agencies, reassertion of central control	Transfer of final decision-making competence, reduce spend	Single cases dealt with via hierarchical methods generate considerable controversy Political desire to reduce immigration
Hospitals	Re-distribution of core hospital functions, focus on centres of excellence More efficient regional use of national hospital network	Greater emphasis on management skills and resources Devolution of authority to super-agency (HSE) (but also post-NPM features of health and social care agency mergers)	Greater co—ordination of local health and social care services Creation of regulatory controls over health sector	Regulation of financing, VFM	De-politicization of health services In practice, health very politicized, calls for local political input re-emerge

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