


Exploring the triggering process of a cancer care reform in three Scandinavian countries

Per Magnus Mæhle^{1,2}  | Senada Hajdarevic^{3,4} | Erna Håland⁵ | Rikke Aarhus⁶ | Sigbjørn Smeland^{2,7} | Bjørn Erik Mørk^{8,9}

¹Department of Health and Society, Faculty of Medicine, University of Oslo, Norway

²Division of Cancer Medicine, Comprehensive Cancer Centre, Oslo University Hospital, Norway

³Department of Nursing and Department of Public Health and Clinical Medicine, Family Medicine, University of Umeå, Sweden

⁴Department of Public Health and Clinical Medicine, Family Medicine, University of Umeå, Sweden

⁵Department of Education and Lifelong Learning, NTNU, Trondheim, Norway

⁶Diagnostic Centre, University Research Clinic for Innovative Patient Pathways, Silkeborg Regional Hospital, Denmark

⁷Department of Clinical Medicine, Faculty of Medicine, University of Oslo, Oslo, Norway

⁸Department of Strategy and Entrepreneurship, Norwegian Business School, Oslo, Norway

⁹Warwick Business School, University of Warwick, Coventry, UK

Correspondence

Per Magnus Mæhle, Department of Health and Society, Faculty of Medicine, University of Oslo, Norway.

Email: pemm@ous-hf.no

Funding information

Norges Forskningsråd, Grant/Award Number: 272945

Abstract

Cancer incidence is increasing, and cancer is a leading cause of death in the Scandinavian countries, and at the same time more efficient but very expensive new treatment options are available. Based on the increasing demand, high expectations and limited resources, crises in public legitimacy of cancer care evolved in the three Scandinavian countries. Similar cancer care reforms were introduced in the period 2007–2015 to address the crisis. In this article we explore processes triggering these reforms in countries with similar and well-developed health care systems. The common objective was the need to reduce time from referral to start treatment, and the tool introduced to accomplish this was integrated care pathways for cancer diagnosis, that is Cancer Patient Pathways. This study investigates the process by drawing on interviews with key actors and public documents. We identified three main logics in play; the economic-administrative, the medical and the patient-related logic and explored how institutional entrepreneurs skillfully aligned these logics. The article contributes by describing the triggering processes on politically initiated similar reforms in the three countries studied and also contributes to a better understanding on the orchestrating of politically

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2021 The Authors. The International Journal of Health Planning and Management published by John Wiley & Sons Ltd.

initiated health care reforms with the intention to change medical practice in hospitals.

KEYWORDS

cancer care, health care reform, institutional logics, integrated care pathways, qualitative study, Scandinavia

1 | INTRODUCTION

Cancer is among the leading causes of death in the Scandinavian countries that witness an increasing number of patients diagnosed with cancer. Modern cancer diagnostics are more and more complex and treatment is multimodal, that is a combination of surgery, radiotherapy and/or medical therapy. This requires coordination within and between hospitals because in a progressive and potentially deadly disease unnecessary delays are a psychological burden and may worsen the prognosis for the patients. The field of cancer comprises vibrant issues that include a strong and highly professionalised medical community, complex patient trajectories between hospitals and across organisational structures within hospitals, increased expenses and expectations due to new technologies and drugs and a strong patient's voice. The increase in number of patients, treatment opportunities and insufficient coordination all lead to unacceptable waiting times that led to elevated political attention and a need for action to solve the crisis. In Denmark these processes developed through the first decade of this century and in Norway and Sweden emergence can be set to the beginning of the second decade with political decisions mad respectively in 2007, 2014 and 2015.

Politically imposed changes in health care involve highly complex processes for changing behaviour at the clinician level in hospitals.^{1,2} This makes this domain particularly interesting to study. Some of the measures launched to address these challenges are expressions of international trends. One example is 'integrated care pathways'.^{3,4} The concept of integrated care pathways (ICP) developed in the US during the 1980s and 1990s and subsequently evolved in several European countries and in a variety of diagnoses and patient groups.⁵⁻⁹ ICPs vary in their content, which can include introducing specific roles responsible for patient coordination, developing local standardised processes, establishing recommended monitoring indicators, and designing arenas of cross-disciplinarity in diagnostic work and treatment plans. Moreover, they can be motivated by different factors, ranging from economic considerations to medical and care quality and patient satisfaction. Often an ICP is launched as a panacea solution to several problems and today there is not one dominant way of implementing an ICP.

In addition to their diverse content, ICP processes can be distinguished as either top-down or bottom-up in their development and implementation. Several scholars have investigated this dichotomy.¹⁰⁻¹² Top-down processes are often connected to the implementation of general guidelines from evidence-based medicine, growth in expenditures, the need for increased risk control, or to reduce variation or transaction costs. The bottom-up approach is more often motivated by increased interdependence in decision making, patient logistics, and medical development with the aim of improving medical outcome or as a part of a local quality improvement process. Some scholars interpret ICPs, explicitly¹⁰ or implicitly,³ as a phenomenon that bridges bottom-up and top-down motives, while others argue that these are basically two different types of processes, which should be distinguished from each other.

Through the period from 2007 to 2015, the governments in the three Scandinavian countries Denmark, Norway and Sweden all introduced similar reforms called cancer patient pathways (CPP), triggered by intolerable waiting times for cancer patients. These pathways reflect the implementation of ICPs in cancer care. In each country CPPs were expressed through documented main patient trajectories for all major cancer diagnoses. CPPs set national standards for the time from referral to the start of treatment for each cancer type, in addition to

establishing mandatory structures and positions for care coordination and multidisciplinary team meetings. Examples of normative time frames from received referral to start first treatment are shown in Table 1 below and the phases of breast cancer CPP are shown in Figure 1.

When examined together, the similar reforms in these three Scandinavian countries with analogous health care systems provide a unique opportunity to elaborate on the mechanisms behind the emergence of politically initiated reforms in this kind of health care system. Previous research has described the cancer care reforms in Denmark and Sweden, respectively.¹³⁻¹⁵ This paper will contribute by addressing the following research question: How did the need for these reforms emerge as necessary and what created the opportunity for political action?

2 | ANALYTICAL FRAMEWORK

To answer the research question and explore the process behind the triggering of these reforms we looked to concepts and insights from organisation studies. Research linked to institutionalism is relevant for explaining the processes behind the Scandinavian CPP reforms. We will present an analytical framework to shed light on how the driving forces in these cases evolved, how changes were emulated in other national contexts, how the specific situation precipitating action was generated, and created room for crucial roles filled by the various actors.

First, research on institutional logic is relevant for understanding the basic underlying forces and motivational structures driving the reforms. Institutional logics are cultural beliefs and roles that determine how practices and structures are assessed.^{16,17} Allen¹⁰ and Shaw et al.¹⁸ consider institutional logics as a useful analytical tool to understand the processes connected to ICP and coordinated care. Allen¹⁰ identified two separate logics in play in ICP processes: the logic of quality improvement and the logic of evidence-based medicine the first working bottom-up and the second top-down. Martin et al.¹⁹ discuss ICP as an expression of combined influence from both professional logic and a managerial logic. Several publications on ICP implementation discuss the diverse perspectives on the phenomenon of institutional logics based on either managerial or professional logics.^{3,20-23} ICP is presented as a kind of panacea that dissolves the potential tension between the logics or interests involved. Other contributions underline that whether interests or logics merge or not depends on the context and process of implementation.^{9,10,24,25}

Second, the dynamics of the change process may be explained as the interplay between competing institutional logics. Competing logics have been cited as a source of institutional change in institutional theory.²⁶ Several studies of change processes in health care have applied the concept of several competing institutional logics.²⁷⁻³⁰ They have described distinct logics including the professional logic, the logic of care, the political logic and the scientific logic. However, the coexistence of multiple institutional logics does not necessarily imply conflict. According to Besharov,³¹ whether the coexistence of several logics causes conflict or change or leads to stability depends upon

TABLE 1 Cancer patient pathway target times (days)

	Denmark ^a	Norway ^b	Sweden ^c
Breast cancer, surgery	27	27	28
Prostate cancer, surgery	50	66	68
Lung cancer, medical treatment	41	35	40
Head and neck cancer, surgery	28	28	30

^a2017_aarsrapport-forloebstider.pdf (cancer.dk).

^b<https://www.helsedirektoratet.no/produkter?tema=pakkeforlop>.

^c<https://cancercentrum.se/globalassets/vara-uppdrag/kunskapsstyrning/varje-dag-raknas/vardforlopp/kva-koder/sammanstallning-av-angivna-ledtider-for-svf.pdf>.

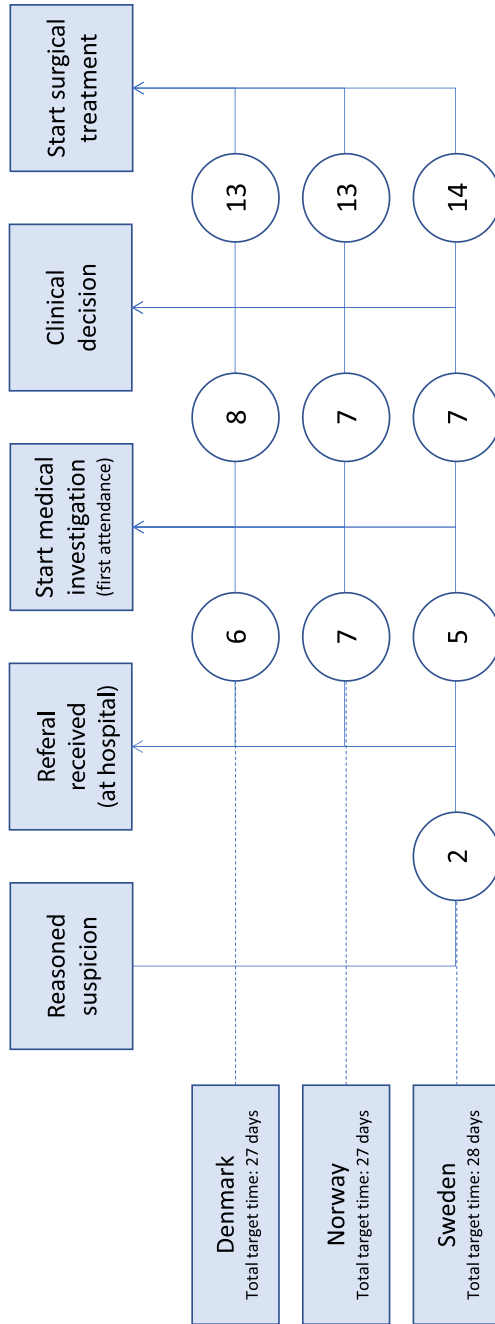


FIGURE 1 Target times for the phases of surgical breast cancer pathway [Colour figure can be viewed at wileyonlinelibrary.com]

the compatibility and centrality of two or more logics. Compatibility refers to multiple logics causing consistent organisational actions, while centrality implies that logics are connected to core features of an organisation. Thornton and Ocasio¹⁶ identify four mechanisms linking the coexistence of institutional logics to change: institutional entrepreneurs, structural overlap, event sequences, and competition. While Smets et al.³² provide insight in to how bottom-up based initiatives contribute to institutional change in a situation characterised by novel institutional complexity, urgency to act and serious consequences of not acting.

Third, this is a study of three cases with similar reforms introduced in three Scandinavian countries. The transfer of policy from one country to another is often interpreted as a process of mimicking mediated by the search for successful solutions to a problem.³³ If a solution is a success in one country, it is adapted into a new and somewhat different context to act as a legitimate solution in the second country as well. According to Dobbin,³⁴ this is a kind of ritualistic process governed by the urge to solve an existing problem. Boxenbaum and Battilana³⁵ show that this is not just a question of transfer but also of translation. In other words, the original organisational idea needs to be customised to the new local environment. Mur-Weeman et al.³⁶ show how the concept of integrated care is implemented differently according to the characteristics of specific health care systems. Socio-cultural linkages, similarities in political institutions, ideological positions of central actors and neighbours are more likely to be copied without translation.^{34,37} As Obinger points out, in these cases, there is a risk of processes simply being emulated without any mutual learning taking place.

Fourth, explaining the process behind these reforms calls for a conceptual understanding of the triggering mechanisms at the political level. The literature is limited in this respect but Mahoney's³⁸ work on path dependency analysis and breakpoints is relevant. A breakpoint is defined as the point where a course of action is determined in some way. Along the same lines, Goerz and Levy³⁹ use the expression 'critical juncture', while Tuohy⁴⁰ talks about creating a state of punctuated equilibrium. All of these terms refer to the point at which a window of opportunity is present and specific catalyst factors are active.⁴¹ Exworthy and Powell⁴² argue that opportunity must be present simultaneously at central and local levels. Hilgartner and Bosk,⁴³ underline that claim makers' success in dominating the public arena depends on their ability to frame social problems using both 'facts' and emotional rhetoric and on winning the battle between competing framings.

Fifth, reforms need institutional entrepreneurs as agents, exploiting the uncertainty created by the window of opportunity.⁴⁴ Several authors within institutional organisational research have identified key players connected to several organisational logics who are in a position not only to build legitimacy for different interest groups but also to transfer and translate ideas across organisational borders.^{35,45-49} They may do so by crisscrossing different institutional arenas.⁴³ Within this understanding, entrepreneurs are building on processes and concepts that are already present.^{47,50} Their scope of action is defined by the rise of a state of uncertainty.⁴⁴ By creating a narrative to interpret this uncertainty and the resulting crises, they identify an opportunity to communicate and build support for a particular solution.⁴⁶

3 | METHODS

The scope of this empirical study is the politically initiated reform in cancer care enacted in three Scandinavian countries. We consider each country's reform process as a case. According to Ragin⁵¹ 'case-oriented researchers see cases as meaningful but complex configurations of events and structures'. The reform processes we examine comprise a complex set of events and actions on several institutional levels including the national political level, the level of health care actors, and the level of hospitals and general practitioners. Moreover, they took place in a composite structure of processes and organisations. Introducing a similar reform in three countries with health care systems characterised by public ownership, tax-based funding and principally equal and free access gives a unique possibility to identify specific features of such reforms in this type of health policy context.

Our empirical material consists of both documents and interviews with interviews as our primary source of data. This resonates with other studies of institutional logics.^{16,52-54} During the data collection process, cross-fertilisation between these two sources allowed us to identify additional relevant documents and additional informants.

The document data consisted of publicly available documents related to the process found at relevant organisations' web sites. Together they constitute the official documents for the political or administrative reform process.⁵⁵ Such documents cover the official analyses, rationale and measures of the problem at hand and also represent opinions about the documents.⁵⁶ We have not conducted any systematic content analysis or discursive analysis of the official documents since the meanings expressed in the documents are not the primary scope of this study. Other documents such as public presentations given by key players during the process and published research papers served as secondary sources. The information, arguments, and opinions expressed in the documents were a reference for the content of the interviews, as well as a data source for the analyses of each of the phases of the process.

The informants were recruited through purposive snowball sampling.⁵⁷ The selection criteria were that they had played a key role in the whole process or in key events. We regarded the informants as institutional actors⁵⁶ representing the position and organisation they were connected to during the process. Thus, the positions of the interviewees during the timeline of the investigation mirror the active organisational entities in each country. In total, we conducted 26 interviews in the period May to September 2018, nine in Denmark, eight in Norway, and nine in Sweden. On average the interviews lasted 70 min. The positions of the informants varied: Four represented health ministries, 10 national coordinating units, six patient organisations, five regional/hospital managements, and two were researchers. Several of the informants had held other central positions in cancer care before or after the period in question. The time elapsed between the events studied and the interviews, in particular for the Danish case, is a potential weakness in the quality of the interview data. However, using documents written concurrently with the process or closely afterwards reduce time errors and serve as a context that can actively be used as a reference during the interviews.

In line with an abductive approach, we carried out semi-structured interviews with open-ended questions, allowing flexibility to follow the flow of the conversation and address issues as they arose.⁵⁸⁻⁶⁰ We developed an interview guide based on the storyline of the process and adjusted it according to country and interviewee profiles. We started analysing of the material during the initial reading of core documents and continued during the interviews and the process of transcribing and coding. A multi-step coding process was used.⁵⁸ First, we organised quotes from each country case on the basis of the following groups of topics: Information related to the institutional contexts, information on the staging of a need for reform, information on how a situation of urgency to act was created, information on how the dominant way of conceptualising the problem was defined, and information on how actors were mobilised across institutional and country borders. Second, we started searching for similarities and differences across the three country cases. This allowed us to identify possible interrelations, iterations, causalities, and explanations that seem to be valid across the cases. During the analysis, we followed an iterative approach, going back and forth between the empirical material, inductively based analysis, and the literature. On this basis we have constructed the account of how these processes unfolded presented in this article.

4 | RESULTS

4.1 | Background

Cancer came onto the national political agenda in the three Scandinavian countries during the 1990s. In Norway, an expert group delivered an official national report on cancer care and plans for improvement in 1996, which was followed by political decisions to put more resources into cancer care.^{61,62} In Denmark, the National Cancer Board,

a group appointed by the Danish Health Authority, launched the first national cancer plan in 2000.⁶³ Discussions of the development of a national cancer plan in Sweden started the following year. Two major underlying forces in all three countries were the shortage of investments in technological equipment, especially MRI and radiotherapy, necessary to meet the increasing number of cancer patients, and the ambition to take an internationally leading position in cancer diagnostics and treatment. The national reports were all comprehensive, addressing topics like prevention, screening, education, centralisation, quality registers, palliative care and clinical trials, in addition to investments in technology. These initiatives were first taken by medical experts and health care administrators but soon transferred to the political level.

Analytically, we have defined the starting point of each reform process as the first national strategic manifestation of an increased focus on cancer pathways. In Denmark, this was the second national cancer plan from 2005,⁶⁴ in Sweden, this was the national cancer strategy launched in 2009,⁶⁵ while in Norway, this was the third national cancer strategy from 2013.⁶⁶

4.2 | The emerging need for reform—separate stories with similarities

In all three countries, the process of reforming cancer care started when the legitimacy of the existing system was questioned. The critique can be summarised into three elements: First, questions were raised about unequal geographical and socio-economic access to best medical care. Access to new drugs and technologies in a situation with increased incidence of disease and restricted budgets was another. The low survival rates compared to other northern/western European countries, including the other Scandinavian countries, presented a specific challenge for Denmark.⁶⁷

Second, there was an emerging concern on the lack of patient focus and patient involvement. Because of this awareness, the national cancer strategies in all three countries, included measures to increase patient involvement in cancer care. A Swedish interviewee explained,

Patient involvement has been a principle on all levels of the RCC (Regional Cancer Center) structure. Thus, their representatives have been present in all arenas where the structure of cancer care has been discussed and redesigned. (SV8)

Third, the ability of the dominant model of hospital organisation to deliver solutions that could give legitimacy was questioned.⁶⁸ A Danish informant provided the following explanation:

The way hospitals are organized may have the consequence that no one actually feels responsible for the totality and no one has the overview of where the bottlenecks are and who should be responsible for the problem and having the key to the solution. This phenomenon has increased in parallel to the increase in specialization and functional division of labor. This was an even more severe problem in cancer than in other fields like heart diseases. (DK2)

The national cancer strategies were partly a response to the reduced legitimacy of cancer care. Several proposed measures were implemented. Concurrently, national strategies and public focus on cancer also increased the public's expectations. In certain crucial areas, no major improvements occurred. One of the Danish informants described the situation as follows:

As a consequence of the first two cancer plans, lots of resources were allocated to cancer. However, there was a lack of improvement in certain important areas. (DK7)

The lack of expected change illustrated by a Swedish informant:

During the first years after the National Cancer strategy, much development occurred: national treatment programs, quality registers and so on. However, hardly any improvement in processes such as waiting times was reported. (SV3)

To understand the dynamic created by the reduced legitimacy and unfulfilled expectations, two more elements must be addressed. The first is the structure of national multidisciplinary groups connected to each major cancer diagnosis. These groups recruited members from the relevant medical disciplines involved in each specific diagnosis. One Danish informant stated,

The existence of the national multidisciplinary cancer groups was of the utmost importance to the general improvement of quality parameters and the harmonization of quality standards in cancer diagnostics and treatment. (DK6)

The first task of these multidisciplinary groups was to produce a unified action program comprising national guidelines for diagnostics and treatment. In Norway and Sweden, the groups were run and the diagnose-specific action-programs approved by the Norwegian Health Directorate and the Swedish Association of Local Authorities and Regions (SKL), respectively. In Denmark, in contrast, the groups were independent medical non-governmental associations.

The second element contributing to change was the emergence of alternative institutional organisations. In Denmark, innovations in standardised diagnostic processes were developed at some hospitals as a solution to experienced problems caused by ineffective work processes, unjustifiable waiting times, and bottlenecks in cross organisational coordination.¹³

An anecdote told by several of our informants was spread through national media when the stories of the CPP birth should be told. Based on personal experience with an acquaintance with lung cancer, a radiologist at Vejle Hospital introduced a standardised system for delivering predictable slots and standardised waiting times for all lung cancer patients. A Danish informant summed up Vejle's position as a role model:

Vejle Hospital played a major role; not least, they managed to create a culture that expresses the understanding of what this is all about. They were frontrunners and managed to transform the idea into practice. (DK8)

The case of the diagnostic cancer pathways at Vejle Hospital was described in a separate appendix to the Danish 2005 national cancer plan.⁶⁵

Similar problems as in Denmark were experienced in Sweden and Norway, and several informants recount that the Danish model was regarded as a role model in the search for solutions. Politicians and managers from these two countries visited Denmark to learn. Southern Sweden is geographically very close to Denmark, and the existence of a more or less overlapping labour market facilitated the exchange of ideas across the border. Specifically, the RCC of southern Sweden arranged seminars inviting speakers to tell about their experiences in Vejle. In Norway, the national program for hospital leadership development visited Vejle Hospital for several years, partly because of its diagnostic cancer pathway.

Models focussing more on process-oriented work organisation were acknowledged and the recommended direction given in the national cancer strategies in all three countries. As one Norwegian informant explained,

The CPP experimentation and mind-set were already present in some departments and hospitals ahead of the reform. The philosophy of the CPP had started to penetrate into health care. System thinking with the CCP offered a way to address tragic patient cases. (NO1)

The first phase of what we might call a national cancer reform process can be summarised by three key conditions leading to reduced legitimacy of cancer care: lack of patient focus, scarcity of access to new technologies for all patients, and emerging critique of the dominant organisational model. The latter was due to its lack of coordination across organisational borders in hospitals and between hospitals as not being beneficial for cancer patients. These conditions created a dynamic that led to the initiation of specific new cancer-related structures and the emergence of alternative institutional solutions to facilitate change.

4.3 | Conceptualisation of the problem and the content of the reform

In Denmark, the lower survival rates and higher incidence of certain cancers had been an underlying driving force behind the national cancer plans. However, given the perceived state of urgency and the great public and political awareness in 2007, this was not the main narrative. The narrative that emerged from a combination of patient stories and statistics was about cancer patients' experiences of not being taken seriously. A Danish informant said,

When the reform was launched, it was not about the relatively poor survival rate. It was about unnecessary waiting times and about immediate action to improve this. This was the political message. This was the driving force and then also the main issue among oncologists and other cancer-related specialists. (DK2)

However, when implementing the first part of the cancer reform, it was not obvious to the actors in the political landscape that the core narrative should be about eliminating delays in diagnosis or time to start treatment. One competing narrative was early diagnosis. Other more complex approaches was differentiating between cancers, cancer stages and diagnostic indications and patients' total medical and personal situation.⁶⁹ Patient waiting times during treatment were also an issue, namely the time to diagnosis and to treatment start. This simple message about no delays in diagnosis was chosen as the premise for a solution.⁷⁰ At the peak of the political process, the core narrative of the reform coincided across the three countries. The consequences for patient safety and predictability had to be addressed. For Denmark, as the first country to release the reform, these issues were connected to medical arguments about time delay as an adverse prognostic factor. The battle to define cancer as an acute disease was a symbolic expression of this discussion. One Danish informant said,

The news was simply filled with horrible stories about patients waiting for diagnostics and treatment and beneath the pictures was the following sentence: The patient is waiting – the cancer is not! (DK8)

In Norway and Sweden, however, the arguments related to waiting times were more based on patient experiences and putting the patient's perspective in front. The slogan extensively used in Sweden, 'each day counts', 'not one day wasted', evokes the medical impact of time. A Norwegian informant describes the patient perspective as follows:

In spite of a satisfactory relative survival outcome in Norway, politicians were increasingly aware of the waiting times, and voiced patients' experiences in that situation: 'I feel very uncomfortable not knowing'; 'Do I have cancer or not? And what will happen to me if the answer is yes?' So the overall target of the reform was to create a feeling of safety and predictability. (NO5)

The narrative of this phase of cancer reform also put forth an underlying question: what actually has to be changed for waiting times to become acceptable? This part of the narrative critiqued some fundamental conditions of health care and hospitals, calling into question mindsets and work processes. Informants in Denmark talked about the need to change mindsets, as exemplified by this quote:

The doctors had to adopt the mindset that patients shall be served in due time aligned with the CPP and not when the doctor thinks there is an available time for a diagnostic procedure or an outpatient appointment. (DK5)

These deeper narratives of mindset, attitude, and work process are inter-related and connected to waiting times. The more dramatic narrative regarding waiting times was probably needed to initiate change. Thus, in all three countries, the political decision was that waiting times must be improved. In Denmark, possible cancer was to be treated like an acute disease, while Sweden labelled their reform the Waiting Time Reform.¹⁴

How should the challenge of unacceptable waiting times be managed? Several options flourished on the political battleground. Certain existing models had a major impact on the decision to introduce CPPs because they seemed to give the desired outcome. The model created at Vejle Hospital was one such major source of inspiration for Denmark, and later the Danish reform interpreted as a success functioned as model for Norway and Sweden.¹⁴ One Swedish informant said, 'It was decided to reduce waiting times and we should look to Denmark for the solution'. While Norway and Sweden were able to benefit from close contact with Denmark, Denmark did not follow a comparable cross national translational process.

The content of the CPPs was similar in the three countries: a standardised process defining normative targeted time frames from referral to hospital and to the start of first treatment, the introduction of patient case managers, mandatory multidisciplinary clinical decision meetings in each pathway at every hospital and a standardised referral guide defining reasoned suspicion of cancer. The introduction of CPPs was often perceived as a reform of logistics, although some also saw it as a reform of quality because CPPs built on the clinical action program for each diagnosis and specified the steps to deliver best outcome.

To summarise, even though motives and drivers for the emergence of national cancer reforms differed slightly among the three countries, when the peak of urgency was reached, there was one dominant narrative behind the call for action—unacceptable waiting times. While this narrative was originally linked to medical outcomes and the prognostic impact of waiting times in Denmark, the first country to roll out a reform, subsequently the focus was overwhelmingly on patients' subjective demands for safety and predictability for all three countries. At a deeper level of the narrative, we discovered a supplementary demand for change in mindset at the hospital level. In the prevailing narrative, there was one dominant solution, namely implementing CPPs. This was based on an existing solution that seemed to work.

4.4 | The urgency to act—mobilisation for change

During spring 2007, the situation regarding cancer care in Denmark was marked by an urgent need to act. A Danish informant summarised as follows,

Lots of stories were exposed in the media expressing experiences of terrible waiting times. This was combined with medical research claiming that waiting times in certain cancers might influence survival. This coincided with a general trend addressing the demand for a more patient-focused health care higher up on the agenda of public debate. (DK7)

Findings from several PhD projects supporting the decisive arguments were presented at a crucial meeting of the parliament in March 2007.⁷¹ Another Danish informant told us,

We documented that tumors grew from one stage to another during the patient's waiting time and that a lot of patients had long waiting times. There was one story for the heart and one story for the brain. There was a message that left the heart cold and another escalating the engagement of the brain. (DK3)

In Norway and Sweden, there was hardly any research-based documentation connected to the situation of urgency in cancer care. In both Denmark and Norway, scandals had been uncovered regarding waiting times for cancer patients, and the media played a major role in all three countries by continuously raising this issue, not least through patient cases.⁷² A Norwegian informant said,

There were lots of negative stories in the media, especially connected to patients waiting for treatment, people that seemed to be forgotten by the system. Patients got no answer about what was going to happen, living in uncertainty for a long time not knowing whether they had a cancer or not. (NO6)

The research and the media coverage in Denmark evolved partly as a result of a well-organised process between medical researchers in Aarhus and core players in the patient organisation the Danish Cancer Society. Several informants argued that they managed to exploit the situation and that they created alliances. The national multidisciplinary cancer groups and the Cancer Union cooperated to organise the important meeting at the parliament. One Danish informant formulated it like this:

There was this decisive meeting at the parliament in addition to the alliance between the Cancer Union and the doctors. That is an extraordinarily strategic, strong alliance. This was not the triggering cause. Nevertheless, this reform would not have happened without this alliance being present. (DK3)

Involvement and engagement of top-level politicians from the largest parties also played an important role; they served as both agents, constituting the urgency of the situation, and as actors expected to execute action. This happened in 2007 concurrently with a major politically imposed administrative reform in Denmark. The counties were merged into five regions. One argument for this fusion was the need for health care reform. The chair of the umbrella organisation of the regions was from the Labour Party while the government was led by the conservative and liberal parties. Solving what was understood as a crisis in cancer care became a decisive task. The national government and the regions partly competed and partly joined forces to deal with the task. A Danish informant stated that,

The crucial point in this reform process was the decision at a very high political level. People might argue against certain elements or the total reform. However, this was totally overruled by the fact that this was a governmental decision and confirmed by the agreement between the government and the Danish regions. For the enforcement of the implementation, this was a major advantage. (DK2)

In Norway and Sweden, the political situation also contributed to mobilisation for change and a sense of urgency. In both countries' general elections (Norway in 2013, Sweden in 2014), both political sides addressed the crisis in cancer care and possible solutions in their campaigns. Despite agreement about the importance of the problems and the need for action, the politicians disagreed about which tool to use.

At an administrative level, a contribution to action also came from the structuring of health care administration at the national level. The national health agencies had ambitions in terms of playing a role in the development of cancer care. However, in none of the countries did these agencies have an executive line to the hospitals. Coordination between these entities was accomplished through different systems: through the politically elected regional governments in Denmark, through the corporate structure run by regional health authorities in Norway, and by the counties and their coordinating structure of regional cancer centres in Sweden. The need for both the executive structures and health agencies to consolidate and strengthen their position in the strategically important cancer care domain likely encouraged a combined process of competition and cooperation when the situation became urgent.

In Norway and Sweden, there were even challengers among patient societies mobilising for urgently needed rapid change. In Norway, the Cancer Union was challenged by Action 48, a very active group on the Southwest coast, and their demand for a 48-h wait time from referral to diagnosis. In Sweden, the organisation Unified against Cancer emerged alongside the dominant Cancer Fund. Both the new Swedish and Norwegian organisations were inspired in part by Denmark, and they worked closely with politicians, not least on the topic of waiting times. In addition, the newly elected health minister in Norway was inspired by the Danish CPP reform. During this period, the established Norwegian Cancer Union engaged the former president of the Danish Cancer Union as an adviser to support their work influencing politicians regarding cancer waiting times.

Altogether, political mobilisation increased as a result of persistent media focus, systematic documentation,¹⁵ engagement from medical communities and cancer societies, and the demonstration of agency by skilled and well positioned actors in identifying and capitalising on a situation of political and administrative competition. A Danish informant expressed it as follows:

The constituting mechanism of this reform was a mixture of some patient cases, some public dissemination of relevant medical research and the active engagement from central politicians. This was exceptional compared with the traditional way of preparing political reforms in Denmark through huge studies and thorough analysis. The combined input was crystalized into a political initiative that immediately migrated into the system and opened for new ideas. (DK8)

A situation of urgency and a need to act were created through combination of medical reports, heavy engagement from media and patient organisations and a combination of competition and need for consolidation among relevant organizations and health administration, all skillfully articulated by strategically situated actors. Action was accomplished through the launch of waiting time reforms in Denmark in 2007, in Norway in 2014, and in Sweden in 2015.

5 | DISCUSSION

This article explores how relatively similar cancer care reforms emerged in three Scandinavian countries with similar health care systems. In our analysis, we identified three distinct institutional logics in play during the reforms. The institutional logics are present in the initiating processes, in the conceptualisation of the problem, in the choice of measures, and at the crucial point of urgent decision making. First, the medical logic is anchored in best medical practice, expressed in scientifically based methods and guidelines, with measurable clinical results as outcome variables. The medical logic is executed through clinical discretion based on experience and scientific reports. The main carrier of this logic is the medical profession at field level, also represented by multidisciplinary groups and medical specialist associations. The influence of this logic is mainly bottom-up.

Second, we identified an economic-administrative logic connected to effective production through optimal use of available resources. It is monitored through activity parameters, budget targets, and indicators for optimal

deployment of resources. This logic is primarily represented by the management and by the administrative agencies governing health care. This logic works top-down through the hierarchical, executive line and governance systems.

Third, we identified the patient-related logic. The patient-related logic has a subjective, emotional and personalised basis and is anchored in their treatment experience. This logic is expressed mainly outside-in, by groups and persons who are not part of the institution. For all three Scandinavian countries, we have described an increased focus on the perspectives of patients, whose experiences with the lack of coordination in cancer care led to a demand for improvements.

Our study indicates that in spite of several years of improvement initiatives and more funding allocated to cancer care, a crisis emerged in all three countries. This crisis was on legitimacy and of outcome versus expectations, and it eventually created a window of opportunity. More resources did not solve the crisis and the origin was traced to the lack of real institutional change at the ground level, change in behaviour, in work processes, and in mindset to manage complex patient pathways. A common conceptualisation of the problem emerges across the three institutional logics in play: unwarranted waiting for treatment, each day counts. This narrative is easy to communicate and creates meaning, and thus legitimacy, in all the three logics. Medically, cancer is a progressive and deadly disease and accordingly there may be a connection between delay to start of treatment and treatment outcome. The reform narrative is connected to the economic-administrative logic through arguments for more optimal deployment of care, including planning and coordination, and more optimal allocation of available resources. In the patient-related logic the reform narrative creates meaning through the effect on experienced safety and predictability in a vulnerable time with a recent possible or confirmed cancer diagnosis. There was a demand for both compatibility and centrality,³¹ defining a critical juncture.³⁹ A window of opportunity evolved⁴¹ through fairly similar causal steps in all three countries. Starting with increased public and political focus on cancer care, several centrally defined measures were launched in parallel with local initiatives at the hospital level. Because growing expectations were not met, and serious dissatisfaction was expressed in the media and medical communities, a crisis of legitimacy and a state of urgency for action emerged. The catalyst factor⁴¹ triggering action is then the coincidence in time and content of the perceived crises, problem definition and solution related to all the three dominant logics and this creates together a situation alternatively termed breaking point,³⁸ critical juncture³⁹ or punctured equilibrium.⁴⁰ The problem was framed in terms of competing alternatives with the winning message speaking to both the head and the heart.⁴³

Agency is clearly present in these reforms. Resonating previous literature,^{44,46,47} we can identify several institutional entrepreneurs characterised in previous literature on this topic.^{44,46,47} Some of the actors playing a decisive role on the national level had a connection to several distinct institutional fields, either concurrently or over the course of their professional career. They thereby had high legitimacy at least for two of the logics in play and in many ways filled the role of boundary bridging. They were active in taking advantage of the emerging crisis, elaborating how it should be perceived and articulating the urgency to act. The entrepreneurs acting on the public stage used the shared legitimation between the logics as a kind of momentum to initiate immediate action that managed to involve several levels of the institutional field. These reform cases also illustrate how competition between actors primarily representing the same logic may impose a course of action.

By literally crossing the Scandinavian national borders some individuals were important boundary-spanners. This example of mutual cross-country influence recalls arguments from previous research about policy transfer, which conclude that the transfer of specific ideas and measures is more likely to occur between neighbours with similar political and administrative systems.^{34,37} As previously outlined, international trends regarding the introduction of ICPs had emerged before the Danish reform process started. Thus the reforms introducing CPPs could be interpreted as part of an isomorphic process mimicking³³ or emulating³⁷ a measure that had seemed to refute a legitimation crisis internationally. However, each country's reform movement had its own strong and distinctive sources, and though there were clear elements of translation from the Danish to the Norwegian and Swedish cases the reforms in the latter two countries contained distinct features based on their unique political processes and the particular context of their health administrative systems.

ICP-type measures may be imposed from both above and below. Aligned with this dual perspective, previous research have described that institutional change across field levels may be based on a top-down perspective⁷³ or a bottom-up perspective.³² The reform processes in the three countries combine these two models. The CPP was a solution to reduce long waiting times not least developed as concept at Vejle Hospital and pushed by groups of clinicians in all three countries. The translation to a field level reform largely followed the elements and dynamics of the model of Smets and colleagues³² emphasising the bottom-up perspective. Development projects related to patient flow at other Danish hospitals and some Norwegian and Swedish hospitals seem to fit into the same pattern. Hence, the CPP reforms appear to be based on this interplay between bottom-up and top-down institutional change. This finding is in accordance with the more general arguments of Bretton et al.⁴¹ and the empirical findings of Allen.¹⁰ Our contribution, however, is putting all these elements together in a comprehensive puzzle: A similar conceptualising of a problem according to all three institutional logics present, occurring at a critical point when political action grew urgent. And simultaneously there was an window of opportunity seized by actors in the potential position of bridging interpretation of problem and solutions between representatives of the different logics and across the three countries while building on existing models of CPP thus combining processes bottom-up with top-down in triggering the political decision of the CPP reform.

6 | CONCLUSION

This study shows that the launching of political reforms in cancer care in three Scandinavian countries, targeted at changing practice at clinic level of hospitals, can be explained by the presence of several elements. First, a causal path of events along a timeline undermined the legitimacy of cancer care in general. During a situation marked by urgency this undermining process was nourished by the national institutional field of cancer care by applicable sources from below, from above, from outside, and from abroad relating to the three institutional logics present at this stage. Second, the series of events originated from the different sources created a window of opportunity for a reform initiative. The specific reform action was precipitated by the articulation of a definition of the problem and a solution that appeared to be simultaneously aligned with all three prevailing logics. The emergence of this seemingly triple aim solution was dependent on the presence of institutional entrepreneurs carrying the discourse that bridged the various logics and had the skill, legitimacy and urge to exploit this window of opportunity. Based on our analysis of three specific cancer reform cases, we suggest on a more general level that reform initiatives in health care might be explained and characterised by a situation of urgency where four dimensions are at least apparently aligned; content of reform, direction of change, interpreting time for action and actor involvement in three prevailing institutional logics. This can therefore be an interesting avenue for further research.

ACKNOWLEDGEMENTS

We will thank Ingrid Kristine Small Hanto for support in preparing the manuscript. This study is part of a project funded by The Research Council of Norway, project no 272945.

CONFLICT OF INTERESTS

None.

ETHICS STATEMENT

This material is the authors' own original work, which has not been previously published and not currently being considered for publication elsewhere. The paper reflects the authors' own research and analysis in a truthful and complete manner. The paper properly credits the meaningful contributions of co-authors and co-researchers. The results are appropriately placed in the context of prior and existing research. All sources used are properly

disclosed (correct citation). All authors have been personally and actively involved in substantial work leading to the paper, and will take public responsibility for its content.

DATA AVAILABILITY STATEMENT

Interview data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions. Document data that support the findings of this study are available in open sources given in the list of references concerning documents referred to in Result chapter in the article.

ORCID

Per Magnus Mæhle  <https://orcid.org/0000-0003-3392-5969>

REFERENCES

1. Liberati EG, Gorli M, Scaratti G. Reorganising hospitals to implement a patient-centered model of care. *J Health Organisat Manag.* 2015;29(7):848-873. <https://doi.org/10.1108/JHOM-07-2014-0129>
2. Segato F, Masella C. Integrated care in action: opening the "black box" of implementation. *Int J Health Plann Manag.* 2017;32(1):50-71. <https://doi.org/10.1002/hpm.2306>
3. Whittle C, Hewison A. Integrated care pathways: pathways to change in health care? *J Health Organisat Manag.* 2007;21(3):297-306. <https://doi.org/10.1108/14777260710751753>
4. Campbell H, Hotchkiss R, Bradshaw N, Porteous M. Integrated care pathways. *Br Med J.* 1998;316:133-137.
5. Vanhaecht K, Witte KD, Depreitere R, Sermeus W. Clinical pathway audit tools: a systematic review. *J Nurs Manag.* 2006;14(7):529-537. <https://doi.org/10.1111/j.1365-2934.2006.00705.x>
6. Ouwens M, Wollersheim H, Hermens R, Hulscher M, Grol R. Integrated care programmes for chronically ill patients: a review of systematic reviews. *Int J Qual Health Care.* 2005;17(2):141-146. <https://doi.org/10.1093/intqhc/mzi016>
7. Bohmer R. Critical pathways at Massachusetts General Hospital. *J Vasc Surg.* 1998;28(2):373-377. [https://doi.org/10.1016/S0741-5214\(98\)70179-X](https://doi.org/10.1016/S0741-5214(98)70179-X)
8. Panella M, Van Zelm R, Sermeus W, Vanhaecht K. Care pathways for the organization of patients' care. *Bulletin Econ Organ Infrom Healthcare.* 2012;28(2):111-122. <https://doi.org/10.2478/v10221-011-0026-z>
9. Pinder R, Petchey R, Shaw S, Carter Y. What's in a care pathway? Towards a cultural cartography of the new NHS. *Sociol Health Illn.* 2005;27(6):759-779. <https://doi.org/10.1111/j.1467-9566.2005.00473.x>
10. Allen D. Lost in translation? 'Evidence' and the articulation of institutional logics in integrated care pathways: from positive to negative boundary object? *Sociol Health Illn.* 2014;36(6):807-822. <https://doi.org/10.1111/1467-9566.12111>
11. Kodner DL, Spreeuwenberg C. Integrated care: meaning, logic, applications, and implications—a discussion paper. *Int J Integr Care.* 2002;2(4):1-6. <https://doi.org/10.5334/ijic.67>
12. Zuiderent-Jerak T. *Situated Intervention: Sociological Experiments in Health Care.* The MIT Press; 2015.
13. Probst HB, Hussain ZB, Andersen O. Cancer patient pathways in Denmark as a joint effort between bureaucrats, health professionals and politicians—a national Danish project. *Health Pol.* 2012;105(1):65-70. <https://doi.org/10.1016/j.healthpol.2011.11.001>
14. Wilkens J, Thulesius H, Schmidt I, Carlsson CJHP. The 2015 National Cancer Program in Sweden: introducing standardized care pathways in a decentralized system. *Health Pol.* 2016;120(12):1378-1382.
15. Tørring ML. Hvorfor akut kræft? Et bud på en epidemiisk forståelse af tid og kræft-tendenser i Danmark. *Tidsskrift Forskning Sygdom Samfund.* 2014;11(20):13-45.
16. Thornton PH, Ocasio W. Institutional logics. In: Greenwood R, Oliver C, Lawrence TB, Meyer RE, eds. *The Sage Handbook of Organizational Institutionalism.* 2008:99-128.
17. Alford RR, Friedland R. *Powers of Theory: Capitalism, the State, and Democracy.* Cambridge University Press; 1985.
18. Shaw JA, Kontos P, Martin W, Victor C. The institutional logic of integrated care: an ethnography of patient transitions. *J Health Organisat Manag.* 2017;31(1):82-95. <https://doi.org/10.1108/JHOM-06-2016-0123>
19. Martin GP, Kocman D, Stephens T, Peden CJ, Pearse RM. Pathways to professionalism? Quality improvement, care pathways, and the interplay of standardisation and clinical autonomy. *Sociol Health Illn.* 2017;39(8):1314-1329. <https://doi.org/10.1111/1467-9566.12585>
20. Mould G, Bowers J, Ghattas M. The evolution of the pathway and its role in improving patient care. *Qual Saf Health Care.* 2010;19(5):e14. <https://doi.org/10.1136/qshc.2009.032961>

21. Pless S, Van Hootegeem G, Dessers E. Making care organizations great again? A comparison of care pathways, lean thinking, relational coordination, and modern sociotechnical design. *Int J Care Coord*. 2017;20(3):64-75. <https://doi.org/10.1177/2053434517725529>
22. Dennis LK, Cor S. Integrated care: meaning, logic, applications, and implications—a discussion paper. *Int J Integr Care*. 2002;2(4). <https://doi.org/10.5334/ijic.67>
23. Schrijvers G, van Hoorn A, Huiskes N. The care pathway: concepts and theories: an introduction. *Int J Integr Care*. 2012;12(1):1-7.
24. Allen D. From boundary concept to boundary object: the practice and politics of care pathway development. *Soc Sci Med*. 2009;69(3):354-361. <https://doi.org/10.1016/j.socscimed.2009.05.002>
25. Pearson SD, Goulart-Fisher D, Lee TH. Critical pathways as a strategy for improving care: problems and potential. *Ann Intern Med*. 1995;123(12):941. <https://doi.org/10.7326/0003-4819-123-12-199512150-00008>
26. Reay T, Hinings CR. Managing the rivalry of competing institutional logics. *Organ Stud*. 2009;30(6):629-652.
27. Scott WR, Ruef M, Mendel PJ, Caronna CA. *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care*. University of Chicago Press; 2000.
28. Kitchener M. Mobilizing the logic of managerialism in professional fields: the case of academic health centre mergers. *Organ Stud*. 2002;23(3):391-420. <https://doi.org/10.1177/0170840602233004>
29. Dunn MB, Jones C. Institutional logics and institutional pluralism: the contestation of care and science logics in medical education, 1967–2005. *Adm Sci Q*. 2010;55(1):114-149. <https://doi.org/10.2189/asqu.2010.55.1.114>
30. Macfarlane F, Barton-Sweeney C, Woodard F, Greenhalgh T. Achieving and sustaining profound institutional change in healthcare: case study using neo-institutional theory. *Soc Sci Med*. 2013;80:10-18. <https://doi.org/10.1016/j.socscimed.2013.01.005>
31. Besharov ML, Smith WK. Multiple institutional logics in organizations: explaining their varied nature and implications. *Acad Manag Rev*. 2014;39(3):364-381.
32. Smets M, Morris T, Greenwood R. From practice to field: a multilevel model of practice-driven institutional change. *Acad Manag J*. 2012;55(4):877-904.
33. DiMaggio PJ, Powell WW. The iron cage revisited—institutional isomorphism and collective rationality in organizational fields (Reprinted from the American Sociological Association vol 48, pg 147–160, 1983). *Adv Strategic Manag*. 2000;17:143-166.
34. Dobbin F, Simmons B, Garrett G. The global diffusion of public policies: social construction, coercion, competition, or learning? *Annu Rev Sociol*. 2007;33(1):449-472. <https://doi.org/10.1146/annurev.soc.33.090106.142507>
35. Boxenbaum E, Battilana J. Importation as innovation: transposing managerial practices across fields. *Strat Organ*. 2005;3(4):355-383.
36. Mur-Veeman I, Van Raak A, Paulus A. Comparing integrated care policy in Europe: does policy matter? *Health Pol*. 2008;85(2):172-183.
37. Obinger H, Schmitt C, Starke P. Policy diffusion and policy transfer in comparative welfare state research. *Soc Policy Adm*. 2013;47(1):111-129.
38. Mahoney J. Path dependence in historical sociology. *Theor Soc*. 2000;29(4):507-548.
39. Goerz G, Levy JS. Causal explanation, necessary conditions, and case studies. In: Goerz G, Levy JS, eds. *Explaining War and Peace: Case Studies and Necessary Conditions Counterfactuals*. Routledge; 2007:9-45.
40. Tuohy CH. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*. Oxford University Press; 1999.
41. Breton M, Lamothe L, Denis J-L. How healthcare organisations can act as institutional entrepreneurs in a context of change. *J Health Organisat Manag*. 2014;28(1):77-95. <https://doi.org/10.1108/JHOM-07-2011-0072>
42. Exworthy M, Powell M. Big windows and little windows: implementation in the 'congested state'. *Publ Adm*. 2004;82(2):263-281.
43. Hilgartner S, Bosk CL. The rise and fall of social-problems—a public arenas model. *Am J Sociol*. 1988;94(1):53-78. <https://doi.org/10.1086/228951>
44. Beckert J. Agency, entrepreneurs, and institutional change. The role of strategic choice and institutionalized practices in organizations. *Organ Stud*. 1999;20(5):777-799.
45. Rao H, Giorgi S. Code breaking: how entrepreneurs exploit cultural logics to generate institutional change. *Res Organ Behav*. 2006;27:269-304. [https://doi.org/10.1016/s0191-3085\(06\)27007-2](https://doi.org/10.1016/s0191-3085(06)27007-2)
46. Battilana J, Leca B, Boxenbaum E. 2 How actors change institutions: towards a theory of institutional entrepreneurship. *Acad Manag Ann*. 2009;3(1):65-107. <https://doi.org/10.1080/19416520903053598>
47. Castel P, Friedberg E. Institutional change as an interactive process: the case of the modernization of the French cancer centers. *Organ Sci*. 2010;21(2):311-330. <https://doi.org/10.1287/orsc.1090.0442>
48. Lockett A, Currie G, Waring J, Finn R, Martin G. The role of institutional entrepreneurs in reforming healthcare. *Soc Sci Med*. 2012;74(3):356-363. <https://doi.org/10.1016/j.socscimed.2011.02.031>

49. Hodges E, Read S. How might organisational institutionalism support the challenges of the modern hospice? *Int J Health Plann Manag*. 2018;33(4):768-774. <https://doi.org/10.1002/hpm.2556>
50. Cloutier C, Lamothe L, Langley A, Denis J-L. Agency at the managerial interface: public sector reform as institutional work. *J Public Adm Res Theor*. 2016;26(2):259-276. <https://doi.org/10.1093/jopart/muv009>
51. Ragin CC. Turning the tables: how case-oriented research challenges. In: Collier D, Brady HE, eds. *Rethinking Social Inquiry: Diverse Tools, Shared Standards*. Rowman Littlefield Publishers, Inc; 2004.
52. Eisenhardt KM. Building theories from case-study research. *Acad Manag Rev*. 1989;14(4):532-550. <https://doi.org/10.2307/258557>
53. Yin RK. Enhancing the quality of case studies in health services research. *Health Serv Res*. 1999;34(5 Pt 2):1209.
54. Reay T, Jones C. Qualitatively capturing institutional logics. *Strateg Organ*. 2016;14(4):441-454. <https://doi.org/10.1177/1476127015589981>
55. Thies CG. A pragmatic guide to qualitative historical analysis in the study of international relations. *Int Stud Perspect*. 2002;3(4):351-372. <https://doi.org/10.1111/1528-3577.t01-1-00099>
56. Miller G. Contextualizing texts: studying organizational texts. In: Miller G, Dingwall R, eds. *Context and Method in Qualitative Research*. Sage Publications; 1997:78-91.
57. Baker P. Doing health policy research: how to interview policy elites. In: *When Culture Impacts Health*; Academic Press; 2013:309-317.
58. Aberbach JD, Rockman BA. Conducting and coding elite interviews. *Political Sci Polit*. 2010;35(4):673-676.
59. Berry JM. Validity and reliability issues in elite interviewing. *Political Sci Polit*. 2002;35(04):679-682. <https://doi.org/10.1017/S1049096502001166>
60. Leech BL. Asking questions: techniques for semistructured interviews. *Political Sci Polit*. 2002;35(04):665-668. <https://doi.org/10.1017/S1049096502001129>
61. Omsorg og kunnskap–Norsk Kreftplan. Oslo: Sosialog Helsedepartementet; 1997: 428. NOU 1997: 20 – regjeringen. no.
62. Innstilling fra sosialkomiteen om Nasjonal kreftplan og plan for utstyrsinvesteringer ved norske sykehus. Oslo: Stortinget; 1998. Innst. S. nr. 226 (1997-1998) (stortinget.no).
63. Kræftplan I, København: Sundhedsstyrelsen;2000.
64. En nationell cancerstrategi för framtiden. Stockholm: Socialdepartementet;2009. SOU 2009:11, En nationell cancerstrategi för framtiden (riksdagen.se).
65. National Cancer Plan II (Danish Health Authority (DHA)). 2005. Accessed September 2, 2019. http://www.epaac.eu/from_heidi_wiki/Denmark_National_Cancer_Plan_II_English.pdf
66. Sammen-mot kreft. *Nasjonalt kreftstrategi 2013–2017*. Ministry of Health; 2013.
67. Coleman M, Forman D, Bryant H, et al. Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995–2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data. *Lancet*. 2011;377(9760):127-138.
68. Vinge S, Rahbæk AE, Albæk J, Martedal A. Erfaringer med kræftpakker. Fra intensjoner til implementering i praksis; 2012. Accessed September 2, 2019. <https://www.vive.dk/media/pure/9171/2050380>
69. Vedsted P, Olesen F. A differentiated approach to referrals from general practice to support early cancer diagnosis–the Danish three-legged strategy. *Br J Canc*. 2015;112(s1):S65.
70. Oppfølging på Kræftplan II. København: Sundhedsstyrelsen;2007:45. Opfølgning på Kræftplan II (sst.dk).
71. Jensen AR, Nellemann HM, Overgaard JJR. Tumor progression in waiting time for radiotherapy in head and neck cancer. *Radiother Oncol*. 2007;84(1):5-10.
72. Risikobildet av norsk kreftbehandling. Oslo: Helsetilsynet–Board of Health Supervision;2010:33. Rapport fra Helsetilsynet 4/2010.
73. Reay T, Hinings CR. The recomposition of an organizational field: health care in Alberta. *Organ Stud*. 2016;26(3): 351-384. <https://doi.org/10.1177/0170840605050872>

How to cite this article: Mæhle PM, Hajdarevic S, Håland E, Aarhus R, Smeland S, Mørk BE. Exploring the triggering process of a cancer care reform in three Scandinavian countries. *Int J Health Plann Mgmt*. 2021;36(6):2231-2247. <https://doi.org/10.1002/hpm.3278>