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6 Integrated Care Reforms
Comparing Policies and Strategies in China and Norway

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Abstract: Integrated care reforms have been introduced across the globe in the face of demographic and epidemiological transitions, increasing threats of fragmented healthcare delivery, and mounting healthcare expenditure. Although these reforms have facilitated and shaped a shift in global healthcare policy and practice, the pace and pattern of reform adoption have differed across various countries. Among them, both China and Norway have been considered "reluctant reformers." This chapter interrogates the policy rhetoric in this transition and examines areas of divergence in reform strategies between both country. Using the structural-instrumental and cultural-institutional perspectives, this study traces the reform process in both nations and analyzes how China and Norway have initiated and implemented their respective integrated care reforms, concluding that Norway's path has been smoother that China's due to existing formal structures and cultural acceptance, while China has faced complex governance challenges and the risk of symbolic implementation.

Integrated Care Reform: Exploring Convergences and Divergences

In 2009, the Chinese central government increased investment in primary healthcare as it introduced the concept of integration in its new healthcare reform documents. This effort led to the formal launch of the "Hierarchical Diagnosis and Treatment Reform" in 2015. Similarly, in Norway, the "Coordination Reform" was passed by Parliament in 2009 and implemented in 2012, aiming to improve coordination between primary and specialist care sectors. One of the lessons learned from COVID-19 is that multi-actor and multi-level entities, i.e., hospitals, community health centers, CDCs, home care agencies, and nursing homes, among others, must work together to ensure public health, although this need existed already before the pandemic. Today, in the context of demographic and epidemiological transitions, increasingly fragmented healthcare delivery, and mounting

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healthcare expenditures, "integrated care" (IC) has become a global buzzword in policy-making. IC aims at transforming global health delivery to make it more collaborative. In support of this transformation, "reformists" focus on reinventing the health system holistically to facilitate the provision of

> health services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system. (WHO 2015)

IC has already driven and shaped major policies and practical changes across both high-functioning health systems and those of middle-income countries (Kodner 2009; World Bank 2019), demonstrating its universal applicability. However, individual countries have acted according to their specific contexts and interests, resulting in varying levels and speeds of engagement in IC reforms. Some countries, such as the UK, with its primary care trusts and integrated care teams, the US, with its patient-centered medical homes and accountable care organizations, and Sweden, with its personal coordinated care plans, have all acted quickly to implement revolutionary changes in their health systems; others have been more cautious, initiating reforms later and progressing more slowly and incrementally.

IC reform entails a shift in the public sector beyond the new public management (NPM) approach. NPM emerged in the 1980s to enhance institutional autonomy, private sector practices, and a leaner state. It sought better performance measurement, accountability, and market-oriented reforms to boost efficiency and reduce costs. Later, in the 1990s, the concepts of governance, networks, partnerships, and trust were embraced. Thus, post-NPM measures were implemented, characterized by an increased focus on integration, networks, and horizontal coordination (Christensen and Lægreid 2007; Christensen and Lægreid 2015). In this context, integrated care reform arose to address both medical and public management issues. Different countries vary in their motivations to initiate reforms, in their project design and implementation, and in their reform outcomes.

A cross-national comparative approach allows for the unveiling of significant similarities across different countries but also variations in their approach to IC. So far, studies have only focused on comparing OECD countries among themselves, for example Germany, the Netherlands, and England (Johri et al. 2003; Mur-Veeman et al. 2008; Nolte et al. 2016; Baxter et al. 2018). While a few researchers have sought to understand IC reform in low- and middle-income (LMIC) countries, conclusions have been too scattered and fragmented to provide an overall vision of global health policy processes (Gilson and Raphaely 2008). The scope of these studies has often been limited to local case studies, such as the experience of tiered healthcare delivery system in the Luohu district of Shenzhen city (China) and that of laboratory innovations in chronic conditions in the municipality of Santo Antônio do Monte (Brazil) (Wang

et al. 2018; Mendes et al. 2019). In this chapter, we advocate for the necessity of additional case studies in LMICs and show that comparing reform strategies in LMICs to those in high-income countries is particularly valuable to more generally understand IC reform rhetoric, decision-making, implementation, and results in different socio-economic contexts.

This research compares IC reforms in China and Norway. China, as the world's most populous developing country with over 1.4 billion people, faces enormous healthcare demands and issues of resource distribution imbalance. In contrast, Norway, a wealthy Nordic European country with a population of only about 5.4 million, benefits from a highly developed healthcare system and extensive public health experience. The vast difference in population size means that China's challenges are more complex and that implementation of healthcare reforms is more diverse, while Norway, with its smaller population and less hierarchical public sector system, can implement reforms more swiftly. Moreover, Norway has benefitted from higher levels of medical resources per capita than China. For example, in 2015, the number of physicians per 1000 people was 1.8 in China versus 4.4 in Norway, and in 2016, the proportion of total government spending on health was 58 percent in China compared to 85 percent in Norway.

Regarding health insurance, both China and Norway rely primarily on social insurance, providing most residents extensive coverage to ensure access to basic medical services. Before 2016, China's health insurance schemes differed in rural and urban areas, based on the New Rural Cooperative Medical System (NRCMS) for rural residents, the Urban Employee Basic Medical Insurance (UEBMI), and the Urban Resident Basic Medical Insurance (URBMI) for urban employees and residents. In January 2016, the government unified the NRCMS and URBMI into the Urban and Rural Resident Medical Insurance system, moving towards universal health coverage (UHC) (Hao and Yu 2023; Liu et al. 2017; Yip et al. 2023). However, significant disparities in reimbursement rates remain. In Norway, all residents are covered under the National Insurance Scheme (NIS) managed by the Norwegian Health Economics Administration (HELFO). The health insurance system guarantees near-complete coverage for inpatients and high coverage for outpatient care. Most private health financing comes from households' out-of-pocket payments, mainly for pharmaceuticals, dental care, and long-term care (Saunes et al. 2020).

Despite significant differences in economic development, population size, and medical resources between the two countries, comparing China's and Norway's IC reforms is highly relevant and meaningful. Indeed, both countries face similar challenges in terms of an aging population, high incidence of non-communicable diseases (NCDs), and growing economic pressures. In China, the percentage of people aged 60 years or over was 16.7 percent in 2016. In Norway, around the same time, 11 percent of the population was over seventy, a sign of "deep aging." NCDs represent the first health threat, causing more than 85 percent of total deaths in both countries, with increasing numbers of people suffering from chronic, complex illnesses. Moreover, both China and Norway have sought to maximize the value of health output. In

China, the hospital-centric system is characterized by weak provider integration and gate keeping, medical over-servicing, diagnostic tests, and high-technology services caused by improper provider payment incentives, which are all largely responsible for unnecessary health expenditures. In recent years, GDP growth in China has slowed down, but cost escalation is not likely to follow suit (World Bank 2019). In contrast, in Norway, health expenditure stood at 9.7 percent of GDP in 2014, but Bjarne Håkon Hansen, who served as Minister of Health and Care, expressed concerns that too much money was not well spent and indicated that the sustainability of the Norwegian welfare system and the Norwegian National Insurance Scheme for future generations were in jeopardy. Increasingly diverse health needs, complex medical scenarios, and varied health risks have challenged healthcare cultures, organizations, and previously implemented policies. Both countries have pursued IC reforms to address these issues. China unveiled an ambitious national healthcare reform plan in 2009 that culminated with the prioritization of a "Multi-tier Diagnosis and Treatment Reform" in 2015 when a national scale policy experiment was started. In Norway, a national scale "Coordination Reform" was passed by the Parliament in 2009 and implemented in 2012.

This chapter reviews the relevant literature on public management reform to establish a theoretical basis for comparing IC reforms in China and Norway. It then analyzes the history and process of these reforms through secondary sources such as government policy documents, research reports, and media content. In particular, two central government documents—China's *Policy Guidance on Promoting Multi-tier Diagnosis and Treatment System* (Guo Ban Fa, No. 70) and Norway's *The Coordination Reform: Proper treatment at the right place and right time* (Report No. 47, 2008–2009)—detail how top-level IC institutional design must abide by certain principles, goals, paths, and evaluations. This examination highlights useful points of convergence and divergence, analyzed through the structural-instrumental and cultural-institutional perspectives. Finally, this chapter includes a comparison of rhetoric, decision-making, practice, and results, confirming that while China and Norway share similar objectives and approaches in their pursuit of integrated care reforms, they diverge significantly in the implementation phase. China's main challenges are in achieving uniform reforms across the nation, with reforms incurring the risk of becoming merely symbolic in some regions, whereas Norway's reforms have been smoother, relying on efficient formal structures and greater cultural acceptance. The comparison underscores the importance of balancing formal structures and cultural factors, emphasizing that effective integrated care reform requires addressing governance issues, building mutual trust among reform agents, and ensuring active participation from all stakeholders.

Public Management Reform Theory: Understanding Cross-countries Convergences and Divergences

Over the past four decades, there have been two waves of public management reforms: new public management (NPM) and post-NPM. Scholars have debated

extensively on the degree of convergence and divergence of these reforms worldwide. Some have supported the convergence thesis, which proposes that such processes are underway in different countries (Osborne and Gaebler 1992). Kettl (2005) has described the NPM movement as "striking" because of the number of nations that have taken up the reform agenda in such a short time and because of how similar their basic strategies have been. Halligan (2007) has advanced that post-NPM trends have emerged and that commonalities represent an "emergent" or "new model." In contrast, other scholars have argued for the divergence thesis, highlighting hybridity and complexity, and suggested that the process is messier and more varied than a simple shift to either NPM or post-NPM. One compelling factor is that public management reform goes through different stages: talk, decision, practice, and results. "Talk" means that an increasing number of people discuss a particular reform idea; "decision" implies that the authorities publicly decide to adopt a particular reform; "practice" refers to the public sector's incorporation of the reform into daily operational practices; and "results" are the outcomes of the actions of public agencies yielded by the reform (Pollitt and Geert 2011). It is easier to analyze announcements and decisions than to examine operational practices and final outcomes, which can exaggerate the real degree of "convergence" in public management reform internationally (Pollitt and Geert 2011).

To describe the degree of convergence and divergence, two points should be considered. First, rhetoric and action must be separated because there are many gaps, divisions, and outright failures that stand between the announcement of a reform policy and the successful implementation of that policy (Pollitt 2001). Indeed, reforms can be merely symbolic. Unlike the substantive outcomes of policy-making and policy implementation, reform policies and programs are often presented with hype, rituals, myths, ceremonies, metaphors, and rhetoric based on symbolic norms and values (March and Olsen 1989; Power 1997). The use of symbols has the potential to arouse support for reforms, but not all symbols are translated into programs, projects, or activities leading to practice and effects (Brunsson and Olsen 2018; Christensen and Lægreid 2003). Therefore, the degree of symbol-practice coupling can vary significantly, leading to divergences. Second, policy experimentation must be considered since it has been a global strategy in reform-making and implementation, but the initiator and the results of experiments can be different. Experiments may entail spontaneous activities from lower-level and smaller-scale organizations or sophisticated plans from top-level government agencies. Reforms can be initiated by single institutions (hospitals), medium-sized entities (municipalities or counties), or large units (national alliances and countries). Complex reforms occur on multiple scales and involve numerous experiments. Different countries might similarly introduce policy experimentation in the reform process, but divergences may emerge when comparing the specific actors and results of these experiments.

Once cross-national convergences and divergences are highlighted, we draw from the transformative approach in organization theory to analyze the complex and dynamic reform process. Accordingly, we use the structural-instrumental and cultural-institutional perspectives to explore how reform actors are influenced by their respective

contexts. The structural-instrumental perspective emphasizes that the formal-normative structure of public administration influences reform processes by channeling attention and shaping frames of reference and attitudes among the political and administrative leadership (Christensen et al. 2016; Egeberg 2012). Reform occurs as a result of deliberate design, collective action, and rational adjustment that alter the rules on either a vertical or horizontal level. In a vertical multi-layer hierarchy, leaders' control and analytical–rational calculations are central. In a horizontal organization, compromises are negotiated between organizations and actors with partially conflicting goals and interests (Christensen and Lægreid 2007). The cultural-institutional perspective highlights the influences of informal values and norms that are rooted in the historical and institutional traditions of political-administrative systems. This perspective underscores that reforms follow gradual and evolutionary institutionalization processes that reflect mutual adaptation to internal and external pressures leading to the development of unique cultural features or identities (Christensen et al. 2007; Selznick 2011). From this perspective, divergences across countries can be tremendously affected by cultural compatibility. High compatibility and consistency across the values that underlay the reforming and cultural traditions of a particular system lead to higher acceptance by politicians, administrators, entrepreneurs, citizens, and other stakeholders, while low compatibility leads to rejection, resistance, or slow and pragmatic adaptation of reforms (Brunsson and Olsen 2018W; Christensen et al. 2008). While cultural traits are difficult to summarize, researchers have identified distinct administrative traditions—Anglo-American, Napoleonic, Germanic, and Scandinavian—that are built into institutional structures, procedures, and ways of thinking (Painter and Peters 2010).

Based on this public management reform theory and transformative approach, comparative hypotheses can be elaborated. Hypothesis 1 proposes that China and Norway are convergent in their IC symbolic rhetoric and experimentation strategies. Both China's centralized authoritarian system and Norway's democratic system require policies that effectively address healthcare challenges. The easiest solution is to "borrow" global technical remedies, especially when international institutions like the World Health Organization (WHO) keep "selling" integrated care reform ideas and packages. To attract domestic support for reforms and enhance reform legitimacy, political and administrative leaders have tended to label IC reform as modern and rational and present reforms as a path to increased equality and efficiency. Another solution arises from policy experimentation. Due to the lack of unified standards, tools, paths, and mechanisms for IC, and the need for multi-departmental and multi-level coordination, local pilot schemes become an effective experimentation strategy. In both countries, local pilot schemes can be initiated before central policy changes and nationwide implementation, either through the centralized control and monitoring of reform progress in China or local autonomy and multi-party cooperation in Norway.

Although convergence is highly possible, reforms must suit the context of the countries in which they are implemented along a wide variety of historical traditions and political-administrative structures. Therefore, hypothesis 2 proposes that China and Norway could be divergent on IC implementation processes and outcomes.

According to the structural-instrumental perspective, reform processes in public organizations are influenced by formal structures. China's authoritarian one-party system provides tighter control than Norway's parliamentary multi-party representative democratic system. In China, reforms are primarily implemented through top-down vertical hierarchies emphasizing leadership control and centralization. Hence, China could be advantaged in the acceleration of the transformative process. However, weak coordination in China's complex, multi-sectoral and multilevel system often hinders implementation. Additionally, local variations can significantly impact the effectiveness of centrally promoted measures, and the gap between promises and performances and between rhetoric and action could be wide as to make reform appear merely symbolic (Christensen and Lægreid 2003). In contrast, Norway's local governments have a high degree of autonomy that allows them to adjust policy implementation according to specific local conditions and realities.

Furthermore, the cultural-institutional perspective provides an understanding of cultural features, such as trust relations and informal norms, that can contribute to successful reform paths and results. Distrust over specialization and managerialism can bring internal resistance to IC within an agency and eventually lead to contradictions between the official discourse about the reform and action. It may also lead to the failure of local experiments and missed opportunities for their diffusion to other places. China's tradition of collectivism and authority makes it easy for reforms to gain support from politicians and administrators but challenges implementation at the institutional level. Norway's tradition of social democracy and cooperation allows reforms to gain acceptance among various stakeholders, including healthcare institutions, but the complexity of negotiation and compromise processes could lead to slower implementation.

Discourse, Decision, Practice, and Results of Integrated Care Reform in China and Norway

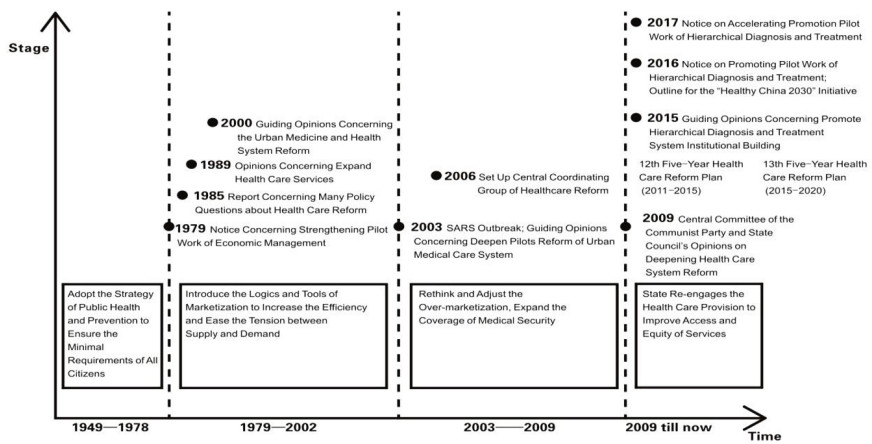
To understand how much institutional change has occurred and what pattern it has followed, it is necessary to first look back at China's and Norway's respective healthcare reform histories in the last half-century. Figure 1 shows that both China and Norway have oscillated between a focus on equality and efficiency and state and market action in the course of healthcare reform. From the 1950s to the 1970s, China implemented a state-run and centralized health system, which provided rather fair but inefficient and low-quality health services. In the 1980s and 1990s, when the government decentralized certain responsibilities to lower-level administrations, individuals, and hospitals, the supply of medical services increased but health budgets allocated by local governments became insufficient, as hospitals became profit-seeking, which increased patients' out-of-pocket expenses. The SARS crisis in 2003 and resulting social discontent put pressure on the government to return as the central healthcare provider, leading to the launching of ambitious institutional reforms. One notable reform that continues to shape reforms

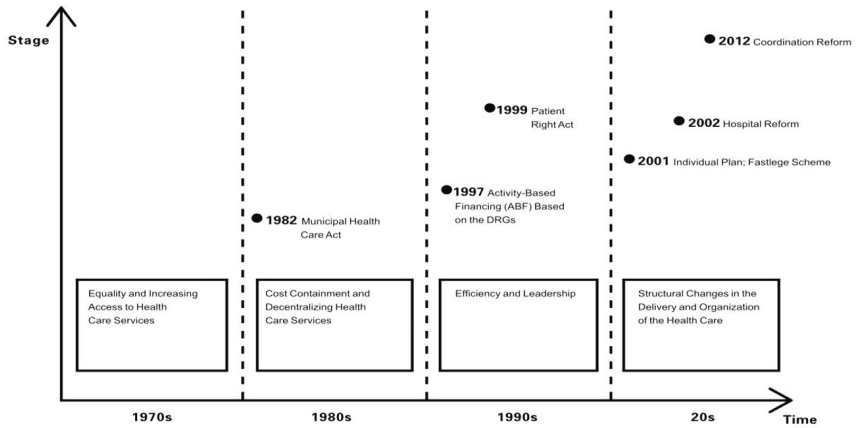
today was the 2009 "New Health Care Reform," which addressed health insurance, essential medicines, primary healthcare, and hospitals.

In Norway, a universal health insurance system was established in the late 1940s to ensure that all citizens receive basic healthcare services. Norway's socio-economic context is characterized as a welfare model with heavy government investment, high levels of access for all, and equitable and balanced healthcare services provision. In 1982, Norway introduced the Municipal Health Care Act, which decentralized healthcare responsibilities to municipal governments. Furthermore, early in the 2000s structural changes were made in the delivery and organization of healthcare services (Johnsen et al. 2006). The 2002 Hospital Reform transferred hospital management from county governments to the central government through five new Regional Health Enterprises (RHEs), which were granted management independence and tasked with overseeing hospital ownership and operations. Additionally, a strict performance evaluation system was introduced to improve hospital operations and service efficiency. This reform has been interpreted as a hybrid reform, as it prescribes both centralization—by transferring ownership from the regional level to the Ministry of Health—and decentralization—by changing hospitals' status from public administration bodies to autonomous health enterprises (Laegreid et al. 2005).

Reform patterns in China and Norway have been part of a general trend in reform that seeks to move control from state to market mechanisms, in an attempt to correct NPM-inspired reforms and quasi-market ideas and practices to move toward more fairness and people-centeredness. However, compared to China's pendulum swings between state and market, Norway's changes have been less drastic.

Figure 1: Timeline of healthcare reform in China and Norway





Source: The authors, based on Duckett (2012); Lian (2003); Laegreid et al. (2005); and Johnsen et al. (2006).

In our comparison of IC in China and Norway we focus on discourse, decision, practice, and results. In both countries, the healthcare system has experienced imbalances and fragmentation between different levels of care, so that resources and responsibility have shifted away from hospital-based care and toward community-based care. In China, a clear hierarchy exists across medical service tiers providers. Chinese healthcare organizations are either hospitals or grassroots healthcare institutions. Hospitals, in turn, comprise three levels, while grassroots healthcare institutions constitute community-based and township health centers and clinics. Tertiary hospitals, which benefit from the best doctors and equipment are the most attractive to patients, while community health centers are easily marginalized and neglected. In 2009, China launched a national healthcare reform that aimed to provide affordable and equitable healthcare to all citizens. The "Opinions on Deepening the Healthcare System Reform" was the first document produced by the central government to articulate the concept of integrated healthcare services. Since then, considerable resources have been diverted into grassroots healthcare institutions to improve their status and capacity. In Norway, the system follows a two-level model of primary and specialized healthcare with different sources of funding and administrative, political, and professional cultures (Romøren et al. 2011), which makes vertical inter-organizational coordination challenging. Health budgets and policy initiatives have been directed mainly toward specialized hospital care, creating competition and imbalance between primary and more specialized levels of care (Krasnik and Paulsen 2009). Thus, in 2003, the Wisløff Committee was appointed by the government to identify coordination problems in the Norwegian health sector and propose practical solutions to strengthen coordination across the whole service system (Romøren et al. 2011).

In both China's and Norway's reforms, the transition "talk" stage lasted for years. It entailed assessing the fragmentation of healthcare systems and formulating a vision for more integrated and coordinated health services, until the "decision" stage, during which the reform framework was designed and national policies were announced. In 2015, the General Office of the State Council in China issued a central policy specifically focused on integrated care: the "Hierarchical Diagnosis and Treatment Reform." This hierarchical care system emphasizes community health centers and encourages patients with chronic conditions to first seek care from a primary-level institution. A dual referral system ensures that critical conditions are immediately addressed through high-level hospitals before patients are referred back to the community level for rehabilitation. This system promotes intra-level collaboration among medical institutions (General Office of the State Council).

In Norway, the Ministry of Health and Care Services initiated the "Coordination Reform," which was passed by the Norwegian Parliament in June 2009 (it was formally launched in 2012). This reform highlights that more patients should be cared for in primary health institutions and that discharges from intensive care hospitals should take place earlier in the care process. Recommendations are made based on the premise that municipalities are rewarded for investing in prevention and reducing patients' need for specialist services. Hospitals and municipalities are encouraged to collaborate, as patients are quickly returned from specialist care to the municipal level for follow-up care (Norwegian Ministry of Health and Care Services).

Local policy experimentation plays an important role in the implementation stage of reforms in China and Norway, as it can validate the effectiveness and adaptability of central reforms (Table 1). In China, local governments, particularly their health-related departments, initiate implementation, focusing on governance mechanisms that promote integration. In Norway, the Norwegian Directorate of Health and professional and health organizations lead the process, accenting the development of methodologies, practical tools, and service models. Before the Coordination Reform was passed in Norway, numerous local projects had been spontaneously launched by hospital leaders, primary healthcare authorities, and professionals such as practice consultants and coordinators (PCs) in health enterprises (Romøren et al. 2011). In China, policy experimentation at the regional level has also played a significant role and has been emphasized by the central government, which has continued to expand the scope of policy experiments, for example by piloting various medical alliance projects in 118 cities, two provinces, and 567 counties.

Table 1: Integrated Care Reform Pilots in China and Norway

Country	Date	Local Pilot Program	Motivation	Initiator	Key Measures	Outcomes
China	February 2015	Tianchang Medical Consortium (Yu et al. 2020)	Patients sought treatment outside their county of residence, spending more medical insurance funds.	Tianchang Health Department, Anhui Health Commission	Three hospitals formed medical service communities with multiple township health centers and village clinics, integrating county, township, and village level medical institutions. Implementation of government prepaid medical insurance funds and public health service funds per capita in communities, allowing internal distribution of surplus funds.	By the end of October 2016, the county-level treatment rate reached 92.24%. Recognized and promoted by the National Health Commission. Created a model for county-level hierarchical diagnosis and treatment.
China	August 2015	Luohu Medical Group (Wang et al. 2018)	District hospitals were small and similar, with repeated resource investment and stagnant development.	Sun Xizhuo, Chief Hospital Director of Luohu Medical Group	Established Luohu Medical Group with five district hospitals, 23 community health stations, and an institute of precision medicine. Formed six resource-sharing centers and six administrative centers by reorganizing 29 institutions. Recruited general practitioners nationwide with high salaries and formed family doctor service teams to provide chronic disease management and integrated medical care.	By July 2017, 39% of the population had signed contracts with primary healthcare teams. In September 2017, the National Health Commission and the State Council held a national conference in Luohu, promoting the "Luohu model" to other regions.
China	2012	Sanming Medical Reform	Rapid increase in healthcare expenses; medical insurance fund deficits; fiscal imbalance; high medical costs for patients; low doctors' income.	Zhan Jifu, Deputy Mayor of Sanming	At the county level, hospitals and primary health institutions joined to form county general hospitals. At the city level, the hospital was integrated with primary health institutions to form two city medical consortia.	Praised by President Xi Jinping. Included as a key task in the annual medical and health system reform plan for 2021, 2022, and 2024 by the State Council. In 2021, the National Health Commission issued a document promoting Sanming's hierarchical diagnosis and treatment and medical consortium construction experience, with 31 provinces formulating corresponding implementation plans.
Norway	April 2018–March 2023	Primary Healthcare Team (PHT) Pilot (Abelsen and Fosse 2024)	Patients' GP services in need of improvement.	Norwegian Directorate of Health	Expanded general practices with the hiring of nurses. PHTs were created that included GPs, nurses, and medical assistants and provided home visits and high-quality services, systematically and proactively addressing complex patient needs in four main categories: chronic diseases, mental health, frailty in the elderly, and developmental disorders/disabilities.	Well-functioning PHTs can provide good-quality primary care and increase job satisfaction for team members. Realization that large-scale implementation may waste resources and create disparities.
Norway	2012	Cancer Coordinator (CC) Project (Lie 2018)	Growing need for patient-centered and coordinated care in primary healthcare.	Norwegian Cancer Society	Cancer coordinators guided, coordinated, and aligned resources throughout the cancer treatment process, focusing on both patient-level and system-level work. The project promoted improvements in cancer care systems by mobilizing necessary assets and adopting a salutogenic approach.	Effectively promoted cancer care system improvements.

Source: The authors

From a comparison of local-level experiments in the two countries emerge similarities and differences; the same is true in the practical organizational models and strategies supporting those experiments. In China, the core organizational models of the hierarchical diagnosis and treatment reform are twofold. One model relies on the idea of the urban medical group, usually led by tertiary public hospitals. Within this group, collaboration takes place on issues of personnel, technology, diagnostics, prescriptions, and services among community health service institutions, nursing homes, rehabilitation institutions, and other entities. The other model is the county-level medical consortium, which integrates county hospitals, township health centers, and village clinics under a unified management. Although the degree of integration varies across both models, they follow a hierarchical structure where stronger institutions support weaker ones (Wu et al. 2022). Norway's coordination reform, while also focusing on vertical integration, involves redistributing administrative duties and cooperation across municipalities and regional health authorities.

Moreover, to remodel a system in which patients receive the right treatment at the right place and right time, both China and Norway have transitioned their existing payment models to better incorporate economic incentives. China has focused on incentivizing healthcare institutions, while Norway has targeted municipal governments. In China, medical insurance payments transitioned from a fee-for-service (FFS) system to a pre-payment system to guide healthcare institutions. The FFS system had led to excessive treatments and a 44.28 percent annual growth rate in medical insurance expenditures from 1998 to 2008. Therefore, in June 2017 the central government proposed a diversified composite payment method that included diagnosis-related group (DRG) payments for hospitals to ensure necessary treatments and capitation payments for primary healthcare institutions to boost community health services (Zheng and Wei 2024; Li et al. 2023). In Norway, the healthcare system has used an activity-based funding (ABF) system, combining capitation-based block grants and DRGs. These mechanisms link funding to treatment types and quantities. While they have promoted hospital efficiency they have historically not provided incentives for coordination outside hospitals. To improve this situation, new measures include municipal co-financing (MCF) and municipal acute units (MAUs). MCF requires municipalities to cover 20 percent of certain DRG costs, such as hospital rehabilitation, to encourage local primary care services. MAUs manage acute conditions locally, which results in reducing unnecessary hospital admissions and promoting integrated care (Monkerud and Tjerbo 2016; La Rocca and Hoholm 2017). Another point of divergence between China and Norway is that in China the reform included administrative-led measures, with the government dominating the establishment of medical groups. In Norway, legal and regulatory means—such as binding agreements between municipalities and regional health authorities—were used to detail how specialist healthcare services must decentralize outpatient clinics, expertise and knowledge transfer, the provision of internships, and the use of general practitioners, in a two-level model that strengthens coordination.

In reforms, the "results" phase is the most important. However, since both the hierarchical Diagnosis and Treatment Reform (China) and Coordination Reform

(Norway) were launched only a few years ago, it is too early to conclude whether China and Norway have succeeded or failed at reducing healthcare fragmentation. Currently, preliminary evaluation results are mixed. On the one hand, some studies show that reforms have increased primary care utilization, improved equity, and enhanced health outcomes for people with hypertension or diabetes. On the other hand, studies indicate some challenges in implementation. For example, while the ratio of senior citizens with chronic illnesses in China who signed contracts with family doctors increased from 28.33 percent in 2015 to 75.46 percent in 2017, most people still go to the hospital for specialized care instead of seeing their family doctor as an initial step. Moreover, coordination among the different actors remains insufficient, and integrated care still has a long way to go. In Norway, the reform has achieved some of its intended goals, such as fewer deaths and hospital readmissions among the elderly, although in some municipalities collaboration in transferring patients to hospitals has weakened (Bruvik et al. 2017) and general practitioners have had negative experiences working with their hospital-based colleagues (Leonardsen et al. 2018). Additionally, it is found that information and communication technologies (ICT) infrastructure and elite medical specialties in major hospitals and health centers may resist cooperation (Dan 2017).

Comparing the rhetoric, decision-making process, practice, and results of integrated care reforms in China and Norway confirms the hypothesis that these two countries converge in their objectives and prospects, as well as in the adoption of experimental approaches to reform. However, they diverge significantly in practice, with China facing more challenges in implementation across the national scale and a higher risks that the reform become merely symbolic practice at the local level.

Instrumental-structural and Cultural-institutional Perspectives for IC Reforms in China and Norway

In both China and Norway, central leaders have had a noticeable influence on reforms. From an instrumental-structural perspective, strong hierarchical steering or negotiating among top political and administrative leaders can accelerate reform agendas (March and Olsen 1983). Chinese President Xi proposed "Health China 2030" in 2016, a new national strategy and the most important political impetus for IC reform. At the same time, a joint report by the World Bank, the World Health Organization, and three Chinese ministries (the Ministry of Finance, National Health and Family Planning Commission, and Ministry of Human Resources and Social Security) recommended that China establish a new model—the "People-Centered Integrated Care" (PCIC)—to strengthen the core position of primary health services. Vice Premier Liu Yandong considered that the recommendations would be valuable in the formulation of the "13th Five-Year" health reform plan (Xinhua News Agency 2016), underscoring the crucial influence international organizations have had on China's reform agenda. In Norway, the Minister of Health and Care in 2008, Bjarne Håkon Hansen, set coordination in health and long-term care as his main foci and political priorities, and he engaged in working

out the new plans for the Coordination Reform very soon after taking office (Romøren et al. 2011).

In China, although central leaders have played an important role in initiating the reform process, implementation has occurred via complex governmental structures. Indeed, the Chinese healthcare reform has relied on numerous cabinets and their counterparts at the sub-central level. Some of these institutions are more influential than others. For example, the National Health and Family Planning Commission, National Development and Reform Commission, Ministry of Finance, Ministry of Human Resources and Social Security office all weigh heavily on policy. The "super-department system reform" of 2018 established two additional departments to lead policy-making- the Health Commission and Health Insurance Bureau- as IC reform in China addresses concerns about supervision, financial support, human resources, investment and pricing, and medical insurance. A political and administrative structure that has diverse, overlapping, and potentially competing organizational dimensions (Olsen 2010) can create challenges in the reform process. To realize overall coordination in political and administrative structure, the Chinese government established a coordinating group that gathers multiple departments related to healthcare reform at both the central and local level. Unfortunately, because it is only temporary, the connection between the various members of this group is quite loose. Moreover, one government department leader might be serving in several coordinating groups in various reform areas. The effects of this mechanism have not been convincing. An alternative would be to develop a strong political impetus at the local level; however, policies are mostly formulated by the health department, and successes have varied across regions. For example, the regions of Guangdong, Fujian, and Zhejiang have had positive reform outcome, with the support of their respective provincial party secretaries who prioritized healthcare reform and negotiated agreements among departments and interest groups. Findings show that collaboration is necessary among departments and multi-level administrators for IC reform, or changes are only symbolic.

Turning to Norway, the political and administrative structure there appears less complex, since Norway's healthcare system is organized around primary healthcare providers as part of the responsibility of municipalities and specialist health services (hospitals), which are owned by the Ministry of Health. Yet, horizontal coordination among the different sectors can be difficult to attain at the central level. For example, the Ministry of Education and Research, responsible for planning and partially subsidizing the education of health personnel, may conflict with the National Insurance Administration, which provides significant financing for the activities of the health system. So, in general, Norway is characterized by relatively low coordination levels across the internal administrative hierarchy within each ministerial area (Lægreid et al. 2016). Because the Minister of Health has the authority to overrule all structural decisions that have been made at a lower level, the central government likely gives more weight to cost and quality of specialized care than to that of primary care (Iversen et al. 2016). But in the first wave of the New Public Management reform, Norway adopted many formal instruments, such as a performance management system and formal steering dialogue pathway. These measures have introduced more network arrangements in the shadow of the hierarchy

and have built a good foundation for agencies and ministries to merge during the second wave of post-NPM reform. The use of cross-boundary collegial bodies, such as working groups and project groups that transcend policy areas and administrative levels, is also rather common in Norway (Lægreid et al. 2016).

The last factor that can be analyzed is whether IC reform was already part of the institutional landscape in each country at stake. During the 1990s, China broke its system of strict gatekeeping, referral, patient discharge, and handover and let healthcare organizations make profits as if they were corporations. In order for institutions to value cooperation again, China needed to revise the design of many detailed standards, norms, regulations, and laws. In contrast, rather than entirely rebuilding its system, Norway only needed to improve it. Indeed, that system was already stable and comprehensive because it already imposed limits on patients' visits to specialists and had developed clinical pathways.

Moreover, informal integration—based on culture—is important, as it serves as "institutional glue" and reaches beyond formal structural boundaries (Christensen and Lægreid 2020). This "horizontal width" (Krasner 1988) means that when actors care about what occurs in other units within their respective organizations, collective action will be enhanced. Three main actors have been involved in IC reform in China and Norway. First, the "regulators" are government entities that invest in and purchase healthcare services and manage and supervise healthcare providers. Second, the "providers" are multi-level and multi-type healthcare organizations that provide healthcare products and services. Finally, the "service objects" are the citizens/patients who need a variety of healthcare products and services, including health enhancement, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care. From the perspective of the regulators, China has established a modern administrative system, but it inherited the characteristics of "factionalism" from its long history of bureaucracy, which has caused long-term damage in trust among administrations at different levels of government or in different categories. In contrast, Norway is characterized by high level of mutual trust and understanding across the local, regional, and central levels in the health policy sector, which means that homogeneity in norms and values presents less of a potential conflict or tension (Christensen et al. 2006). Moreover, in Norway, the relationship between regulators and health professionals is highly professional, although political endeavors can sometimes result in compromise solutions that are not in harmony with professional values concerning what yields high-quality healthcare (Ahgren 2014).

In China, the ability to engage in reform has been challenged by the legacy of the "command and control" approach, as well as by the subordinate role hospitals play in policy-making. The current internal driving force for reform comes from local governments rather than medical institutions themselves. Only hospitals seem to participate in IC reform, but the top-down administrative intervention and mandatory integration prevents most of them from implementing new policies. For example, while all public medical institutions are administered by the government, the bargaining power of medical institutions differs. For instance, the president of a large hospital has much more influence than the head of a community health center. This power differential

may explain why some of the policies that favor lower-level medical institutions meet difficulty in implementation. By contrast, in Norway's corporative political system, it is quite common that various interest groups shape policy. For example, before the government proposed its Coordination Reform, there had already been extensive rounds of consultations with stakeholders and parliamentary debates on the issue (Pedersen 2012). In particular, medical professionals in Norway have been able to influence health policy through their institutional integration into the state machinery (Erichsen 1995).

When examining the providers' perspective, it appears that a competitive culture is at the root of the Chinese health system. Although the Chinese government tried to transfer high-quality resources from large hospitals to the grassroots level, some hospitals siphoned off patients and medical personnel from the local community to grow even larger. In China, there is also a lack of consensus between specialists and GPs about how to evaluate diseases and when to refer patients. However, unbalanced power and poor communication also exist in Norway's two-tier model. There, primary healthcare professionals face a fragmented hospital system, which makes it difficult for them to know with whom to communicate or collaborate (Wadmann et al. 2009). While China's cultural harmony is mainly caused by competitive interest among healthcare institutions, Norway's is due to professional disjunction. Thus, in Norway, the way professionals protect their respective domains, whether they are involved in specialist or primary care, could limit their reciprocal understanding of actors' needs, resulting in insufficient coordination (Colmorten et al. 2004).

There are also cultural differences in citizens' preferences and level of involvement in the healthcare reform process in the two countries. In the past few decades, the Chinese have shown to prefer seeking care at large hospitals. Because the classification of healthcare organizations has been based on an administrative hierarchy rather than on medical disciplines, and because higher quality resources have been concentrated in tertiary hospitals at the top level of healthcare organizations, patients have made rational choices in a context in which the demand and supply of information in the health market is extremely asymmetrical. Therefore, it is anticipated that the Chinese government will struggle to incite citizens to trust and choose community healthcare institutions. The unequal relationship between hospitals and primary healthcare institutions also extends into the hierarchical diagnosis and treatment reform, potentially transforming vertical integration into a dependency relationship. In Norway, people have perceived positively the division of responsibility and labor based on specialization among general practitioners in clinics and specialists in hospitals. Additionally, there is no quality gap across services in Norway. Moreover, while both China and Norway characterize the philosophy behind IC reform as people-oriented, China, in its present stage of reform, regards citizens as subjects to be guided. For example, the reimbursement rates for hospital services differ and favor grassroots institutions. But little has been done to create opportunities for citizens' participation in IC reform. In contrast, the Coordination Reform in Norway has invited more involvement from Norwegian patients and citizens' organizations, which are encouraged to implement structures and systems for more cohesive patient pathways.

Balancing Structural Factors and Cultural Dynamics in Reforms

When comparing healthcare systems in China and Norway, a new paradigm of integrated care can be defined. Points of convergence emerge out of internal pressures to reach specific objectives in these respective national health systems. Both countries have used a similar policy rhetoric of integrated care to correct issues left over from previous NPM reform, such as increased heterogeneity among different healthcare organizations, weakened traditional values supporting public service (such as equal and convenient access to health), and fragmentation and departmental egoism in the healthcare management system. However, it can be concluded that Norway's path, although incremental, has been smoother than China's, and that China's reform route is more complex. There may be strong mobilization and administrative drive in China because of formal structures, but there is also ambiguity and discretion that lead to higher risks of regional disparity and mere symbolic implementation.

Formal structures are not merely the backdrop for reform implementation; they are, in fact, one of the critical factors determining the success or failure of reforms. The instrumental-structural perspective highlights that China's healthcare management system is consistent with the government's administrative management, which exhibits a hierarchical, organized, and multi-departmental cross-management style, as well as segmentation characteristics. China's reforms are not only about improving the relationship between healthcare institutions but are fundamentally about improving collaboration among departments and delegating power from the government to healthcare institutions, which comes with challenges. One the one hand, China's "command and control" approach significantly aids pilot projects. On the other hand, the top-down pressure also leads to symbolic implementation, where reforms appear to be in place but are not effectively executed at the grassroots level. Norway too faces challenges from unbalanced hierarchical structures and departmentalism across its leading agencies. But reform in Norway has benefitted from the pre-existence of efficient formal instruments and institutions that have allowed the government to launch and implement IC reform more efficiently than in China,

Divergence in the implementation of IC reforms in China and Norway can also be attributed to cultural and institutional factors. Culturally, China might meet invisible but lasting resistance to IC reform from a triangle of regulator-governments, provider-healthcare institutions, and service objects-citizens. There are four facets to the cultural incompatibilities that exist between IC reform and old informal institutions in China: the cultural legacy of a factionalist inner political-administrative system; command and control relationships between administrators and professionals; competition among healthcare organizations; and habitual preferences and participation level of citizens and patients. In Norway, IC reform is more culturally accepted, as it is compatible with historical traditions and reform path-dependency patterns that are based on a high level of mutual trust in and understanding of the healthcare system. Hence, reform agents' and stakeholders' reciprocal trust has more to do with chosen strategies and the pace of reform implementation in both China and Norway than the formal structures of

political-administrative systems that manage healthcare service provision. Comparing IC reforms in China and Norway highlights the importance of considering both formal structures and cultural factors in the reform process. Future reform efforts should address power relationships, governance structures, and management rules while also considering cultural compatibility tests to build mutual trust among reform agents. This approach may ensure that reforms are not only well designed but also effectively implemented and embraced by all actors.

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