The emergence of an organizational idea

The development of Centers for Healthy Living in Norway

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Abstract

BACKGROUND: Over the past 20-30 years we have seen a tremendous increase in lifestyle related diseases. This problem also affects social inequalities in health. Those who generally have a lower income have a lower health status; hence, a higher risk of developing lifestyle related diseases. Centers for healthy living (CHLs) target both these issues in being centers for people who need assistance in changing their lifestyle.

OBJECTIVE: Study the CHLs to see how they have developed as an organizational idea from initiation up until today. The aim is to see whether it can be characterized as a trend according to new institutional theories, and how the idea has developed as it has been implemented in different contexts; shows signs of variation. And finally, study what mechanisms; coercive, normative or mimetic, that influences both trend characteristics and how it has developed.

METHOD: A qualitative document study of the development of the CHLs, and a quantitative questionnaire of a sample of 30 CHLs in Buskerud and Nordland.

RESULT: The CHLs can be characterized as a trend as predicted by new institutional theories. However, it does not fit entirely with the categories that trend theories suggest.
Furthermore, there is some variation between CHLs in Buskerud and Nordland, which indicate that the idea both diffuse and translate as it is implemented in new settings. In the beginning the imitative mechanism is important, before the CHLs become integrated into national politics. Then, it seems as if both the coercive and the normative mechanism become more influential.

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Abbreviations and acronyms

Center for healthy living (Frisklivssentral) – CHL

Green prescription (Grønn resept) – A prescription doctors can give patients with diabetes, hypertension or obesity

Guidelines for municipal CHLs (Veileder for etablering av kommunale Frisklivssentraler) - GMC

Health talk 1(Helsesamtale1) – HT1 The introductory consultation at the CHL

Health talk 2 (Helsesamtale2) – HT2 The follow-up consultation at the CHL

Healthy living prescription (Frisklivsresepten) – HLP The prescription used in the program

New Public Management – NPM

Norwegian Kroner – NOK

Norwegian labor and welfare administration (NAV) - NWA

PHYAC - FYSAK

Research question - RQ

The Norwegian Directorate of Health (Helsedirektoratet) – NDH

World health organization – WHO

Yellow prescription (Gul resept) – The original name of the Healthy living prescription

1.0 Introduction

1.1 Lifestyle diseases – a global and national challenge

According to the World Health Organization (WHO), non-communicable diseases are the leading cause of death around the world and pose the greatest threat to health in our time (Caldwell, 2011). In the Global burden of disease, a report released in December 2012 the authors state that tobacco-smoking, a deficient diet, overweight and lack of physical activity are what reduce the quality of life to most people in the world (Solbraa, 2013). Norway is not an exception, 80 percent of deaths that happen each year are related to so-called *lifestyle diseases*; conditions that are related to, or a result of pattern of behavior of Norwegians (Supernature , 2012). The most general lifestyle diseases are diabetes type two, high blood pressure, heart- and cardiovascular diseases, stroke, certain types of cancer, depression, osteoarthritis and HIV/AIDS (Norsk Helseinformatikk, 2012).

A major risk factor for lifestyle diseases is overweight. Since 1980, occurrences of obesity have more than doubled, and 65 percent of the world's population lives in countries where overweight kills more people than what underweight does (WHO 2. , 2012). The WHO calls it a global epidemic or "globesity" (WHO 1. , 2012). In Norway, 25 percent of the population at the age of 16 and older is overweight (SSB 2. , 2009). Average weight has increased in all age groups since 1970, more specifically: 6, 5 kilos among men and 5, 5 kilos among women since 1985 (FHI, 2011).

At the same time, another challenge is rising accordingly; social inequalities in health. While most people have improved their health status over the past 30 years, the improvement is not distributed proportionally across the world's population. Those who already were at a relatively high level of health have progressed more than those who initially were at a lower level. As a result, social differences in health have accumulated. Several studies show that health status is related to income, and that people with a higher income are less likely to develop lifestyle diseases. A study performed in Norway reveals that there are more overweight people on the east side of Oslo, than on the west side (Average income on the west side is higher than on the east side) (FHI, 2012).

These facts indicate that low income groups are more susceptible for overweight. Hence, they also have a higher risk of heart– and cardiovascular disease, diabetes and other diseases related to overweight (Sund & Krokstad, 2005).

1.2 Centers for healthy living –from local initiative to national policy

On April 9th 2013, the King and the Queen visited the Municipality of Modum and met two users of the CHL. The users shared testimonies of how the center has assisted them in changing their lives (Frisklivssentralen 1. , 2013). Two weeks later the King signed the governments white paper on public health (Report No. 34, 2013, to the Parliament: The Public Health Report) (Folkehelsemeldingen). The report has the subtitle "Good health - shared responsibility". One of the main strategies of the report is to "mobilize through public health efforts in order to combat social inequalities" (HOD 1. , 2013). In order to achieve this, the state would take several small measures such as arrange campaigns for physical activity, mark calories on restaurant menus, improve biking trails and establish *Centers for healthy living* (CHLs) (Hornburg, 2013, p. 3) (HOD, 2013).

A CHL is by definition a center of competence for guidance and follow-up within three main areas, namely physical, mental and social health. Its primary focus is on physical activity, nutrition and tobacco-smoking. It assists people in how to change their lifestyles in order to improve their health, and find ways to cope with physical and mental illnesses. They offer a variety of activities and courses for individuals, groups or local enterprises (Helsedirektoratet 1. 2011).

Furthermore, they are a preventive service targeting people at risk of developing lifestyle diseases, or that already have developed one. They have low out-of-pocket payments and recruit people with lower income (Helsedirektoratet 1. 2011). Thus, they target the two impending challenges mentioned above; the increase of lifestyle diseases, and social inequalities in health.

The first CHL in Norway was established in 1996, and today there are 150 centers around the country (Helsedirektoratet 1. , 2012). In 2011, the Minister of Health, Anne-Grete Strøm-Erichsen, used the CHL in Modum as the site for media presentation of the "Cooperation reform", which was the biggest health reform of the Stoltenberg II Government. This event showed how much emphasis Norwegian health administration now laid on health promotion (Frisklivssentralen, 2012). The Minister of Health promises to provide financial support to CHL in the so-called revised national budget, presented to Parliament in May 2013 (Finansdepartementet, 2013, p. 86). Obviously, CHLs are going to become a cornerstone in the new public health policies of Norway.

Why did this happen? This is the topic of discussion in this thesis. I will elaborate on the theory and state the research questions (RQ) in the following chapter.

2.0 Theory and Research question

2.1 New institutionalism – the myth perspective

In the late seventies scholars started to recognize that organizational structure often stems from ideas and reforms in the social landscape that surrounds an organization (Sahlin & Wedlin, 2008). This stirred a new orientation in organizational theory that emphasized the effect of heterogenic institutional forces such as law, public opinion, knowledge and norms on the structure and development of an organization. Contrary to former hypotheses offered through instrumental or institutional theories that argued that rational decision makers or culture within a unit is determining its development. Organizations can be defined as "open systems that are coalitions of interest groups highly influenced by their environments" (Scott, 1992, p. 26).

New institutionalism stresses that organizations are located in a social and political context, which influences and confronts them because they constantly have to respond to the development of norms and values in society in order to meet expectations. Parsons was the first scholar to propose that organizations have to operate efficiently as well as be progressive and renew itself in order to obtain legitimacy from its surroundings (Røvik, 2007). Meyer and Rowan added to this theorem by contending that organizations need to appear modern to receive acceptance (DiMaggio & Powell, 1991).

However, what is considered to be modern is inconsistent and driven by myths; "popular belief or tradition that has grown up around something or someone; especially: one embodying the ideals and institutions of a society or segment of society" (Merriam-Webster, Myth, 2013). Myths are generic ideas or perceptions in society about how something should be. When it becomes a common conception that an idea, a strategy or a concept is the rational approach it has become a myth. It is according to the "logic of appropriateness", the natural and obvious thing to do (March & Olsen, 1989). It is institutionalized and taken for granted as a recipe for how to accomplish a certain goal, and turns into a behavioral model for others. It will often be adopted almost without questioning because it appears rational, even though it may not be scientifically proven (Røvik, 2007).

In organizational theory, ideas that have become myths will often be referred to as the most efficient option, the one "that works best in real life", and be a symbol of progress and

modernity. They will often be adopted by politicians or other influential people, whom will enforce implementation and rapid standardization. In sum, when something is perceived as being modern it has turned into a myth which determines the development of organizations (Røvik, 2007).

2.2 The popularity curve: Abrahamson's theory

Myths that are short lived can also be understood as trends; here defined as; "the temporal and social logics of processes of adoption" (Sahlin & Wedlin, 2008, p. 222). Since the beginning of the 1980s there has been a surge of ideas that have been exported from the private to the public sector. New Public Management (NPM) is a collective description of the divergence of concepts providing recipes on "how to" modernize management, leadership and structure. Some examples of management fashions are "Total Quality Management", "Business process reengineering", and "Lean Production" (Christensen et al. 2004).

Many of the ideas that have come during the NPM "ear" were short lived; they were implemented and replaced by new ones in a short matter of time. Accordingly, there has been a relative increase in the number of organizations, which has strengthened the competition between them and intensified the demand for ideas. Globalization has also brought the international community together and created what can be described as a global market. This is enforced by advancement in communication and technology which has reduced the impact of physical distance (Røvik, 2007).

These observations laid the foundations for the emergence of a specific orientation within new institutionalism; the Fashion perspective. Organizational ideas are quickly replaced by new ones because they are driven by trends, similar to other fashions. - "A management fashion is a relatively transitory collective belief, disseminated by fashion setters that a management technique leads to rational management progress" (Røvik, 2007, p. 31). Abrahamson, an influential scholar within the Fashion perspective, introduced the idea in the 1990s. He proposed that organizational ideas go through a cycle that can be separated into five stages (Røvik, 2007).

In "Modern Organizations" Røvik, a prominent Norwegian scholar has characterized the different stages. The first is the beginning phase; the *creation*, when someone comes up with an idea or rediscovers an old idea. The second stage is where the *selection* takes place. There

is often a cluster of different ideas within the same field that are hybrids of each other. They are tested and tried before one "wins" the competition, and is selected (Røvik, 1998).

Then, the cycle reaches its third stage, the *adaptation* stage. In this stage the idea is improved, shaped and adjusted to fit various surroundings, and eventually conceptualized in order for it to be transported into other settings. This is when the idea becomes institutionalized and turns into a myth; the rational thing to do. This kick starts the fourth stage, called the *spread*. This is when the idea travels to new actors, units, organizations, regions, nations etc. This can happen through the media, the press, management books and readings for professional groups. The magnitude and the speed of the spread depend on the level of legitimacy of the idea and to what degree it is institutionalized. The latter denotes the success of the idea. If it becomes popular and starts to attract attention it can spread like wildfire around the world in a very short time (Røvik, 1998).

Yet, the spread is also what leads to the fifth stage, the *de-institutionalization* stage. This stage represents the downfall of the idea. When it is used in a variety of settings it loses its exclusivity and newness, and the demand for it starts to decline. A new idea will enter that will seem more modern and make the other one appear old and like "yesterday's news". It will quickly replace the former idea, and become the new trend. Thus, the idea is de-institutionalized just as fast as it was implemented (Røvik, 1998).

The time span of a cycle can vary between a few months and up to a century or even several centuries. Some argue that when an idea is institutionalized and standardized and the third stage lasts for a century it is not a fashion. However, according to scholars within the Fashion perspective every idea goes through this pattern, and will eventually be replaced by another (Røvik, 2007).

2.3 Trend characteristics: Røvik's arguments

Numerous ideas are introduced each year, nevertheless only a few end up as "hits". Most of them have a very short and temporal effect, which in the literature is referred to as fads - "A fashion that is taken up with great enthusiasm for a brief period of time; a craze" (FreeDictionary, 2013). Fashions, on the other hand have a longer and wider impact. In "Modern Organizations", Røvik presents seven characteristics that are likely to increase the probability that an idea will turn into a fashion.

The first aspect is social authorization. The new idea is legitimized by certain actors who transport the ideas (Sahlin & Wedlin, 2008). It is connected to something that has achieved great success; a big company, a well-known business person, or someone that people want to follow. The basic information that follows the concept is also fueled with success stories of people or firms that have implemented it. The second characteristic is theorization; its effect is scientifically proven. Or at least, it claims to be founded on theories based on a causal relationship. Hence, it is supposed to have universal value and to yield the same effect anywhere, given it is implemented correctly. It is contextually independent and can work "anywhere, at any time under any circumstances" (Røvik, 1998).

The third aspect is conceptualization. This signifies that the idea is turned into a product. It is presented as a commodity that can be bought and attained, and portrayed as a package solution with its own terminology and features. The product (idea) is tangible, accessible and user-friendly, and it is clearly evident to possible users that it is worth the cost and effort to implement it. The fourth aspect is timing. This signifies that the idea is introduced at the right time. It appears as if it is today's modern response; that it is new and future oriented. Simultaneously, it makes existing ideas look old and outdated. The next feature is harmonizing. This feature tells us that the idea has become neutral. It does not offense strong interest groups or show favorites. It now seems as if no one has a hidden agenda for, or personal interest in the idea. It is put forth as if it will benefit everybody (Røvik, 1998).

The sixth aspect is dramatizing. This aspect says that the idea represents a compelling story. The presentation of how it was invented and established is told in a dramatic manner, often one that concentrates around events that involve conflict, deadlines and financial insecurity. The story will sometimes follow a narrative about a person or group who had to fight against competing and existing ideas that were highly regarded in society, but are now outdated. The narrative will eventually resolve in a turning point where the "right" idea finally wins. The gripping account will evoke emotion, compassion and engage those who hear it. The final characteristic that Røvik underlines is individualization. This aspect tells that the idea benefits the individual. It reforms and develops the organization, but now it is also emphasized how beneficial it is for the individual. It can offer everyone something, and improve and enhance everyone's fortune (Røvik, 1998).

2.4 Isomorphism: DiMaggio and Powell's theory

Another observation that was made after the 1980s and the "ear" of NPM, was that organizations were becoming structurally homogeneous. Scholars like DiMaggio and Powell, two highly acknowledged researchers within new institutionalism, proposed that units in different geographic locations and sectors become increasingly complex and similar because they implement the same elements, which in turn leads to new proto types and universal models (Røvik, 2007). They describe homogeneity through the term isomorphism: "a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions" (Dimaggio & Powell, 1983, p. 149). Isomorphism can be explained as objects that resemble one another even though they have different ancestry because of convergence (Merriam-Webster, 2013). They are similar because they meet the same set of norms and expectations (Dimaggio & Powell, 1983).

In «Iron Cage revisited» DiMaggio and Powell introduce a framework to explain why isomorphism occurs (why organizations institutionalize the same elements), and how one can distinguish between three mechanisms that influence this. The first mechanism is a coercive one: "Formal and informal pressures" compel units to choose particular strategies (Dimaggio & Powell, 1983, p. 150)". This can be the law, rules, politicians or other influential people whose recognition and support an element is dependent upon. In a study, Zucker and Tolbert found that when influential people in society or departments of the state require a certain procedure or way of structuring things, it is often integrated rapidly. They claim that such influential people and the use of law increase the legitimacy of a particular regulation (organizational innovation) and in turn, the pace and extent to which it is implemented (Zucker, 1983) (Dimaggio & Powell, 1983).

The second mechanism is normative; norms and values within professional groups drive change. An idea or strategy inherits legitimacy through moral authorization. An example from the Health Care sector is Evidence Based Medicine; "a method of improving service procedures" (Coggan, 2004). It was initiated by epidemiologists at Mac Masters University in Canada in 1990, and has grown to become an international and authoritative standard in medicine. Influential also in other disciplines (Donald, 2002).

The third mechanism is mimetic; units copy those who are considered to be successful. DiMaggio and Powell argue that the presence of uncertainty drives units to copy one another because they do not know how to tackle a problem or what the best strategy is. Thus, they will

look to an organization that seems to be successful and attempt to copy its strategy. Being successful is determined by culturally supported standards about what is considered to be modern (Dimaggio & Powell, 1983).

The Swedish social scientist Sahlin, distinguishes between three types of imitation; chain, broadcasting and mediation. In a chain model, the spread of an idea goes from one unit to another. Just like the game «Whisper» that children play. Here one person whispers something to the one sitting next to him, and then he whispers what he heard to the next child and so on. In the broadcasting mode, everyone copies the same model, which then serves as a proto type for the others. And thirdly, under mediation, an idea is transported by actors that do not use or implement the idea themselves, and do not even have any particular interest in it themselves. The broadcasters are referred to as *carriers* in the literature. Some examples are the media, researchers or international organizations. Sahlin claims that these actors are likely to affect the idea, and therefore refers to them as *editors* (Sahlin & Wedlin, 2008).

2.5 Translation and Decoupling

A common term in new institutionalism is diffusion; “Something diffuses from a center to a periphery” (Brunson, 1997, p. 309). Brunson uses the example of an infection: Units are likely to become infected as they are in contact with “the center of contagion”, meaning that units are likely to adopt strategies from other units they relate to. Diffusion is a process where similarities arise, and is therefore used as a tool to explain homogeneity when ideas are implemented in new contexts (Brunson, 1997, p. 309).

Sahlin, on the other hand, argues that ideas are subject to change as they are passed on from one unit to another. She refers to this process as translation; an active and dynamic process, where development, reshaping and adaptation follow as the idea is implemented into a different setting. Ideas are non-material, contrary to physical objects where the form is set; henceforth, they are easily influenced and likely to change as they are transmitted (Sahlin & Wedlin, 2008).

The study of how ideas develop as they are passed on has been widely discussed in new institutionalism. One particular theory which has received attention is the theory of “decoupling of formal policies from daily practices in an organization’s internal technical core” (Meyer & Rowan, 1977). It refers to a situation where a strategy is implemented at a superficial, general level, but without really affecting the running operation of an organization

(Røvik, 1998). It is based on the observation that "organizations adopt(ed) policies to conform to external expectations regarding formally stated goals and operational procedures, but in practice do (did) not markedly change their behavior" (Scott, 2008).

DiMaggio and Powell argue that organizations face contradictory demands; efficiency and modernity. That they will adopt strategies at a superficial level in order to maintain legitimacy from the surroundings and appear responsive to rationalized myths. Meyer and Rowan claim that organizations deliberately adopt strategies decoupled from the running operation as a formal policy in order to say that they have adopted the strategy (Røvik, 1998). When an idea is integrated at the top level, yet disassociated from practice, it can be incorporated and replaced relatively fast; thus, decoupling is used by observers as a tool to explain how and why ideas are able to circulate and sweep across the globe in such a short manner of time (Meyer & Rowan, 1977) (Røvik, 2007).

Nevertheless, Sahlin argues that since the beginning of the 21st century the focus of discussion has "turned from why and how ideas circulate to what kinds of ideas that circulate, and how the nature of them changes" (Sahlin & Wedlin, 2008, p. 22), which she refers to as a move from proto types to templates. By proto types she means models or examples that are imitated and integrated by others, while templates are frames or targets for how to assess and evaluate practice. Templates are often used as benchmarks to compare and measure success. She asserts that translation and decoupling still takes place, but rather with templates than with proto types (Sahlin & Wedlin, 2008).

2.6 Organizational field

Ideas or templates circulate in an *organizational field*. This is a common concept in new institutionalism, and can be defined as "structured spaces of positions (or posts) whose properties depend on their position within these spaces and which can be analyzed independently of the characteristics of their occupants (which are partly determined by them)" (Bourdieu, 1993, p. 72). According to Sahlin, a field consists of groups of organizations that have activities that are defined in similar ways, while Powell claims that it is a community of organizations that are connected due to certain activities, including consumers, producers, overseers, advisors (DiMaggio & Powell, 1991). They often share a relational and cultural membership and are under the same "reputational and regulatory pressure" (DiMaggio & Powell, 1991, p.3) DiMaggio and Powell distinguishes between a few elements that are necessary to form a field:

1. An increase in the amount of interaction among organizations within a field

2. The emergence of well-defined patterns of hierarchy and coalition

3. An upsurge in the information load with which the members of a field must contend.

4. The development of mutual awareness among participants that they are involved in a common enterprise (DiMaggio & Powell, 1991, p. 3).

2.7 Research question

The CHL can be an example of an organizational idea. It is a center of competence to prevent lifestyle diseases and promote health. It is a form of structuring and organizing a certain type of health care service. It has had rapid growth over the past decade, is relatively new in the Norwegian context, and can be said to be "in tune" with demands in society. In this thesis I will direct my attention to the development of the CHL as an organizational idea, and analyze it in light of new institutional theory. My aim is to study to what degree the CHLs can be said to represent a trend, and how it has been passed on to new settings. I will also discuss what mechanisms seem to have influenced both of these processes. The range of events which have shaped the development of the CHLs is too large to be properly analyzed within the scope of this paper; therefore, I will limit my attention to the most significant ones.

1. In what ways does the development of the CHLs fit into the pattern of the popularity curve discussed by Abrahamson and follow the trend criteria discussed by Røvik?
2. According to the theory offered by Sahlin regarding translation; how has the CHL developed as an organizational idea as it has been implemented in different settings?
3. Based on the theory offered by DiMaggio and Powell about isomorphism, what mechanisms seem to be influencing its development; coercive, normative or mimetic?

3.0 Method

3.1 Case study

I have chosen to perform a case study of the CHL. In this context this refers to a research method where a particular matter, individual or group is investigated and analyzed in-depth. It provides the researcher with the opportunity to focus on a specific area that may be of certain interest or actuality. The aim of a case study is to find the answer to a research question, and use the results to illustrate an example that can be applied in a different context. The researcher often relies on former research, and attempts to investigate the why and the how behind theoretical concepts. In a case study, the researcher should take an observational role and try to approach the case holistically; i.e., analyze the study object from different angles and perspectives. Case studies can have a single or multiple study design. A single study follows a subject or a group, whereas the multiple designs match similar cases trying to find the same results (NCTI, 2013).

The advantage of case studies is that they provide exhaustive insight and knowledge about a particular phenomenon. They allow the researcher to look at details and detect what mechanisms are influencing the study object. Hence, case studies often have strong internal validity; they show what intervention or program is causing the change, and detects causal relations (Trochim, 2006). On the other hand, researchers tend to choose cases that are outliers or abnormalities, and do not represent the majority. They tend to have poor external validity; results cannot be transferred to a different context or be generalized to a wider population (NCTI, 2013).

Finally, case studies can take on three forms; qualitative or quantitative study design, or a combination of both: mixed methods (NCTI, 2013). Qualitative research is used to explore an object in “all” its details; it studies an event closely hoping to get accurate information, information that may reveal a causal relation. Common ways of collecting data for qualitative research is through interviews, observation or triads. The advantage of a qualitative study design is that it provides extensive insight and detail. High accuracy increases the probability that it will reveal what mechanisms are at work; henceforth, it tends to have strong internal validity. Though, as mentioned, this comes at a cost – it will often jeopardize the external validity of the results (Mora, 2010).

Quantitative research, on the other hand, tries to quantify the prevalence or frequency of an intervention or an event in a population. The aim is to draw conclusions that can be applied in a wider context. They may not capture nuances; however results are designed to be generalizable and therefore tend to have strong external validity. Figures are often gathered through audits or surveys through the Internet or on paper (Mora, 2010).

The combination of the two; mixed methods, or triangulation, seeks the better of two worlds; depth and generalizable results; internal and external validity. The motivation for using mixed methods is that results often will complement each other and provide a more holistic picture. Nevertheless, mixed methods are more complex and demand that the researcher master both study designs. The challenge is to find an appropriate dynamic between the two and make sure different angles are targeted evenly (Burton, 2009).

3.2 Document studies and graphs

The thesis is divided into three parts. In the first part (chapter four), I discuss in what ways the development of the CHLs fit into the pattern of the popularity curve discussed by Abrahamson, and follow the trend criteria discussed by Røvik (ref. RQ1). In the second part (chapter five), I direct my attention towards how the CHLs have developed as they have been passed on to new municipalities (ref. RQ2). Finally, in the third part, I discuss what mechanisms seem to be influencing its development; coercive, normative and mimetic? This is according to the theory offered by DiMaggio and Powell about isomorphism (ref. RQ3). I have performed a case study using mixed methods; qualitative in the first part and quantitative in the second part. The third part is based upon both of these two analyses.

In order to get qualitative data I have done document studies; content analysis of relevant literature. In this method the researcher systematically goes through relevant articles, reports, books, journals etc. in order to find trends, correlations or causal paths. Document analysis mainly takes on two forms; case study or content analysis. The first follows a specific field within a given time frame. The other studies the document itself, and focuses on the content. Some of the advantages of document studies are that they can provide information about people who are inaccessible, there is no reactivity, sample size can be big for a low cost, and they are easy to replicate (Stocks, 1999).

There is, however, in these types of studies, a risk of bias; systematic unevenness. If one perspective or point of view is over- or underrepresented there is a form of bias, or error. One

example of this is selection bias, that is, unevenness in the sample; another is bias in the analysis, i.e. error in the coding of the material (Stocks, 1999).

Furthermore, documents can be distinguished between primary and secondary sources. Primary documents are original documents, self-reports or eyewitness reports, while secondary documents are republications derived from primary sources. Primary sources tend to be more exact and rigorous, nonetheless they may be hard to retrieve and they may even be incomplete. Then again, secondary sources are generally more accessible, yet more inclined to be inaccurate (Stocks, 1999).

I have done a document study using primary sources. I have been given access to original papers, articles and applications that were written during the beginning stages of the first CHL. Furthermore, I have used documents from the Norwegian Directorate of Health (NDH) to get the "date of birth" of centers in Norway (Appendix 1 point 9.1). Several publications from the Parliament and other individual reports have also contributed to the analysis.

I have used Norwegian documents, and have therefore been granted a unique opportunity to analyze original documents. Clearly, this contributes to the quality and reliability of the research. Still, the risk of selection bias is present as sources are mainly derived from people who currently work with, represent, or have been associated with the CHL. Their opinion or point of view may be reflected in the material. Thus, there may be unevenness in the analysis despite attempts to observe them objectively.

As part of the analysis I have constructed several graphs; "visual representation(s) of the relations between certain quantities" (Graph, 2013). Graphs display extensive amounts of information in ways that are easy to read, comprehensible and appealing. Yet, they risk being too simplistic or overemphasize the impact of certain trends (WHA, 2012). I have constructed a graph showing the accumulated number of new establishments of CHLs between 1996 and 2012 (Figure 1); data originate from Appendix 1, point 9.1. The same graph has been used to show the transitions of Abrahamson's popularity curve (Figure 3), and a comparison with the development of training centers (Figure 4). It should be noted that Appendix 1 does not contain the year of establishment for all of the centers that have been started between 1996 and 2012. I succeeded in finding this information for some of the CHLs on their official web pages, however not for all. I have not included the latter centers in the material. Thus, the total number of CHLs in the graphs (124) is lower than the number that is presented in the text (150). The 26 centers (150-124= 26) that are not included in the graph are likely to have

affected the shape of the graph, for example by making it steeper. However, this cannot be proven. Regarding training centers, figures are taken from a report performed by Kvarud Analysis for Virke and an article in Dagbladet (Virke, 2012) (Dagbladet, 2009).

3.3 Analysis 2: Questionnaire

The quantitative method I have used is to have a group of respondents fill out a questionnaire. Questionnaires can be distributed through the mail, the Internet, over the phone or in person. Questionnaires are inexpensive, easily replicable, and reach many actors at the same time. Nonetheless, it can be a challenge to pose questions in a manner that is comprehensible. Prefixed answers may be phrased in a way that do not capture relevant elements or overemphasize some factors. It can also be difficult to find questions that apply to all of the respondents (Hellevik, 2011).

I have sent out questionnaires to 30 CHLs in Buskerud and Nordland in my attempt to reveal variation between centers. There are about 150 centers in Norway, however many of them have recently been established and are fairly small. The first CHL that was started, and which still exists, is in Buskerud, and the majority of the more established centers are situated here and in Nordland (Helsedirektoratet 1. , 2012). Therefore, I chose to strategically sample these two regions for my questionnaire, based on the assumption that they were more stable than the most recent establishments, and would portray a more concise picture of how centers actually function. I also thought the probability was higher that they had information, resources and capacity to respond to the questionnaire compared to other centers.

The aim of my questionnaire was to get insight into how the CHL idea has been passed on to different settings, and explore any variation or sign of decoupling. In order to study this I organized my questions into seven categories.

1. Organization: Including questions regarding when the center was established, its name, size of the population (in the municipality), organizational position in the municipality, the length of the project (permanent/trial), size of its budget, if it was cooperating with other municipalities and what actor took the initiative to start the center.

2. Employment and possible other participants: who works at the center, and man-years.

3. Referrals: who writes prescriptions and for what reasons; how many are referred, how many have health talk 1(HT1) and health talk 2 (HT2). Health talks are consultations held at

the CHL. They start their program with an opening consultation (HT1), followed up by a training period and concluded with a follow-up consultation (HT2). What the talks represent will be further elaborated later (point 4.2.3). I also asked about how many repeat the program.

4. Activities and courses arranged by the CHL: what activities/courses the center arranges and how often. Here I also included ascribed characteristics of the participants, such as gender and age.

5. Cooperation partners: who the center cooperates with, regarding what activity and what type of collaboration (length).

6. Social status of the participants: education or current occupation.

7. Success factors for the CHL: how it functions/not functions and why, what criteria are considered important for it to run well, and what the respondent would highlight if he/she was to start a center today.

The questionnaire is attached in Appendix 3, point 9.3.

I received a list of addresses from the regional leaders of the CHLs in the two regions, and distributed all of the questionnaires by email, except for one that was conducted over the phone. For explanation of the methods I have used in organizing and handling the responses, see Appendix 4, point 9.4.

The strength of this questionnaire is that it provides explicit and hands-on information. Respondents currently work at centers and have firsthand knowledge about what they do, who their users are and what they struggle with. They are relevant and reliable informants. This offers the opportunity to perform a comparative analysis between CHLs. The response rate was 70 percent (21/30) which is equal to 14 percent of all of the CHLs in Norway (Helsedirektoratet 1. , 2012). Thus, it renders information about a substantial amount of centers.

On the other hand, it should be noted that 30 percent did not respond. Several wrote back that they did not have the capacity to respond, or the necessary information to do so. A few also replied partially and skipped one or more questions or categories of questions. It seems likely that there is smaller centers are underrepresented. One could argue that my questions were too general and not made sufficiently relevant to all of the CHLs. Furthermore, some questions were not formulated clearly enough. One example is: “What is the size of your budget”,

where responses varied greatly in form and detail. It was not possible to compare responses because of the inconsistency of the data. If the question had been formulated/ phrased differently it is likely to have yielded information that may have contributed to the analysis.

4.0 How has the CHLs developed?

I start this chapter by giving an account of how the CHLs started, before I move on to what they are and what they do. Then, I describe the development in the number of CHLs in Norway until 2012. In this section I have included a few events that I consider to be relevant to their dispersion.

Then, I discuss the story in light of the theoretic framework offered by Abrahamson and Røvik. My aim is to analyze to what degree the CHLs can be characterized as a trend or organizational fashion (ref. RQ1). I will first discuss whether the development of the CHLs seems to fit into the pattern of the popularity curve described by Abrahamson, and try to distinguish between its different stages. Then, discuss the trend criteria presented by Røvik.

4.1 The story of CHLs

In 1995 the municipality of Modum was faced with an impending challenge. Sick pay per person was fourteen percent higher than the country as a whole. Nationally, the cost per capita was about 279 Norwegian kroner (NOK) on average, in the region of Buskerud it was peaking 290 NOK per capita, and in Modum it was strikingly 319 NOK per capita, adding up to 10 million per year (Kaggestad, 1996). The percentage of the population on sick leave was significantly higher in Modum than in other places. Accordingly, the primary health care sector and sports foundations reported a downward sloping trend on people's activity level and physical shape (Kaggestad, 2013).

The statistics were a concern to the administration in the municipality (Stenbro & Killingstad, 1999). Johan Kaggestad, the former trainer of several Norwegians athletes and the current commentator for the Tour the France, was the head of the department of Culture in Modum at the time (Kaggestad, 2013). He was determined to do something about the situation and inspired by "Friskvårds" in Sweden and the newly established CHL in the municipality of Stange. He took the initiative to start a similar project in Modum. Kaggestad formed a group that started to work on creating a CHL. It consisted of an economist who also was a consultant in the Service for Work Life (Arbeidslivstjenesten), the head of the department of Social Security (Trygdeetaten) in Modum and a community doctor. The CHL in Stange contributed with assistance and advice during the starting process (Stenbro & Killingstad, 1999).

It took quite a lot of effort to put the idea into practice, and in the fall of 1995 the group finished setting up the financial plan and formulating the organizational framework. Funding would come through the department of Social Security in Modum (Trygdeetaten), the Occupational health care service (Bedriftshelsetjeneste), the regional administration in Buskerud, the Confederation of Norwegian Enterprises (Næringslivets hovedorganisasjon), the department for the Labour Market (Arbeidsmarkedsetaten) and out-of-pocket payment. The department of Social Security made it the condition that they should be formally responsible and the primary employer of the center. The first project leader also was the head of the department of Social Security in Modum. Today, leaders of the CHLs are called Healthy living coordinators, and the positions are often filled by workers with a health care background (Helsedirektoratet 1. 2011).

The first center was separated into two separate (organizational) units; one for the project and another for management. The operative project group consisted of representatives from the head of departments for Social Security and Culture, a community doctor, a consultant and the leader of the CHL. The managerial group consisted of representatives from the Social Security office in the region, the municipality, the National Organization for Employment (Landsorganisasjonen i Norge), the department for the Labour Market, and businesses, doctors, physiotherapists and sports foundations in the municipality. These actors were gathered and involved in order to create a platform for cooperation across different spheres and arenas within public health and preventive work. After this was put into action, the CHL in Modum was officially opened during the spring of 1996 as a three year trial project (Stenbro & Killingstad, 1999).

4.2 Core values and foundational concepts

Before we move on with the story about how the CHLs developed I will briefly present some of the main features of the CHLs.

4.2.1 Core values

Their philosophy is that physical activity improves physical, mental and social health. Physical activity prevents people from developing diseases and chronic illness, and has few side effects as long as it is done in moderate forms. It will improve people's general health condition and quality of life, and in turn reduce sick leave and the need for health care. Furthermore, people tend to enjoy training more when it is experienced as fun, and this will change their attitudes and associations to physical activity (Stenbro & Killingstad, 1999).

When they started in Modum, they formulated specific goals with a three year deadline; curb sick leave by 20 percent, bring down sick pay by 20 percent for local companies and the public sector, and increase the share of people who return to work after longer sick leaves. They also wanted to reduce the number of people feeling excluded from work life when being on sick leave. However, they realized that they were aiming too high, and eventually lowered their ambitions. Instead, they settled for more generic objectives such as; reduce unhealthiness and develop society in a direction where health is more valued (Kaggestad, 1996). Today, the vision of the CHL is to make it easy for people to make good choices regarding their health, and contribute to the building of sound attitudes towards healthy living and the effect of physical activity (Stenbro & Killingstad, 1999).

The CHLs should be so-called *low-threshold* services affordable for people on sick leave or retirement. Thus, fees to enter are low, activities do not demand personal equipment and they rely as much as possible on the local nature. The target group was originally people in the work force (age 20 and up) (Stenbro & Killingstad, 1999). Nonetheless, it has been expanded over the years, and today some CHLs arrange activities for youth and children. In Alstahaug for example, they run a project called “Active school road” which tries to get children more active on their way to and from school (Alstahaug Frisklivssentral).

Activities take place in groups. This is because people tend to push and stimulate each other when training with other people, but also because the fellowship can give a sense of belonging as people get to know each other. In the beginning of a session the instructor is supposed to ask everyone to say their names. This makes the atmosphere including and personal, and turns it into a social arena where people easily can make friends. Social interaction can be extremely valuable for people who are on sick leave or retired and do not interact much with others during their day. In turn, the fellowship itself can motivate people to come (Stenbro & Killingstad, 1999).

The CHL in Modum have developed a model called; “Play makes well”, which is founded on the belief that playing and having fun change how people perceive training and increases their satisfaction. Traditional games such as “Hide-and-seek” are used. They are light, easygoing and often a good laugh. At the same time they demand lots of running and abrupt stops which is good interval training. People tend to forget the training and focus on the game while playing, and they bring the group together and light up the atmosphere. Everyone can participate at their own speed and ability. Hand in hand with the informal and playful

ambience is the absence of competition at the CHLs. People should not train to win but instead to cope with their situation or health status. This is an important distinction to other sports arenas where competition often is essential (Stenbro & Killingstad, 1999).

4.2.2 The "Healthy living" prescription

When they started in Modum, they developed a "Yellow" prescription granting patients follow-up and guidance, and access to activities for eight weeks. Today, the training period is 12 weeks and the prescription is called "Healthy living" (Frisklivsresepten) (HLP) (Bugge, 1997). Attending the CHL does include some out-of-pocket payment. A patient can choose to pay 20 NOK per time, or purchase a "Healthy living membership card" (Frisklivskort). Current prices in Modum are 300 NOK for three months and 700 NOK for six months. People who have been given the prescription receive some discount on the membership card, which also entails rebates at gyms and other cooperation partners (Frisklivssentralen 2. , 2013). Modum has also developed a "Healthy living YOUTH" prescription, for people in the age between six and eighteen needing guidance regarding physical activity or nutrition (Frisklivssentralen 3. , 2013)

An important premise for setting up a prescription was that it would give people something tangible to bring home. It was also considered important that prescriptions were issued by doctors, because patients tend to give much respect to their opinion, and likewise to prescriptions. People may feel more compelled to act when they are issued a prescription. It also brings safety to those working at the CHL and their users knowing that a doctor has written the prescription. Finally, going through doctors is a way to secure that the target group is reached (Båtevik, et.al. 2008). Today, the Norwegian Labor and Welfare Administration (NWA), physiotherapists and other health care professionals also issue the prescription. This extension was granted based on the assumption that it is possible to reach more people when the body of actors making referrals is larger (Båtevik, et.al. 2008).

4.2.3 The program

Most of the users at the CHL are referred by professionals; however some people make contact on their own initiative. In either case, when people call the CHL they are scheduled for an introductory consultation (HT1). This consultation should provide the patient with qualified guidance, and lead to whatever action is necessary within the areas of physical activity, nutrition and tobacco-smoking. The agenda of the HT1 is to identify the person's health status, needs and motivation to change. Health status is examined by testing the clients'

capacity to obtain oxygen and work aerobically. Furthermore, the participants set up a plan for the next 12 weeks with concrete goals they seek to attain. Details on prices, time, frequency of training and location are thoroughly outlined in this plan. Reluctance to change and other potential barriers are acknowledged and discussed (Helsedirektoratet 1. 2011).

The atmosphere to the consultations should be positive, encouraging and motivating. The consultations are run according to a specific technique called “Motivating interview”, which emphasizes the importance of empowering the user. The representative from the CHL should not approach the person from a top-down perspective and provide answers, but rather invigorate the user to initiate and lead decision-making. It is a goal in itself to enable the participant to find reasons why he/she should change lifestyle, and come up with suggestions on how to accomplish this. At the end the follow-up consultation (HT2) is scheduled. In this talk the representative of the CHL and the user analyze the period that has just passed. They evaluate what goals have been achieved and test health status (Helsedirektoratet 1. 2011).

The CHLs have open admission to their training sessions; people can start at any time during a semester. Some centers require that people participate in training arranged by the CHL during their twelve week period, while this is not obligatory in other places. Most centers cooperate with other associations, such as regular gyms and schedule sessions with them as part of the period. The intention is to make people familiar with opportunities and facilities because this raises the likelihood that they will continue with training once the program is over (Helsedirektoratet 1. 2011).

However, the CHL arranges a wide span of different activities themselves; interval training, walks, swimming, hiking, spinning, stretching, senior activities etc. The selection of activities varies greatly between centers. They also arrange courses on how to stop tobacco-smoking, make nutritious food, cooking for other people and handle light depression and mental illnesses. These courses are held occasionally depending on the number of participants and capacity of the center. The price for attending a course is not included in the prescription and is approximately 500 NOK per course (Frisklivssentralen 2. , 2013) (Helsedirektoratet 1. 2011).

4.3 Further development of the CHLs

4.3.1 Discovered by media and ministers

After the establishment in Modum in 1996, the CHL quickly became popular in the local community, and the number of participants grew from 30 to 350 during the first two years. Several other municipalities also gave attention to the project. Information was spread through brochures, at meetings, on the Internet, and by health care personnel and by word of mouth. Aftenposten made an article with the headline: "Training by a Yellow prescription" and TV2 followed shortly by broadcasting a brief reportage about training by prescription. In the article Kaggestad challenged the current Minister of Health, Dagfinn Høybråten, to come and visit the CHL in Modum (Bugge, 1997). And incidentally, he came two years later, accompanied by the Director of the department of National Social Security, Arild Sundberg (Stenbro & Killingstad, 1999).

The CHL in Modum continued to attract attention from different actors as the concept was developed and adjusted to its surroundings. One example being the Norwegian School of Sports Sciences, which in 1999, started to assist the CHL with development and professional teaching of their employees. However, the trial period (1996-1999) was about to run out and the CHL in Modum was living off of savings. They sent an application to the regional administration to get increased funding from the state in order to sustain the project, and to get it anchored at a higher level (Frisklivssentralen, 1999). The administration in Buskerud had taken notice of the attention the CHL in Modum received from other municipalities inside and outside of the region, and knew that it was becoming known as the "Modum Model" (Modum- modellen). Therefore, Buskerud decided to incorporate the CHL into the regional administration in 2000. With Modum it became an important advisor and mainstay for others who wanted to establish a CHL (Stenbro & Killingstad, 1999). Two years later the CHL was made part of the department for Social and Health Care in Modum (Frisklivssentralen , 2012).

4.3.2 Public initiatives: "Prescription for a Healthier Norway" and the "Green prescription"

In 2002, the Norwegian Government ("the Bondevik II Government") released the 16th report to the Parliament called "Prescription for a healthier Norway" (2002-2003). The subject matter was public health, and the main goals were to create more (life) years with high quality, and reduce differences in health in the population. It proposed four main strategies for how to accomplish this: increase people's prerequisites to take responsibility for their own

health, build alliances and infra-structure in public health, prevent more and fix less and base more on experienced-based knowledge (Helsedepartementet, 2003).

In association with this, the Minister of Health, Dagfinn Høybråten introduced the "Green prescription", which provides patients with skilled advice on how to change their lifestyles, and reimburses doctors for investing time in motivating and following up their patients. It is intended to stimulate guidance, and move treatment and prevention of lifestyle diseases away from medicines and expensive treatment, and over to lifestyle changes, for examples changes in diet and physical activity. At first, it was restricted to people with diabetes type two or high blood pressure (Helsedepartementet, 2003). More recently it has been opened up also to people struggling with obesity (Engedal et al. 2008)

4.3.3 Cooperation, networking and research projects

Other projects resembling the CHL were also started in other municipalities and regions. One example is the project introduced in Nordland called PHYAC (FYSAK) (Helseopplysningsutvalget, 2003). It followed the same procedure as the CHL, with health talks, test of physical shape and 12 week training period (Engedal, et al. 2008). The primary distinction was the name (Killingstad, 2013). Several other centers were also established, many received assistance from Buskerud and Modum. Accordingly, coordinators started to communicate and cooperate more within and across regions. Buskerud and Nordland for example started to collaborate more closely during this period. Every region with a CHL, or similar offer, started to hold annual gatherings with representatives from active municipalities. As a result, the NDH set up national meeting places and one day seminars for coordinators. And soon after, coordinators participated at their first Nordic gatherings (Engedal, et al. 2008).

Simultaneously, evaluations of the "Green prescription" were published. Results showed that the prescription was inadequate without an appropriate and organized system to follow-up on patients, and doctors requested places to direct their patients (Helsedirektoratet 1. 2011). The CHL was aiming to intercept people who were falling short of the "Green prescription", or needed guidance regarding their habits and lifestyles (Båtevik, et al. 2008). Hence, in 2004, the NDH entered into an agreement with five regions; Buskerud, Nordland, Oppland, Troms and Vest-Agder, to financially support the development of different low-threshold programs, working with follow-up of patients with lifestyle diseases (Engedal, et al. 2008).

There were thirty-two centers across these regions, differing according to size, organization, funding, association to the municipality, etc. They shared the same goals; however they varied according to several standards. CHLs in Buskerud and PHYACs in Nordland were based upon the "Modum Model". Centers in Troms had trained activity leaders to follow-up "Green prescription" patients. "Vest-Agder had developed a program called "Activity on a prescription". Oppland ran "Physioteck"s, and referred patients through the "Prescription of Oppland" (Båtevik, et al. 2008) (Engedal, et al. 2008).

Four years after the NDH initiated the agreement, "Research of Møre" (Møreforskning) published a report called "A prescription worth fighting for?" They evaluated each program and compared them to one another. They also found evidence indicating that the Healthy living prescription (HLP), in general reached more people than what the "Green prescription" did (Båtevik, et al. 2008). In the years that followed several studies and research projects were performed on the effect of training by prescription (Engedal, et al. 2008).

4.3.4 Public initiatives: "Guidelines for municipal CHLs" and the "Cooperation reform"

Entering 2011, there were about 100 centers across the country, of which 25 had been established during the past year (Kulturdepartementet, 2011-2012) (Appendix 1 point 9.1).

That year the NDH published a report called "Guidelines for municipal CHLs" (Veileder for organisering av kommunale frisklivsentraler) (GMC), regarding establishment and organization of CHLs. In this report they pronounced that CHLs are central in public health work because they offer preventive measures for both individuals and groups, and encourage municipalities to establish centers (Helsedirektoratet 1. 2011).

In the fall of 2011, the CHL in Modum was paid another visit by the Minister of Health, Anne-Grethe Strøm-Erichsen. She presented the 47th Report to the Parliament (2010-2011), the "Cooperation reform" (Samhandlingsreformen), and some new "health laws" at the CHL (Frisklivssentralen, 2012) (HOD, 2012). The mantra of the reform was to "act rather than react", and three main objectives were predominant; prevent more, treat earlier and cooperate better. Patients should be treated locally and as early as possible. Services should be well suited to the individual needs of the patient and coordinated across the different actors. In practice this meant that the responsibility for a number of different health services should be transferred from regions to municipalities. The reform was set into action January 1st 2012 (Helsedirektoratet 1. , 2012).

What also should be mentioned is the 16th Report to the Parliament (2010-2011) "The National plan for health and Caregiving" 2011-2015. It points to the importance of creating services for people with a risk of, or who already have developed a disease related to lifestyle. It argues that it is the responsibility of society to reduce social inequalities and enable people to live lives that are beneficial for their health. Further, it states that municipalities and local communities are the most important arena for working with public health measures (HOD, 2011).

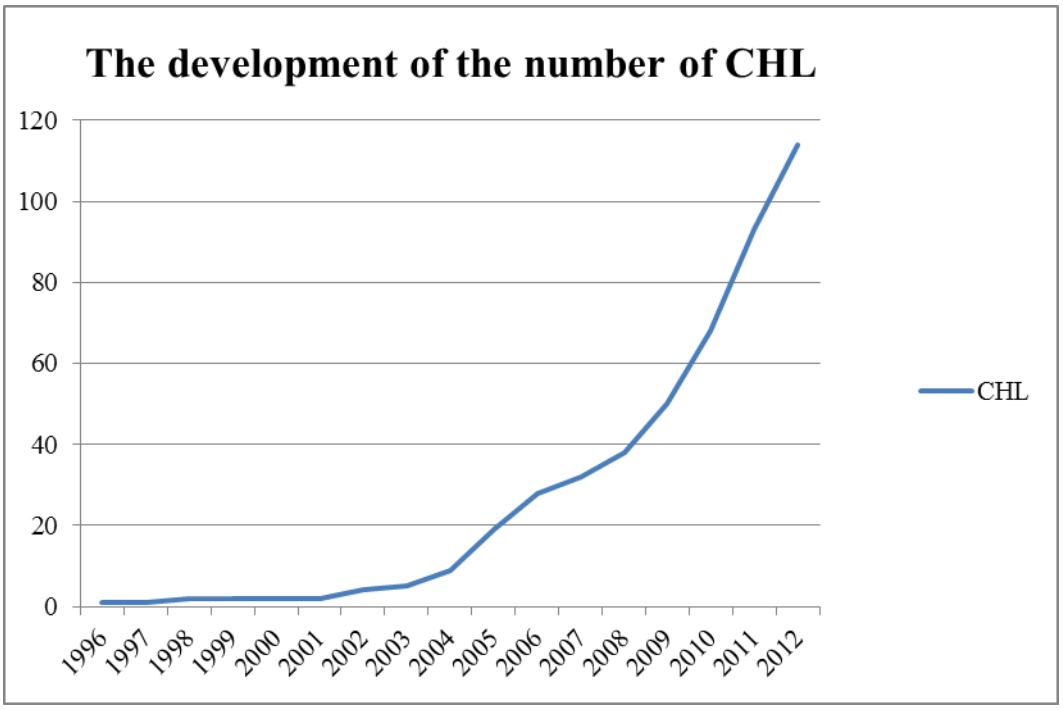

Figure 1

The vertical axis shows the number of centers, and the horizontal axis the time frame. This graph shows the accumulated number of CHLs each year. Figures are derived from Appendix 1, point 9.1.

4.4 Discussion: The CHLs in the popularity curve

In this section I will show to what degree the CHLs seems to fit into the pattern of Abrahamson's popularity curve theory (ref. RQ 1).

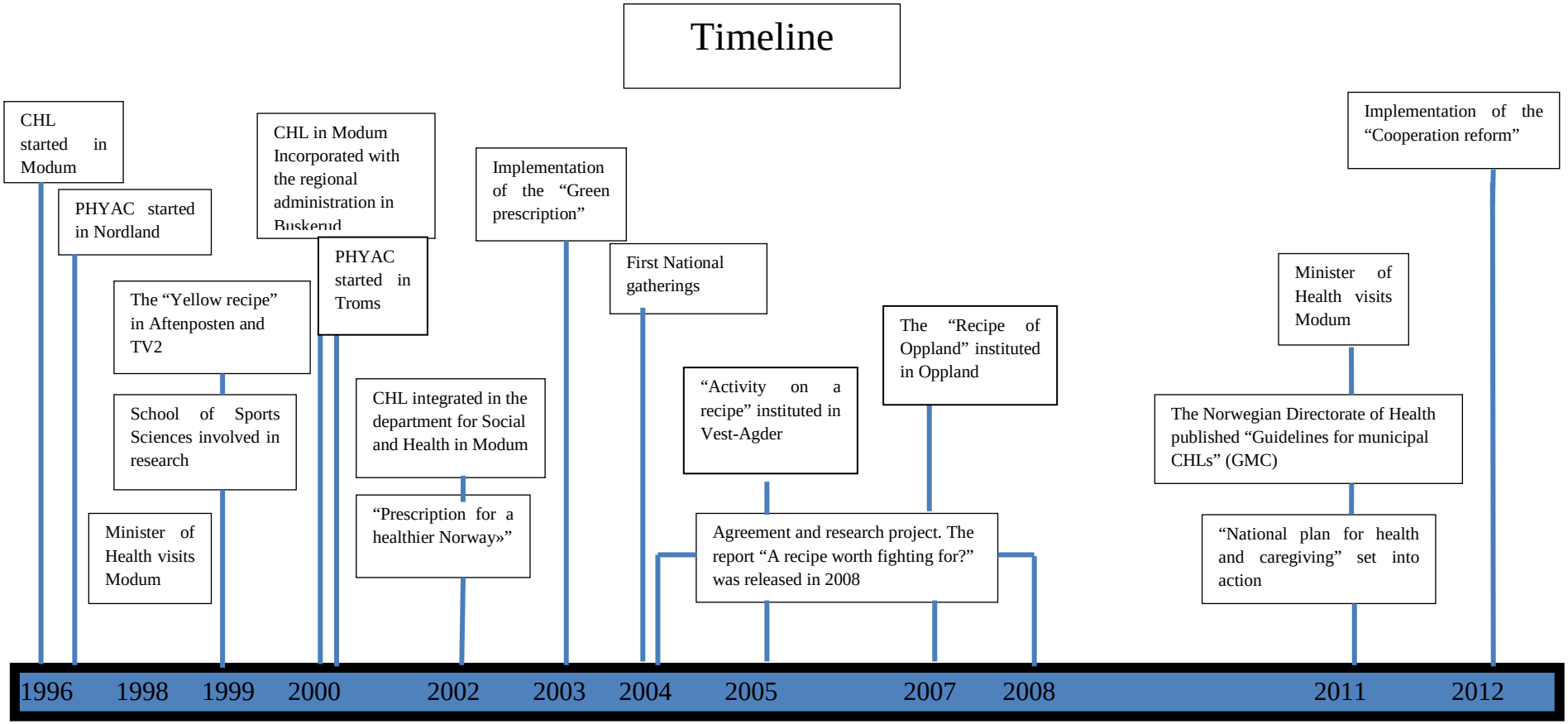

Figure 2

Note: The establishment of PHYAC in Troms, "Activity on a prescription" in West-Agder and the "Prescription of Oppland" are not given in the text and originate from (Engedal, et al. 2008)

This figure shows how the CHLs have developed over time.

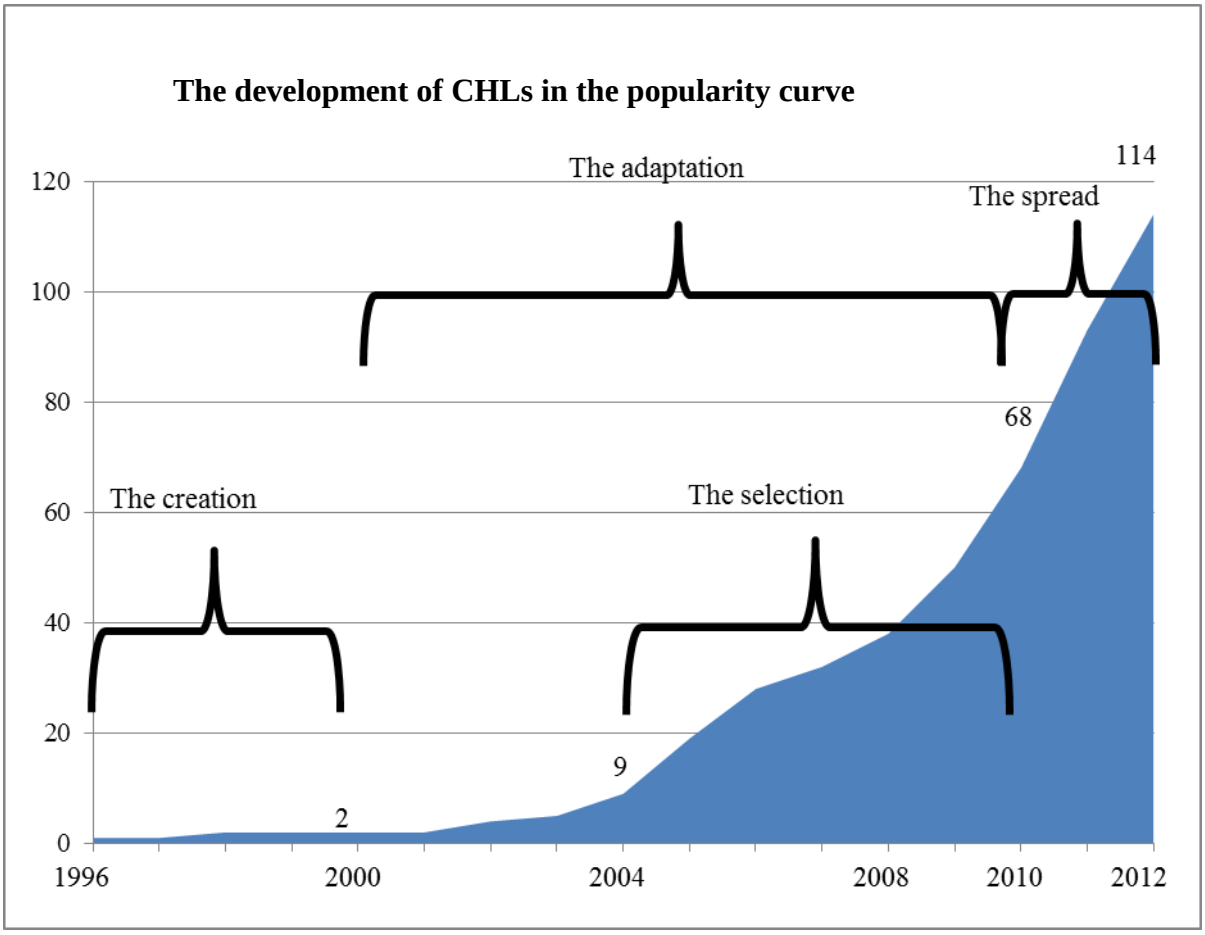

Figure 3

The vertical axis shows the number of centers, and the horizontal axis the time frame. This graph shows the different stages of the popularity curve in regard to the accumulated number of CHLs each year (Figure 1).

4.4.1 The creation

This is the first stage of the cycle, where the idea is invented, formed and set into practice. It seems reasonable to argue that the CHLs entered this stage when the work group was formed in Modum in 1995, and the first center was established the following year. It ended in 2000 when it was incorporated with the regional administration in Buskerud. Both events are shown in the timeline. We have seen that the concept was thoroughly developed, and integrated in the local community, during these years. Hence, it seems likely that the idea experienced a form of creation within this timeframe.

Meanwhile, looking at the timeline we can see that other actors such as the media, the Minister of Health and the Norwegian School of Sport Sciences are getting involved, are to

some extent investing in and showing interest for the center during this period. They are likely to have contributed to the development of the idea, strengthened its reputation and put pressure on the regional administration to incorporate it into their organization. Using Sahlin's assertion about carriers; actors who transport ideas without actually using them themselves. One could suggest that these actors are examples of this because they spread information and bring the idea into new contexts, even though they do not use it themselves. It is also likely that they have effected and developed the idea, which is an example of what Sahlin refers to as editing.

Moving on to the graph (Figure 3) one can see that very few centers were established between 1996 and 2000. By the entrance to this century only two CHLs existed in the whole country; one in Buskerud and one in Nordland (Appendix 1 point 9.1). This illustrates that the idea is being tried out in at a relatively small scale, and supports the argument above that the idea is experiencing the creation in this period.

4.4.2 The selection

At this stage an idea is selected among other similar alternatives, often after a period of testing. A cluster of different ideas that share some of the same characteristics, and which are so-called hybrids of each other, are compared. In our case, several variants of the same basic concept were tested, such as the variant in Troms, "Activity on a prescription" in Vest-Agder and the "Prescription of Oppland" in Oppland. These alternatives have differed according to how they were organized, whether they arranged their own training, length of training period, and whether they do HT1 and HT2 etc. Yet, they have represented more or less the same goals, target groups, values and can be said to operate within the same area of interest. They are an emerging organizational field.

I have suggested that the selection of a concrete model started in 2004, when the NHD entered into an agreement with five active regions to develop and test out the forms in the regions. This agreement led to a research project and the publication of the report "A prescription worth fighting for?" which includes comparisons between the alternatives, and describes differences between them (Båtevik, et al. 2008). Hence, it seems reasonable to argue that the process of selection began when the state entered into the agreement.

As far as the end is concerned one could set it to 2008, when the report from the research project was released. Nevertheless, no idea was declared the "winner" at this time. If we look a bit further we see that in 2011, the Norwegian Directorate of Health (NHD) published the

"Guidelines for municipal CHLs" (GMC), it encourage municipalities to establish a CHL. We may see this as an expression of some kind of selection. It seems likely that the Directorate selected an alternative between the release of the report and the publication of the GMC. That is, at some point between 2008 and 2011. My suggestion is that it happened in 2010. I also assume that it is the Directorate which favored the CHL above the alternatives.

Looking at the graph, one can see that few centers existed in 2004 (9). However, by 2010 there existed 68 centers. There is thus a significant increase in new establishments during these years. This supports our contention that the selection took place around 2010.

4.4.3 The adaptation

The adaptation stage is when an idea is adjusted and shaped to fit its surroundings, and is internalized as a rational myth, and consequently starts to travel. Regarding the transition between this stage and that preceding one, the CHLs do not seem to fit entirely into the pattern of the curve, as illustrated in the graph (Figure 3). The adaptation seems to have started before the selection and end at the same time as this stage. Hence, the idea can be said to have gone through both stages simultaneously rather than successively, as the theory suggests. One reason for this may be that the number of new establishments grows during the selection stage, as just mentioned. Another reason for this is that adaptation seems to have been a drawn-out and unremitting process going from 2000 to 2010.

Looking at the timeline we can see that the CHL in Modum was incorporated with the regional administration in 2000. This led to a further development of the idea and to progressive adjustment to the needs of the most immediate surroundings. Therefore, the beginning has been set to 2000. In the years that follow, we can observe that the CHL in Modum is integrated into the department for Social and Health Care in 2002. This is also likely to have stimulated framing and formulation of the idea.

Furthermore, two events occur soon after; the implementation of the "Prescription for a healthier Norway" and the "Green prescription". They are both likely to have affected the content of adaptation. Both of them emphasize the importance of preventing lifestyle diseases and reducing costs associated with expensive treatment. The "Green prescription" is particularly quintessential as it builds on the same logic as the Healthy living prescription (HLP), and thereby reinforces the idea about training by prescription. The difference between the two prescriptions was that the "Green prescription" was restricted to people with diabetes type two and high blood pressure, while the HLP could be prescribed to people with a

lifestyle disease, or with a risk of developing one. Thus, it regards a wider group in the population. Furthermore, the “Green prescription” could be used to direct people to the CHL; however, this was optional, contrary to the HLP where this is mandatory (Helsedirektoratet 2. , 2011). Being coherent with national guidelines strengthens the position and building of an idea, and increases its legitimacy to its surroundings.

Moving along the timeline we recognize the research project that was commented on in the selection section, and the national conferences that were arranged for the first time in 2004. We know from the story that this was the beginning of a tradition of holding annual regional and national gatherings for the active municipalities. It was also at this time that representatives were sent to Nordic CHL conferences for the first time. National seminars included various sessions for workers at the CHLs on topics such as preventive health care, cooperation partners, becoming part of the municipal health care services etc (Blom, 2013). These new platforms are likely to have influenced the development of the idea.

Continuing along the timeline we can see that the end of adaptation is set to 2010. A few major events take place in 2011; the NDH publishes the GMC, the Minister of Health visits the CHL in Modum and announces the “Cooperation reform”, and the “National plan for Health and Caretaking” is set into action. As discussed earlier the publication of the GMC indicates that the state has committed itself to the CHL model. Additionally, visits performed by the state send clear signals to the public about what the state is concerned with, and how it will prioritize. It shows that the state supports and has great faith in the CHL concept. It also signals that it perceives it to be in line with its strategies, and is modern and future-oriented. Thus, it seems reasonable to argue that adaptation ended before 2011; since evidence suggests that it was internalized by then. Hence, the end has been set to 2010.

The timeframe for this stage can be further confirmed by looking at the graph (Figure 3). Here, we can observe a noteworthy increase in the number of establishments between 2000 and 2010, from two to sixty-eight. This tells us that the idea has started to travel during this period, which it would not have done unless it had been internalized.

4.4.4 The spread

Once an idea has become a rationalized myth and endured adaptation it starts to spread. It travels and moves to new actors, locations, contexts and places where it is rapidly accepted. On the timeline I have suggested that the spread began in 2010, when both the selection and

adaptation processes had ended. I have found it reasonable to assume that the spreading of the idea started at this point since events that occur in 2011 indicate that both the selection and adaptation processes had ended. The end of this stage is set to 2012 in the graph, since our timeframe ends here.

During these two years a few important events take place such as the publication of the GMC and the visit from the Minister of Health to the Modum center. The implication of these (events) has already been (thoroughly) discussed in previous sections. However, the implication of the implementation of the "Cooperation reform" in 2012 has not. The main objectives of the reform were to prevent more, treat earlier and cooperate better. In practice, this meant to move the responsibility of health care from regional to municipal actors, i.e. to the local providers of services (Helsedirektoratet 1. , 2012). The aims line nicely up with the strategic goals and motives of the CHL, namely to assist people at risk of developing lifestyle diseases, or who have already developed such ones.

Turning to the graph (Figure 2), we can note that the number of centers grows rapidly during the entire period (1996 to 2012) Nonetheless; it is evident that this growth intensifies, or some would even say *booms*, around 2010. Over the course of the next two years the number of centers almost doubles from 68 to 114. This supports the argument above that the idea starts the fourth stage, the spreading stage, during this period.

The next stage in the popularity development is the stage of de-institutionalization. Now the new idea becomes the preferred alternative. As the preferred alternative it soon starts to lose its recognition and prominence, and therefore also stops to travel. In a graph this would be expressed through a downward sloping trend. Nevertheless, in this graph this does not seem to be the case; the line is unremittingly pointing upwards. Thus, one can argue that it seems as if the idea has not entered its stage of maturity yet, and that the CHL idea is still in the spreading stage. In the text it was noted that the NDH, on its web pages, currently urges municipalities to establish CHLs. This supports my view that we have not arrived at the stage of deinstitutionalization yet.

4.5 The CHL in light of trend characteristics

In this section I will analyze the CHL in light of the seven traits that Røvik claims often will characterize ideas that become trends (RQ 1).

4.5.1 Social authorization

Social authorization means to what degree an idea is legitimized and transported to others by successful actors. Johan Kaggestad, who initiated the CHL in Modum, is the former trainer of two prominent marathon runners in Norway, and an influential person within training and lifestyle management. He is no longer officially associated with the CHL; however, when he was, his status (as a former trainer) is likely to have increased its recognition. He may also have attracted the media and other actors, such as the Norwegian School of Sports Sciences, to a greater degree than others could have done when it was in its beginning stages.

Furthermore, the two Ministers of Health who have visited Modum (in 1999 and 2011) may also have contributed to its social legitimation. The picture to the left shows the Minister of Health; Anne-Grethe Strøm-Erichsen, while she visits the CHL in Modum in 2011 (Frisklivssentralen, 2012). Such visits attract attention, and will "put the idea on the map" as they rarely go unnoticed by the media. One can often observe that projects will be affiliated with certain politicians after such visits.

To some extent this happened with this project too, at least for some time. One could argue that the CHLs have become symbol politics.

Another feature which influences the process of social authorization is how the content of an idea is treated in policy documents, other documents and mass media stories in the time after the implementation of the idea. A popular idea will often give rise to success stories from centers that have adopted the idea. Brochures, ads and power point presentations of CHLs present stories about users including "witnesses" from individuals who have benefitted from the services of the CHL (Fylkesmannen, 2012). This is illustrated in the brochure that is attached (Appendix 2 point 9.2). Here we find two statements from users that show how they claim the CHL has benefitted them personally. The statements are related at the bottom of the page, written in bold green characters whereas most of the text in the brochure is written in black. The difference in color does not appear as the brochure is presented in this thesis, though. (Frisklivssentraler i Aust-Agder, 2011).

4.5.2 Theorization

Theorization refers to the degree to which an idea rests on theoretical concepts, with a correlation between cause and effect. The causal inference should be recognized and be seen

as an established truth in society. The philosophy behind the CHL is that physical activity has a positive effect on physical, social and mental health, and will be beneficial for people regardless of their health status, whether they are sick or at risk to develop an illness. The correlation between physical activity, nutrition and weight is unquestioned in society (today). Few people would disagree that physical training will positively affect one's health status as long as it is done moderately. It is also shown in studies that training makes people produce hormones that make them happier, which affects a person's mental health (Grønsdal, 2005).

However, the more controversial theory offered by the CHL is the effect of the HLR. It is claimed that the HLR will improve physical shape, reduce weight and improve self-perceptions of health. In the brochure (Appendix 2 point 9.2) we can see that there are made references to the Norwegian master's thesis written by a graduate of the Norwegian School of Sports Sciences, which supposedly proves this, and in other documents they cite studies performed in Denmark and Sweden on the same matter (Engedal, et al. 2008). These studies supplement the theoretical foundation the CHL rests upon.

Yet, the correlation between the prescription and improvements in health status is far from an established truth. Firstly, it may seem as if the effect of the prescription is slightly overestimated. Evidence shows that it will have a positive effect on people's health status, however there is uncertainty related to if it actually will *improve* people's health or, more importantly, *heal* people from their subsequent illnesses. Secondly, the prescription includes a few basic measures (health talks, training period, follow up and courses) and it seems a bit idealistic to believe that this is sufficient to help people facing all kinds of sicknesses, especially mental disorders. Again, it may contribute positively but this does not mean it will be sufficient to heal people or will improve their condition appreciably. Thirdly, the correlation between the prescription and reduced sick leaves is not proven to be causal. Since we do not know if it will improve a person's health status its ability to reduce sick leaves is also unknown.

Reducing sick leaves was one of the premises for starting the CHL in Modum in the first place. It appears, though, as if it cannot be proven to reduce the number of sick leaves. This may explain why this fact is not mentioned in the material about the CHLs, and why user stories are being used instead. However, despite a seeming lack of evidence for this effect the CHLs have developed and have gained support from the state. A basic feature of new institutional theory is that once an idea or a concept has become the logic of appropriateness it

will rapidly be adopted and implemented almost without questioning, even if scientific evidence are thin or non-existing. Above, it was argued that politicians will invest in a concept because they want to be associated with it. The weak theoretical foundations may not be given much attention because politicians are not interested in what works, but what is thought to work and, especially, what is considered to be modern. This seems to be an example of this, and indicates that the idea of the CHL is a trend.

4.5.3 Conceptualization

This pertains to the degree it is turned into a product that is made attainable and thus easily passed on to new contexts. The rapid dispersion of CHLs over the last couple of years is an expression of this, because this would not have been possible unless it had been turned into a product or seen as tangibly good. The fact that the CHL in Modum is known as the first center, even though other offers already existed when it was started (Stange and Sweden), indicates that this center has become a proto type. There are many references to the "Modum Model" in the literature, and it has been used as inspiration and illustration for many municipalities when they have started a center. This further confirms that it has become a proto type of the kind defined by Sahlin, and that the idea has spread through the broadcasting mode: One model serves as a role model for others.

Another example of conceptualization is when a product is given a unique terminology. This is done to strengthen the character and identity of a product and sometimes also to make its name become part of the more ordinary language. When the CHL was established in Modum they created concepts like the Healthy living recipe, Healthy living coordinators and Health talks. These concepts and words were quickly integrated into their language. They are further reinforced in information about the CHL. In the brochure, mentioned above, (Appendix 2 point 9.2) the word Centers for healthy living is written 16 times (27 including the email addresses on the last page). This is rather extraordinary considering that the brochure only have text on two pages

Sahlin claims that there has been a shift in the focus of the research from prototypes to templates and that since the advent of the 21th century targets and frames for evaluation and assessment have become more prevalent. The GMC offers guidelines regarding how to organize and establish a CHL. It contains specifications and defines tasks, motives, goals, etc. and formulates expectations from the state regarding level of competence of the staff and documentation of results. Furthermore, these guidelines clarify and concretize the idea and

represent examples of templates that enforce conceptualization through standardization. In addition to the GMC, the NDH also made an “Electronic toolbox” (Verktøykasse) containing all kinds of tools such as step by step recipes on how to start a center and how to run courses and activities, and how to perform HT1s and HT2s etc. It has ready-made national logos, ads and brochures that are open as profile material, and recommendations that specify how to run the different tests that measure people’s condition and how to report test results.

Looking at the brochure (Appendix 2 point 9.2) we can find several examples of the profile material from the “Tool box” such as the logo, the size of it, the use of colors and fonts and the placement of pictures in relation to the text. The “Tool box” was made available on the web pages of the NDH with the intention of supporting those who are working with and establishing CHLs. These guidelines and this equipment contribute to the standardization of the centers.

4.5.4 Timing

Timing refers to when an idea is introduced, and whether it is perceived as being “in tune” with current ideas and trends in society. The CHL was established when NPM had infiltrated the public sphere with its focus on cost control and time management. The CHL was initiated as a response to rising costs related to sick leaves. The argument that CHLs would tackle this problem was definitely in time with demands in society. Reducing sick leaves have in fact, been a reoccurring theme in Norwegian politics. Just recently the Prime Minister expressed the value of getting people to work “Everyone who can work, should work” (Odenrud, 2012).

Another characteristic of our time is an intense focus on nutrition and exercise. The increase in lifestyle diseases has been a hot topic over the past decade, and it seems as if the Western world is experiencing a “healthiness trend” where being in good shape and having a balanced lifestyle is considered fashionable. The increased health awareness in society can be illustrated by looking at changes in people’s habits and pattern of behavior. One example is training; Norwegians train more than what they did 10 years ago (SSB 1. , 2009). By 2011, every third person over the age of fifteen had a membership in a gym, and the number of training centers has doubled over the past 10 to 15 years (Dagbladet, 2009).

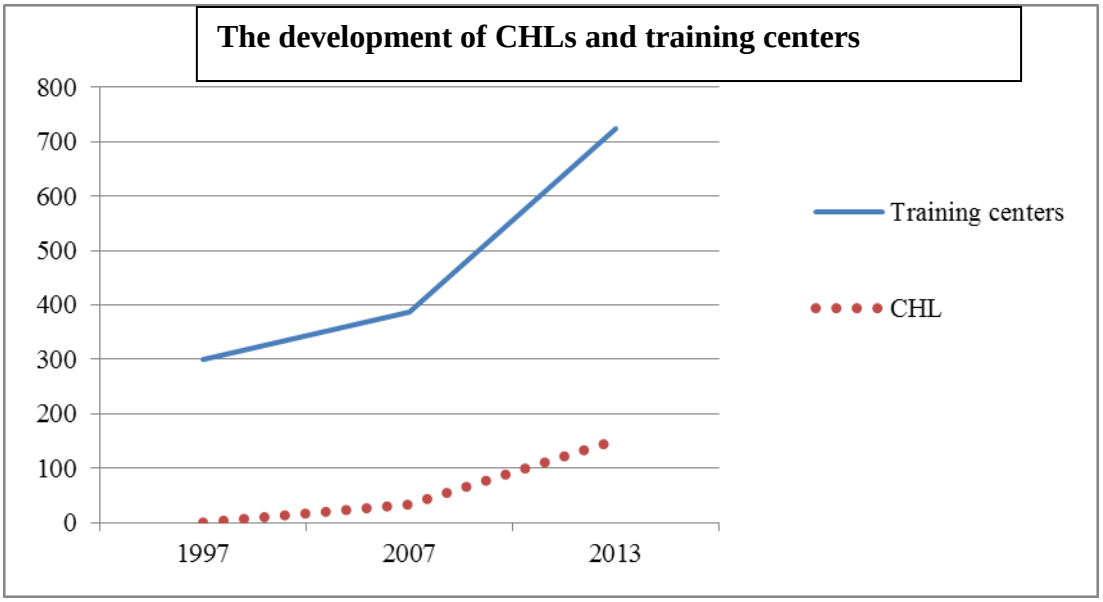

Figure 4 Note: I was not able to find exact figures for training centers in the years between 1996 and 2000, and 2000 and 2007. However, figures for 1996, 2000 and 2007 are accurate.

The vertical axis shows the number of centers and the horizontal axis the time frame. The figure shows the accumulated number of CHLs and training centers in relation to one another. The two lines follow approximately the same pattern within this time frame. Figures have been derived from Appendix 1 point 9.1, (Virke, 2012) and (Dagbladet, 2009).

Looking at the graph one can see that the development of CHLs intensified somewhere around 2005, see Figure 1 (p. 24). It seems reasonable to think that training centers has followed the same pattern as the CHLs in this period. The graph sheds light on the analysis because it shows that the dispersion of CHLs can be correlated with other relevant trends in society, like the increase of gyms. Some of the expansion of both of these concepts (CHLs and gyms) is obviously due to an increased demand for training and especially organized training.

Training centers have changed over time (Virke, 2012). Basic economic theory suggests that increased supply tends to press prices down. Training centers have therefore over the past decade become affordable to more people, and moved from what many would refer to as a luxury good to a normal good. Furthermore, competition also forces the gyms to differentiate their offers. This has led to a variation in the market from the luxury offers with lavish facilities and personal trainers, to the basic centers that offer “just training” (Aarøy, 2012)

(Bare trening, 2013). Thus, one can say that differentiation in price and supply has made training centers available to more and new groups in society.

One of the premises for establishing the CHLs was that they should have low out-of-pocket payments compared to other offers, so that unemployed and retired people should be able to use their services. Today, the membership fee to enter one of the gyms in the low-price segment is NOK 199 per month (NOK 1200 per six months) whereas a "Healthy Living card" costs NOK700 per six months (Modum) (Bare trening, 2013)(Frisklivssentralen, 2013). The difference in costs is moderate and the price argument seems to have become less relevant over the years. Thus, it seems reasonable to say that an expansion of the market for training centers will intensify competition with the CHLs and lead to fewer CHL establishments. Nevertheless, as shown in the graph (Figure 3), the dispersion of CHLs and gyms seems to have happened simultaneously.

One could also argue that gyms and CHL have expanded at the same time because they attract different groups in society, and therefore do not compete but rather, supplement one another. What type of training a person does is often correlated with age and gender (SSB, 2002). Considering this information it seems reasonable that training centers attract different groups in society. This brings us over to the next feature discussed by Røvik, harmonization.

4.5.5 Harmonization

Harmonization has to do with whether a concept is neutral and do not give priority to certain groups or ideals, or cause particular offense to anyone. One could argue that the CHL idea harmonizes because it is not exclusive; to the contrary, CHLs are open to everybody. They are available to large parts of the population, and are currently widening their target group to include youth. Looking at the brochure (Appendix 2 point 9.2), we can see that the CHLs write several statement that can be interpreted as an invitation to join them. They mention how one can get in touch with the CHL, that people do not need a prescription to attend the CHL, or do not need an illness, or even follow their program to get assistance from them. All of these statements signalize that the CHLs want to be open to everybody and not exclude anyone.

Nonetheless, the reality is that users of the CHLs represent a quite small group in the population. The average user is a 50 year old Norwegian female with a low income (Båtevik et al. 2008), as our questionnaire survey showed (point 5.5.2). Båtevik also find that people

who are obese or struggling with mental illnesses, or has a minority background, are underrepresented. This has in fact been some of the critique that has been raised against the CHLs (Båtevik et al. 2008).

In response to this critique it can be argued that these groups have a high prevalence of lifestyle diseases and that benefitting this group is in line with the original intention of the CHLs. They wanted to reduce social inequalities in health by creating low-threshold offers for people who cannot afford to spend money on training.

Another harmonization point has to do with whether the CHLs promote any particular professional group. According to the NDH, physiotherapists are the most frequent professionals at the CHLs (Helsedirektoratet 1, 2011). This is also what I found in my questionnaire survey (point 5.2.1). Thus one could say that the CHLs do not harmonize, since one professional group seems to be so dominating. However, considering the competence and skill of physiotherapists, this may not be that surprising. Physiotherapists have knowledge about how physical, mental and social factors affect the body, and try to assist individuals and groups regaining functionality through treatment and training. (NorskFysioterapiforbund, 2012) (Olsen, 2013). This lines up well with the values of the CHLs: They try to improve people's health condition and quality of life through physical activity. Thus, it is understandable that physiotherapists should be well represented at the centers.

4.5.6 Dramatization

"Jorunn Skjerpan gives thanks the CHL in Vestvågøy for falling in love with the mountains"

Became slender with assistance from the municipality
Because of overweight and muscle related diseases that negatively influenced her physical shape Jorunn Skjerpan was sitting a lot inside. But this was until she saw an article in the local newspaper about the CHL. Now she is so active that the day does not have enough hours. She says:

"*I have increased my heart- and lung capacity. I am able to walk more and spend a lot of time outside in the nature. Before, I used to walk on roads that were as straight as possible, but now I love to hike in hills*" (Skjerpan, 2012).

This is an extract from an article done by NRK in Nordland, on the CHL in the municipality of Vestvågøy. It brings us over to the next feature; if the idea represents a compelling story. Compelling stories often include turning points or spectacular events that are meant to grab hold of the recipient, and follow a narrative.

One can often find references to Modum and Johan Kagestad in introductory presentations of the CHLs (Fylkesmannen, 2012) (HOD, Folkehelsemeldingen, 2013). However, as mentioned, successful stories about people who have benefitted from the CHLs are what is being projected. The article above illustrates example. It includes a short narrative of a person that was "depressed, alone and in a poor physical shape", whom now "enjoy training, is happier and in better shape". There is a clear distinction between then and now, and the CHL represents the turning point in her life; the solution that came in her time of need.

Nevertheless, user stories are less prevalent in the GMC or other places where the NDH informs about the CHLs. It seems as if this is used as a tool in the media, in brochures, yet, not as much in official material of the CHLs (Helsedirektoratet 1. 2011).

4.5.7 Individualization

Individualization stands for the degree to which the idea gives some gain or convenience to the individual. An idea should mainly reform and develop the organizational structure; still it puts emphasis on the actions of the individual, and thereby provides him/her with more opportunities and responsibilities. One of the original premises of establishing the CHLs was to bridge the gap between what we know about lifestyle diseases and what we do about them. The aim was to get people physically active before they become sick or need health care services, and thus make them take responsibility for their own health. The emphasis is on changing communities rather than individuals. In the program they give people freedom to choose what type of activity, with what frequency and in which facilities, they want to engage in. Through the empowering "health talks" CHL professionals give their users both opportunities and responsibilities.

Looking at the brochure (Appendix 2 point 9.2) the word “Individual” is brought up in the first sentence in regards to the health talks. In the second section it is stated that; “The CHL is individual”. This clearly projects its personal focus, and it seems fair to propose that the CHL turns to the individual in their brochure.

The emphasis on changing individuals rather than communities can also be found in political initiatives such as the “Prescription for a healthier Norway”. It rests as mentioned, on four strategies, where one is to “Increase people’s prerequisites to take responsibility for their own health”. And, during the implementation of the “Green prescription”, the Minister of Health, Dagfinn Høybråten pronounced that people should “Be their own Minister of Health!” He argued “You can do the most for your own health”. This shows the states focus on individuals.

5.0 How has the idea been passed on?

In this section I will present findings from my questionnaire, and discuss results in light of the theoretic framework offered by Sahlin. My aim is to analyze how the CHL has developed as it has been implemented into new municipalities (ref. RQ2). In order to study how the idea has developed I have looked for indications of homogeneity and heterogeneity. By homogeneity I mean whether centers respond the same to a question. This is based on the assumption that homogeneity expresses that the idea has diffused rather than translated according to Sahlin's theory.

The contact information from the regional leaders of the CHLs in Buskerud and Nordland counted 55 centers. Knowing that there are 150 CHLs across the whole country this number was surprisingly high. However, many quickly responded that they did not have a CHL in their municipality. Some were planning to establish one or "did not have one yet", while a few used to have one but no longer did, or had "put it on ice". This supports the argument as spelled out in the spread (point 4.4.4): the CHLs are experiencing the spread and have not started de-institutionalization; thus, several centers on the list responded that they are currently establishing a CHL or planning to do so. The fact that so many are even on the list also supports this argument.

According to the NDH, there are 13 centers in Buskerud and 17 in Nordland (Helsedirektoratet 2. , 2012). Thus, my sample consists of 30 CHLs, whereas 21 responded. It should be noted that some centers did not respond to all of the questions. Therefore, I have listed the coherent response rate in parenthesis after each question. All questions refer to CY 2012, and figures are given in percent in all of the tables unless something else is stated.

5.1 Results from questionnaire: Organization

Table 1

Questions	Responses					
Length of project? Permanent/Trial (20)	Permanent	85	Trial	15	Other	0
What department is it placed under? (21)	Health	47	Physio	33	Other	20
What actor took the initiative to start it?(17)	Muni/Regio	47	Physio	35	Other	18
Municipalities with a correlation between who took the initiative and what department it is placed under	**Correlation**	**88**	**No correlation**	**12**		

Note: Muni is the municipality, physio is physiotherapists and regio is the regional administration.

5.1.1 Similarities: Many are made permanent

To the question "What is the length of the project? Permanent/trial" 85 percent responds that they are permanent, whereas the rest place themselves as trials. This is the area where centers seem to resemble the most, and there is the least variation across the sample. This is an example of homogeneity, and that the idea has diffused rather than translated in this area. Then, this finding does not support Sahlin's theory that ideas will translate and develop as they are implemented in new contexts.

5.1.2 Departmental placement correlates with initiation

Turning to the next question; "What department is it placed under?" there is great variation in the sample. Answers range between the department of Health, Culture or Planning and development of Sports, the Rehabilitation service, the Physiotherapy service etc. This variation may seem surprising considering how many are permanent and the directional guidelines from the state (GMC). Regardless, this implies that the idea has developed as it has been passed on, which supports Sahlin's assertion.

Nevertheless, this variation can be correlated to responses in the proceeding question; "What actor/person took the initiative to start the center?" Responses in this question range between several actors, often as a combination of two or three actors. The most frequent are the local and the regional administration and the Physiotherapy service. However, there seems to be a correlation between the *actor that took the initiative* to start the center, and what *department it is placed under*. In the table one can see that the correlation is 88 percent (marked bold in the table). This means that some of the heterogeneity that was discovered in organizational position simply can be explained by the fact that different actors make the initiative to start centers.

This also means that if a particular actor dominates initiation this is likely to affect the organizational position of the CHLs. As one can see in the table, physiotherapists initiate 35 percent of centers, and in turn 33 percent of centers are in the Physiotherapist service. This is the only professional group that sticks out on this topic, and this finding gives reason to believe that they may influence the development of the CHLs. In order to further study this let us move on to the next topic - Employment and referees.

5.2 Employment and referees

Questions	Responses					
Who works at the center, and for how many man years? (20)	**Physio**	**75**	Others	25		
Who refer patients to the center? (16)	**Physio**	**68**	Doctor	100	NWA	56
What actor took the initiative to start it? (17)	**Physio**	**35**	Others	65		

Table 2
Note: The calculations for referees are based upon how many mention the different actors at each center, not the fraction of each one. I.e. Every center mention doctors; thus, they equal 100 percent.

5.2.1 Similarities: Physiotherapists dominate

In this table it is evident that physiotherapists have a unique position regarding CHLs. Under "Who works at the center, and how many man years?" we can see that they preoccupy 75 percent of the total employment. Every center responds that they have a physiotherapist hired. This can be confirmed by the discussion under harmonization (point 4.5.5). Under "Who refer patients to the center?" physiotherapists are the second most common response. On this topic

there is a bit more variation compared to the previous one. Nonetheless, the prevalence of physiotherapists is still relatively high. In sum, this group initiates 35 percent of centers, which is likely to affect organizational placement, they completely dominate employment and refer patients.

5.3 Healthy living prescriptions, health talks and activities

Table 3

Questions	Responses			
	Exact figures			
How many Healthy living prescriptions do you receive? (18)	min	2	max	509
How many HT1 do you hold?(18)	min	2	max	509
How many HT2 do you held? (18)	min	2	max	427
How many of your users repeat the program? (14)	min	7	max	163
	Percent			
Correlation between the number of inhabitants in the municipality and how many Healthy living prescriptions they receive	**Correaltion**	**88**	**No correalation**	**12**

Note: Min refers to minimum and max to maximum.

5.3.1 Variation in the number of Healthy living prescriptions and health talks

In these questions there is great diversity across the sample (See minimum and maximum in the table). Some centers receive several hundred HLPs each year like Alstahaug (235), while others receive less than ten like Sigdal (7). Those who receive more HLPs consequently hold more health talks (HT1 and HT2), which seems quite natural since one follows the other in the program.

In the table one can see that in 88 percent of cases there seems to be a correlation between the number of inhabitants in the municipality and how many HLPs they receive (This is made bold in the table). This means that centers that are in municipalities with *more inhabitants* are more likely to receive *more HLPs*, ("more" is relative to the size of the median in the sample) than those with fewer inhabitants. This appears quite reasonable, since populous municipalities often will have more people in the target group. Henceforth, the diversity in the

number of HLPs and health talks seems to be explained by the consequent number of inhabitants in the municipality.

5.3.2 Variation in how many completes and repeats the program

Table 4

Questions	Responses				
	Individual centers				Total sample
How many percent complete the program?	min	32	max	100	67
How many percent repeat it?	min	21	max	100	37

Note: Complete refers to how many had both HT1 and HT2, and repeat to how many did the program one more time. Minimum refers to the center where fewest users complete and repeat and maximum refers to the opposite.

In this table one can see that the center where "fewest" users complete the program; 32 percent completes. And, the center where the "most" users complete it; 100 percent completes. This means that at some centers 68 percent do not complete the program, while at another everyone complete. In regards to repetition, the center where the "fewest" repeat the program; 21 percent repeats. And, where the most repeat the program; 100 percent repeats. This means that at some centers 79 percent do not repeat, while at others everyone repeats the program. This variation is significant, and was thoroughly investigated; it was compared to the number of inhabitants, HLPs, employees and year of establishment. Nevertheless, none of these factors seemed to explain the variation. Hence, the reason for the difference has not been revealed in the analysis of the material. Yet, the heterogeneity is noteworthy and should not be ignored. It also implies that the idea has translated, which supports Sahlin's assertion.

5.3.3 One out of three do not complete the program

One can also read from the table that 67 percent (in total) complete the program they have started. This means that 33 percent quit before they have had HT2. This could be because people do not want to continue, because they become sick during the period, get back to work, move etc. One could also suggest that it has something to do with the program; that people are not provided with sufficient follow-up, that it takes too long for people to see effects or simply that it does not work. This supports the argument as spelled out under theorization (point 4.5.2): there does not exist sufficient evidence to prove that the CHL improves health, and in turn reduce sick leaves; thus, its effect can be questioned.

Turning to repetition one can see that 37 percent (in total) repeat the program, once they have completed it. This may indicate that the training period is not long enough to change people's

lifestyle, which is supported by former research (Båtevik, et al. 2008). Furthermore, under questions regarding success factors several centers respond that the program would function better with a longer training period. In turn, this finding supports the argument that was raised above, because if the program improved people's health they would not have to repeat it.

From another point of view, a 37 percent repeat rate is not that low. This finding could also be used to argue that it implies that the program in fact *does work*. If not, this many would not have chosen to repeat it.

5.3.4 Similarities: Arrange the same activities

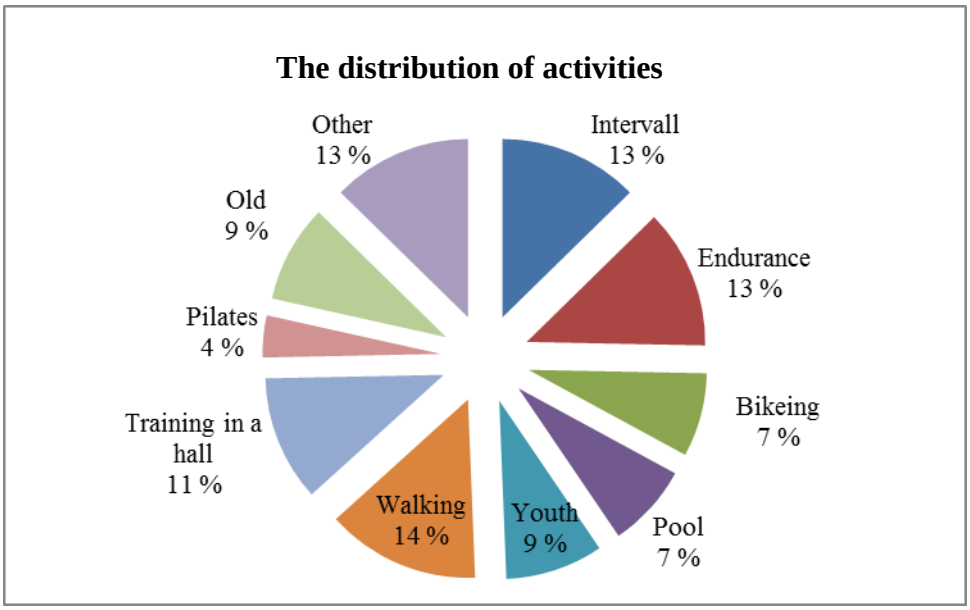

Figure 5 Note: Categories Old and Youth refer to activities arranged for these groups. "Training in a hall" refer to the Norwegian "sal-trening"; a combination of endurance and conditioning.

This pie chart shows the distribution of different activities across the sample, and is based on responses from: "What activities/courses are arranged by the CHL?" (17). Looking at Figure 5 it seems as if CHLs to a great extent arrange the same type of activities. The most frequent is walking groups, followed by interval and endurance training, senior and youth activities, swimming and biking. Looking at the homogeneity in activities, the CHLs seem to have been passed on without being developed significantly, which contrasts with Sahlin's theory.

5.4 Courses, cooperation partners and occupation of users

Table 4

Questions	Response rate
What courses do you arrange?	< 50
Who do you cooperate with?	< 50
What is the social status of you participants?	< 50

On these topics the response rate is considered too low to make any predictions about the sample. Thus, they will not be included in the analysis.

5.4.1 Variation in report writing indicates decoupling

Nevertheless, regarding "What is the social status of your participants" several centers write that they do not sit on this information, or have the capacity to find it, whereas others provide information. This variation is noteworthy considering that the GMC includes several demands regarding report writing and documentation of social characteristics of users (Helsedirektoratet 1. 2011). Yet, it seems that this is not reflected in many of the CHLs. This indicates that the idea has developed as it has been passed on, which supports Sahlin's theory.

Furthermore, is also implies that there is a gap between the expectation from the state and actual practice. The latter can be used to illustrate an example of decoupling; when a strategy is implemented at the top, disassociated from the running operation. Here, the state represents the top level and the CHLs the running operation. The state has formulated specific guidelines for report writing, nonetheless, many of the CHLs do not do this. Thus, there is a gap between formal policies and actual practice.

5.5 Participants

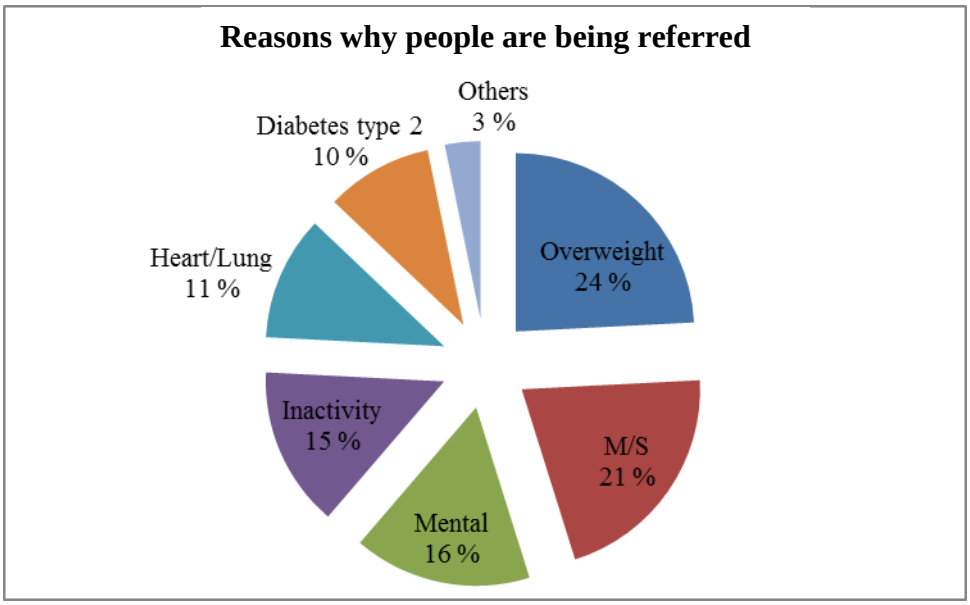

Figure 6 Note: M/S refers to muscle and skeleton diseases, mental to mental illnesses and heart/lung to heart- and cardiovascular diseases.

5.5.1 Similarities: Homogenies group of users

This pie chart shows the distribution between the reasons for why people are being referred to the CHLs. It is based on responses from “Mention the five most frequent reasons people are being referred to the CHL?”(16). In the figure one can see that responses only range between seven different categories, in which several of them are closely related, such as overweight and inactivity. One can also observe that the different reasons distribute fairly evenly across the sample. This indicates that the CHLs attract the same type of people as it is implemented in new contexts, which implies that it has diffused rather than translated in this topic. It also indicates that the group using the CHLs is rather homogeneous. This can be confirmed by other factors that characterize participants. See the section below.

5.5.2 Similarities: Overrepresentation of women and older people

Table 5

Questions	Responses					
What is the gender of your participants? (14)	Percent	Women	75	Men	25	
What is their age? (14)	Average	49	min	43	max	55

In the table one can see that there is a clear overrepresentation of women; 75 percent compared to 25 of men. This relationship is consistent across the sample, though the ratio varies slightly. Moving on to age, the average is 49, ranging between 55 and 43. The response rate on these two questions is slightly lower than the rest (14). However, these results are also found in the report that was released by Research of Møre (Båtevik, et al. 2008), see harmonization (point 4.5.5) for further explanation.

5.6 Success factors

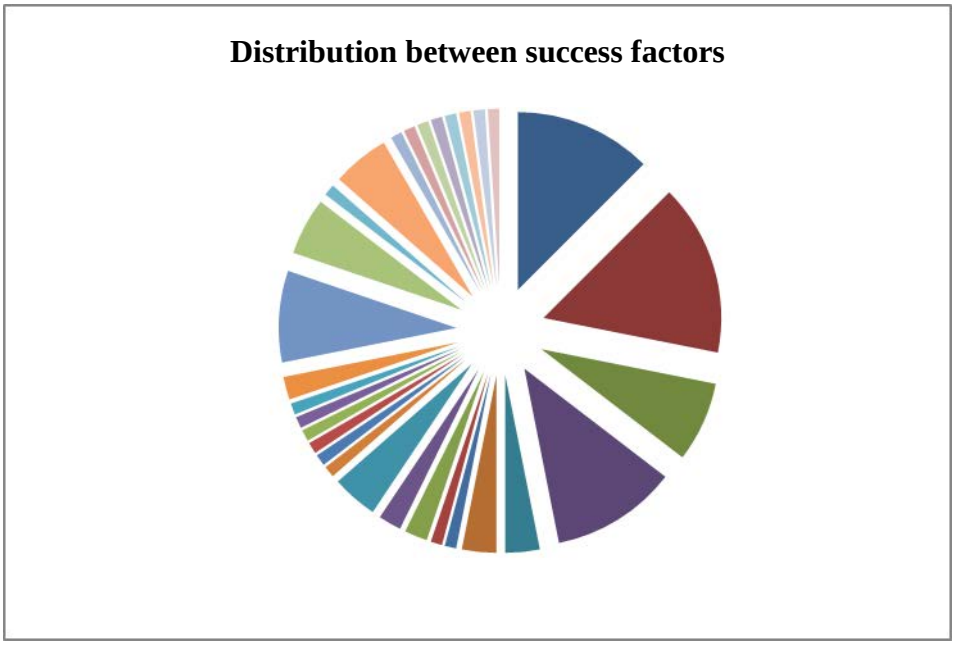

Figure 7

5.6.1 Variation in important success factors

The pie chart above shows the magnitude of different responses to questions regarding success factors: “What is important for it to function?” (18) “Mention 5 elements you consider important” (18) Questions on this topic are of a different character than the others

because they ask for descriptions, personal opinions and recommendations rather than facts. Thus, one might expect that responses diversify more here, compared to the previous topics. Indeed, the diversity showed in the pie chart is significant. Respondents list various reasons; better training facilities, better media coverage, develop the competence of workers etc. They seem to face a great variety of challenges and highlight different success factors. This indicates that the idea develops as it is passed on to new contexts, according to Sahlin's argument.

Meanwhile, one can also see that a few categories occur more often. These are outlined in the table below.

Table 6

Questions	Responses					
What is important for it to function? (18) Mention 5 elements you consider important (18)	Cooperation with referees	70	Sufficient funding	70	Political anchoring	60

Note: In the last two questions responses are summarized and the presented responses are accumulated from both questions.

5.6.2 Similarities: Forgotten by referees

Interestingly, 70 percent mention that their relationship with refereeing parties is troublesome. They report of poor communication, lack of cooperation and inconsistency in the flow of referrals. It actually seems as if doctors and others who prescribe tend to forget that CHLs are an option. An example is "Aktiv Eiker" the CHL in Øvre and Nedre Eiker which actively communicated information about the CHLs in 2011, and as a result experienced a significant increase in the number of referrals, yet only to observe that it trickled down to its initial level the following year.

5.6.3 Similarities: Lack of financial resources

Furthermore, 70 percent bring up financial resources and especially lack of them, as a challenge. Under "What is important for is to function" one write: More resources! This may explain why many did not respond to questions regarding occupation of users (point 5.4.1). They do not have resources and capacity to write reports and perform documentation. The fact

that such an extensive number report to experience financial shortages may indicate that they do not receive sufficient funding.

5.6.4 Similarities: Not anchored locally indicates decoupling

As many as 60 percent underline the importance of political anchoring with local administration, and brings this up as being defiant. Many seem not to be integrated sufficiently in the local health care sector, and struggle to inherit sufficient support and recognition from the administration in the municipality. This gives reason to believe that CHLs are not well anchored with the local administration.

On the other hand, considering the efforts of the NDH to develop CHLs, it seems appropriate to argue that they are integrated in policies at a higher level. This can be described as an example of decoupling. In our case, the NDH and the Minister of Health represent the top level, and the local health care sector including doctors and the municipality the running operation. This can be supported by the finding above: Many lack financial resources. CHLs are mostly funded through municipalities (Helsedirektoratet 1. , 2011). If the idea was integrated in to local authorities it does not seem likely that this many would have reported of financial shortages.

6.0 What mechanisms influence the development of the CHLs?

In this section I will discuss what mechanisms; coercive, normative or mimetic have influenced the development of the CHLs, according to DiMaggio and Powell's theory about isomorphism (ref. RQ3). I will first discuss (how mechanisms have influenced) the CHLs in the popularity curve. Then, turn to the trend criteria offered by Røvik and the results from the questionnaire. These two will be discussed simultaneously.

6.1 Mechanisms that influence the CHLs in the popularity curve

6.1.1 The creation: Mimetic

When the idea was introduced in Modum, it was the Head of the department of Culture, Johan Kaggestad, who took the first initiative. He can be said to have been a representative of the local government due to his position in the public administration in the municipality. Thus, one could argue that coercive mechanisms have influenced creation through public initiative. This is the mechanism where formal or informal pressures compel units to choose a strategy. This mechanism often manifests itself through laws or rules, but it can also do so through state-led initiatives; initiatives taken by politicians or people in other public positions.

On the other hand, Abrahamson describes this stage as the stage when the idea is launched and tested in practice for the first time. When Kaggestad formed the work group, he was inspired by similar projects that existed in the municipality of Stange and in Sweden. One could argue that he copied and reshaped a concept that was already created. Taking this into consideration, it seems reasonable to say that the ides was not invented in Modum, but in Stange, Sweden, or even somewhere else. In applying DiMaggio and Powell's framework, one could argue that the mechanism we are seeing in action in the case of Modum is the mimetic one. One unit copies another, successful one, and one that also seems to be supported by important cultural standards. Kaggestad looked for instance to Sweden, whose centers ("Friskvårds") already were well-functioning and properly integrated in society. The Swedes had done studies which documented the effect of training by prescription (Stenbro & Killingstad, 1999). Yet, the idea was still relatively new, and not explored much with-in the Norwegian context.

6.1.2 The selection: Mimetic and coercive

When municipalities and regions started to hear about the "Modum Model", they wanted to establish something similar themselves. One can say that a cluster of different organizational ideas that were hybrids of each other emerged. The various alternatives copied the "Modum Model", which seemed successful in handling challenges related to lifestyle diseases. Hence, the mimetic mechanism is likely to have influenced the process of creating an organization field, and the selection stage.

On the other hand, the state initiated the agreement with five regions which lead to the release of the report; "A prescription worth fighting for?" (Båtevik, et al. 2008), and produced the "Guidelines for municipal CHLs" (GMC). According to the discussion (point 4.4.2), both publications seem to contribute to the selection. Thus, one could argue that coercive mechanisms have influenced this stage.

6.1.3 The adaptation: coercive and normative

When the CHL in Modum was incorporated with the regional administration in Buskerud, it is likely to have started the adaptation stage. The state is a common denominator to events that have been assigned to adaptation; "Prescription for a Healthier Norway", the "Green prescription", the GMC and the announcement of the "Cooperation reform" (4.4.3). Thus, one could suggest that coercive mechanisms have influenced this stage.

Nevertheless, during this period the CHLs also started to hold regional and national conferences. It seems likely that this was initiated by groups within the organization, which can be characterized as examples of the normative mechanism; norms and values within professional groups legitimize change. Henceforth, normative mechanisms may have influenced this stage.

However, looking at the program of the National "Health living conference" (Frisklivskonferansen) of 2013, it may seem as if the state impinges upon these seminars. The NDH hosted the event, and invited politicians, leaders within areas of health care, community doctors, and representatives of the CHLs. Both the Minister of Health and the Director of Health spoke at the conference (Blom, 2013). The frequency of politicians at these seminars implies that the CHLs have become so-called symbol politics. This can be supported by the discussion under social authorization (point 4.5.1). Thus, one could propose that even though national seminars initially were driven by the normative mechanism, it seems as if the coercive have become dominating.

6.1.4 The spread: coercive and mimetic

In the discussion of the spread started when the idea started to travel faster to new contexts. During this stage the "Cooperation reform" was announced. The goals of the reform correspond to the goals of the CHLs (point 4.3.3). Thus, it is likely that the announcement of the reform led to the establishment of new centers, and that coercive mechanisms influenced this stage.

On the other hand, by this point (2010), several research studies had been released. They provided evidence of the effectiveness of training by prescription (point 4.3.3). The CHLs were considered to be "in tune", modern and successful. Therefore, it seems likely that municipalities implemented CHLs because others did, and that the mimetic mechanism also contributed to this stage.

6.2 Mechanisms that influence trend characteristics and results from questionnaires

6.2.1 Social authorization: normative and coercive

According to the discussion about social authorization, the CHL in Modum became legitimized by Johan Kaggestad (4.5.1). Kaggestad has gained reputation because of his success as a trainer and spokesperson. His charisma and entrepreneurship has put him in a position to influence the (public) discourse on training and lifestyle, and affect the opinions of professionals. This type of influence can be described as normative, and one could suggest that this mechanism have affected the development of CHLs.

On the other hand, it is also indicated that the visit from the Minister of Health, Anne-Grete Strøm-Erichsen in 2011, contributed to this aspect. Thus, one could argue that both normative and coercive mechanisms influenced social authorization.

6.2.2 Theorization, report writing and problems with referees: normative

The theoretical foundation of the CHLs is questioned because it appears as if they cannot prove that they improve health, and in turn reduce sick leaves (4.5.2). Reviewing the story it does not seem as if health care professionals have been heavily involved in the development of the idea. One could propose that this has influenced the discussion of the theoretical evidence, and that causal inference would have been further questioned if they had been more prevalent. This represents an example of the absence of normative pressures.

This can be correlated to results from the questionnaire. Firstly, they show that many do not sit on or have this information about social characteristics of their users. In the health care sector in general, report writing and journaling is obligatory. However, here this does not seem to be extensively enforced. One could argue that if more health care professionals had been involved in the development of the CHLs, this would have been emphasized more.

Secondly, results from the questionnaires show that many centers seem to face challenges cooperating with referees (5.6.2). One could suggest that the CHLs run into endeavors with referees because the idea is not supported or "carried" as Sahlin calls it, by the right professional group namely; doctors. They have a pivotal role in the health care sector, and are the primary referee to CHLs. Doctors may not cooperate because they do not have anything to gain from the program, or simply because they have not become accustomed to it. Regardless, one can suggest that resentment from doctors represents examples of the normative mechanism.

6.2.3 Conceptualization: Mimetic and coercive

It is suggested that the CHLs have become a concept through the "Modum Model" (4.5.3). It seems likely that CHLs have copied Modum on several standards. Results from the questionnaires indicate that CHLs arrange similar activities (5.3.4). These seem to be the same activities that are arranged in Modum (Frisklivssentralen, 2, 2013). Thus, one could argue that CHLs have copied one another and that the mimetic mechanism is relevant here.

Furthermore, it is also implied that the state has contributed to conceptualization by their production of the GMC and the "Electronic toolbox". These templates are likely to have enforced standardization of the CHLs. Thus, one could suggest that the coercive mechanisms have become more influential in recent years through initiatives of the state.

6.2.4 Timing and individualization: coercive and mimetic

In timing, it is proposed that the introduction of the CHLs corresponds to economic and political demands, such as NPM and preventive action (4.5.4). Thus, coercive mechanisms seem to influence the timing of when the CHL was launched.

Nevertheless, the emphasis in section about timing is on trends in society to be healthy and to do physical training. It seems reasonable to propose that such trends arise because people observe one another. Hence, the mimetic mechanism may be influential here.

However, a healthiness trend can also be related to coercive initiatives. Under individualization (4.5.5), it is argued that public reports and political statements in this timeframe focus on changing individual rather than communities. Examples are “Prescriptions of a healthier Norway”, the “Green prescription” and the statement of the Minister of Health, Dagfinn Høybråten: “Be your own Minister of Health!” These initiatives do not force people to train, yet it seems reasonable that the state has contributed to the healthiness trend, and that coercive mechanisms are relevant.

6.3 Harmonization

6.3.1 Homogenous group of users: mimetic, coercive and normative

It is argued that the CHLs do not harmonize because their users represent a rather small group in the population (4.5.5). The overrepresentation of women and older people is confirmed by results from the questionnaire. Here, it is added that people are referred to the CHLs for the same reasons (5.5.1). One could suggest that the homogeneity is related to social stigma; “the extreme disapproval of (or discontent with) a person on socially characteristic grounds” (Wikipedia, 2013). That CHLs are associated with women who are old and poor, or have a low social status, and as a result, people with a higher social status will not turn to the CHLs, because they do not identify with this group. Stigma is formed as people observe who, and what type of people attends something. This forms the basis of opinion and creates a picture of who the users are. Hence, stigma is likely to be enforced by the mimetic mechanism.

On the other hand, CHLs are consistently being referred to as low-threshold services in public documents (Helsedirektoratet 1. 2011). Being low-threshold implies that users have a lower social status. One could suggest that terminology in public documents reinforce stigma, and that coercive mechanism influence this.

Finally, the combination of users is also influenced by referees. They decide for what reasons, and who are being referred to the CHLs. If doctors tend to prescribe a certain group of people because they are similar to other users, or exclude another group because of the same reason, this affects who is being referred, and consequently who use the CHLs. The doctor’s propensity to refer a certain group can be related to social stigma, but also to habits, training or the shared opinion of colleagues. Patterns or norms for practice within professional groups can be denoted as expressions of the normative mechanism. Thus, this may be relevant here.

6.3.2 Physiotherapists dominate: normative

It is proposed that the CHLs do not harmonize because one group dominates employment; physiotherapists (4.5.5). This is confirmed by results from the questionnaire (5.2.1). Employment is determined by official guidelines for competence and education, and one could suggest that this affects the frequency of physiotherapists. In the GMC, the state has formulated requirements on employment; workers should have a minimum of three years of education in health related subjects, such as physical activity and nutrition, and have competence in reducing tobacco-smoking (Helsedirektoratet 1. 2011). These specifications are relatively wide, and do not imply that physiotherapists should be employed. Hence, it does not appear as if physiotherapists are promoted through official guidelines, or the coercive mechanism.

Furthermore, results from the questionnaires indicate that physiotherapists are involved in other areas of the development and organization of the CHLs (5.2.1). They initiate 35 percent of centers, which is likely to affect organizational placement, and are the second most common referee. One could suggest that they are involved in order to promote their own group, and expand their labor markets and opportunities. This indicates that a normative mechanism is at work; manifested through their involvement.

6.4 Many are permanent: coercive and mimetic

Results from the questionnaire show that many of the CHLs are made permanent (5.1.1). This may have come as a result of the guidelines produced by the state (the GMC). In the guidelines the state writes that CHLs should be incorporated into the preventive health care service in the municipality. And, this may give reason to propose that the GMC has influenced municipalities to incorporate CHLs permanently (Helsedirektoratet 1. 2011). Hence, coercive mechanisms are active here.

On the other hand, one could argue that municipalities have incorporated CHLs on a permanent basis because they have observed that the “Modum Model” is permanent. The CHL in Modum has been permanent since 2000 (Figure 3), whereas the state did not publish their directional guidelines for organizational framing until 2011. Thus, it seems reasonable to argue that centers have copied the “Modum Model” and that the mimetic mechanism has influenced the level of permanency.

7.0 Conclusion

In this section I will sum up the discussion of the three research questions by order.

Research question 1

In what ways does the development of the CHLs fit into the pattern of the popularity curve discussed by Abrahamson and follow the trend criteria discussed by Røvik?

The first part of this question concerns how the development of the CHL seems to fit into the pattern of Abrahamson's popularity curve. This entails that the idea has gone through the subsequent five stages; creation, selection, adaptation, spread and de-institutionalization. According to the discussion, the CHLs have experienced a form of creation which most likely started before it was established in Modum. Interestingly, this center is often referred to as the first center. This indicates that the "Modum Model" has developed to become a proto type of an organizational idea, which supports Sahlin's theory regarding the spread of ideas through the broadcasting mode.

Furthermore, as the "Modum Model" developed and became known, similar alternatives were initiated elsewhere. These can be said to be hybrids of the CHL and an example of a cluster of different ideas. This corresponds to the selection stage. In the analysis it appears as if the CHLs have been selected by the state when they were internalized. Thus, it is indicated that selection and adaptation occurred simultaneously, and that the development differs from the order in the popularity curve.

In the graph showing the accumulated development of new establishments (Figure 1), one can see that more CHLs are established towards the end of the timeframe. Hence, it is suggested that the CHLs enters the spread towards the end of the timeframe. In the theory, the spread is followed by the de-institutionalization. Considering the fact that several municipalities responded to the questionnaire that they are planning to start a CHL, that the state encourage municipalities to establish CHLs, give reason to argue that the CHL is currently experiencing the spread, and have not entered de-institutionalization.

The second part of research question 1 concerns whether the development of the CHLs follow the trend criteria discussed by Røvik. He proposes that ideas that become trends are characterized by seven different aspects; social authorization, theorization, conceptualization, timing, harmonization, dramatization and individualization. According to the discussion, have

Johan Kaggestad and Ministers of Health given the CHLs publicity and recognition, which are examples of social authorization.

In regards to theorization, it does not seem like studies can show that the CHL improves health, and in turn reduce sick leaves. This is worth mentioning, because this was one of the premises for starting the CHL in Modum, and gives reason to question the theoretical foundations for the CHLs. This indicates that the CHLs differ from Røvik's characteristic regarding theorization.

Many of the centers that are established imitate the "Modum Model". This entails that the CHL has become a concept and a product, according to Røviks aspect about conceptualization. Nonetheless, in recent years templates for evaluation and assessment have been made such as "Guidelines for municipal CHLs". This supports Sahlin's theory that focus has shifted from proto types to templates.

The timing of the introduction of the idea seems to be rather good. The CHLs corresponds to public demands to be cost efficient, reduce sick leaves and take preventive action, and is coherent with trends in society regarding training and healthiness. Gyms and CHLs have developed accordingly, and it is suggested that this explain some of the reason why CHLs expand. However, it is suggested that CHLs and training centers develop simultaneously because they attract different groups in society. This is supported by studies showing that the group using the CHLs represents a small group in society: poor, older women. This indicates that they are not neutral, and differs from Røvik's aspect regarding harmonization.

Ministers, reporters and Royalties get to hear stories about users that have benefitted from CHLs. People who used to be sick and alone who now have become happy and healthy. One can argue that this represent examples of dramatization. The projection of user stories also shows that the CHL put attention to the individual; what it can do for you! This is reinforced in the program and can be recognized in coherent publications from the state. Hence, one can find examples of dramatization and focus on the individual, which is according to Røvik's theory.

Research question 2

According to the theory offered by Sahlin regarding translation; how has the CHL developed as an organizational idea as it has been implemented in different settings?

A sample of 30 CHLs in Buskerud and Nordland were sent a questionnaire with topics on organization, employment, referrals, activities, courses, cooperation partners, social status of participants, and success factors. Courses, cooperation partners and occupation of participants had a response rate that was considered to be low; therefore, these topics were not included in the analysis.

Variation was used as an indicator that the idea had been passed on through the process of translation according to Sahlin's theory. There is variation in how many "Healthy living" prescriptions centers receive, how many health talks they hold, how many repeat and how many complete the program.

Furthermore, there is variation in what department CHLs are organizationally positioned under, which seems to be explained by what actor took the initiative to start it. An interesting finding is that physiotherapists initiate one third of centers. They stand out as the only professional group, and influence pivotal levels of the CHL (initiation, organizational position, employment and refereeing).

The CHLs appear to resemble across several standards, such as the length of the project; many are made permanent. They seem to arrange the same activities and attract a homogeneous group of users. This implies that the CHLs have diffused on various matters, which contrast with Sahlin's assertion.

Finally, there is variation in what centers bring up as important success factors. This is the topic where the differentiation is the greatest. However, a few factors are mentioned more frequently; cooperation with referring parties, financial support and anchoring in the local administration. These areas seem to cause challenges to many of the centers in the sample. Considering efforts of the state to implement and develop the CHLs, this indicates that there is a gap between formal policies and the running operation. This can be described as an example of decoupling.

In sum, it seems as if the implementation of the CHLs to new contexts have led to both diffusion and translation; similarities and variation. And, there is not sufficient evidence to conclude whether the development of the CHLs support or differs from Sahlin's theory regarding translation.

This questionnaire reveals variations in numbers and quantities. However, it would have been beneficial to get insight into differences on qualitative data on how things are done at the

centers. This would have made it possible to compare whether the content in for example a health talk, is the same at different centers. Further case studies on quality measures may reveal this and provide more in-depth analysis of how the idea has developed as it has been implemented into new contexts.

Research question 3

Based on the theory offered by DiMaggio and Powell about isomorphism, what mechanisms seem to be influencing its development; coercive, normative or mimetic?

According to the discussion of the popularity curve, centers seemed to have copied others when establishing centers. This regards the CHL in Modum and other centers around the country. Thus, the mimetic appears to be relevant in creation and selection. Yet, the state was the one who selected the CHLs above other alternatives and internalized it into several reports and publications. Hence, one could argue that coercive mechanism have influenced the three final stages, and become more dominant towards the end of the period.

In sum, one could argue that the popularity curve has been influenced by all three mechanisms, yet the coercive and the mimetic appear to have been more prevalent than the normative.

In regards to the discussion of the trend criteria offered by Røvik and the results from the questionnaire Kaggestad seem to legitimize the CHL, which can be characterized as an example of the normative mechanism. The prevalence of physiotherapists also implies that this mechanism is relevant. Nonetheless, under theorization the question as to whether they improve health and reduce sick leaves is correlated to the low response rate on occupation partners and that many seem to face difficulties with their referees. This can be characterized as lack of normative mechanisms.

Conceptualization seems to be driven by copying of the “Modum Model”, and templates for assessment made by the state. It seems as if in recent years the state has created tools for standardization which implies that coercive mechanisms have become more dominant. Public initiatives also seemed to have influenced the degree the CHLs are in time with demands of society, especially through its focus on individualization. Hence, the coercive seem to have influenced these topics as well.

The homogenous group of users can be explained by social stigma attatched to users of the CHLs. This is created by people observing one another; in that case the mimetic is influencing

this relationship. However, both the state and referees can enforce this; thus, coercive and normative mechanisms are also relevant.

Finally, the reason many centers are permanent can be related to public initiatives as well as imitation, and one could argue that both the coercive and mimetic mechanism are active here.

In sum, it seems that one mechanism rarely excludes another, and they often appear in combination of two or three. All three mechanisms appear rather influential in different aspects. More normative pressures have been revealed in the analysis of the trend characteristics and the questionnaires, compared to the popularity curve.

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9.0 Appendix

9.1 Appendix 1

List of CHLs and year of establishment.

Region	Municipality	Year
Buskerud	Modum	1996
Nordland	Alstahaug	1998
Buskerud	Gol	2002
Buskerud	Ål	2002
Buskerud	Øvre/Nedre eiker	2003
Rogaland	Hå	2004
Nordland	Vefsn	2004
Nordland	Brønnøy	2004
Nordland	Bindal	2004
Buskerud	Drammen	2005
Buskerud	Sigdal	2005
Buskerud	Hemsedal	2005
Nordland	Hamarøy	2005
Nordland	Hattfjelldal	2005
Oppland	Nordre land	2005
Oppland	Østre Toten	2005
Oppland	Søndre land	2005
Troms	Storfjord	2005
Vest-Agder	Kristiansand	2005
Akershus	Rælingen	2006
Akershus	Aurskog-Høland	2006
Buskerud	Flå	2006
Nordland	Narvik	2006
Nordland	Vestvågøy	2006
Troms	Gratangen	2006
Aust-Agder	Grimstad	2006
Aust-Agder	Arendal	2006
Oppland	Gjøvik	2006
Troms	Bardu	2007
Akershus	Asker	2007
Vest-Agder	Kvinesdal	2007
Vestfold	Stokke	2007
Sør Trøndelag	Trondheim	2008
Buskerud	Nore og Uvdal	2008
Buskerud	Hurum	2008
Nordland	Rana	2008
Oppland	Ringebu	2008

Oppland	Lillehammer	2008
Troms	Målselv	2009
Sør Trøndelag	Fosen	2009
Sogn og Fjordane	Sogndal	2009
Nordland	Sørfold	2009
Nordland	Fauske	2009
Aust-Agder	Lillesand	2009
Aust-Agder	Iveland	2009
Aust-Agder	Froland	2009
Aust-Agder	Birkenes	2009
Sogn og Fjordane	Gloppen	2009
Telemark	Bamble	2009
Telemark	Skien	2009
Østfold	Indre Østfold	2010
Vestfold	Sandefjord	2010
Vest-Agder	Mandal	2010
Troms	Salangen	2010
Telemark	Bø	2010
Telemark	Vinje	2010
Rogaland	Bjerkreim	2010
Oppland	Dovre	2010
Oppland	Gran	2010
Nordland	Meløy	2010
Nordland	Flakstad	2010
Nordland	Bodø	2010
Nordland	Bindal	2010
Akershus	Oppegård	2010
Aust-Agder	Gjerstad	2010
Finnmark	Hasvik	2010
Troms	Kvænangen	2010
Troms	Skjervøy	2010
Sogn og Fjordane	Sogndal	2011
Vest-Agder	Vennesla	2011
Troms	Lyngen	2011
Troms	Dyrøy	2011
Troms	Kåfjord	2011
Troms	Balsfjord	2011
Troms	Lenvik	2011
Møre og Romsdal	Surnadal	2011
Møre og Romsdal	Ålesund	2011
Oppland	Nord-Aurdal	2011
Oslo	Bydel Frogner	2011
Telemark	Seljord	2011
Telemark	Porsgrunn	2011
Nord/Sør -	Værnes	2011

Trøndelag	regionene	
Nord - Trøndelag	Grong	2011
Møre og Romsdal	Eide	2011
Hordaland	Øygarden	2011
Hordaland	Tysnes	2011
Akershus	Eidsvoll	2011
Akershus	Nittedal	2011
Akershus	Ski	2011
Rogaland	Karmøy	2011
Vestfold	Andebu	2011
Vestfold	Nøtterøy	2011
Vestfold	Re	2011
Akershus	Lørenskog	2012
Hordaland	Bergen	2012
Hedmark	Hamar	2012
Hordaland	Stord	2012
Hordaland	Sveio	2012
Hordaland	Kvam	2012
Hordaland	Askøy	2012
Møre og Romsdal	Fræna	2012
Møre og Romsdal	Molde	2012
Møre og Romsdal	Skodje	2012
Møre og Romsdal	Rauma	2012
Nord - Trøndelag	Innherred	2012
Nord - Trøndelag	Midtre Namdal	2012
Oslo	Bydel Sagene	2012
Oslo	Bydel Stovner	2012
Oslo	Bydel Bjerke	2012
Rogaland	Karmøy	2012
Sogn og Fjordane	Hyllestad	2012
Sogn og Fjordane	Hornindal	2012
Sør Trøndelag	Hitra	2012
Troms	Tromsø	2012
Oslo	Bydel Alna	No info
Aust-Agder	Tvedestrand	”
Vest-Agder	Lyngdal	”
Vest-Agder	Søgne	”
Vestfold	Tønsberg	”
Vest-Agder	Songdalen	”
Vest-Agder	Audnedal	”
Vest-Agder	Flekkefjord	”
Troms	Kåfjord	”
Vest-Agder	Åseral	”
	To be	

Aust-Agder	Bykle	2013
Telemark	Kragerø	2013
Telemark	Drangedal	2013
Troms	Harstad	2014

9.2 Appendix 2

Extract from a brochure for the CHLs in Aust-Agder (Frisklivssentraler i Aust-Agder, 2011).

Foto: colourbox.com

Frisklivssentralen hjelper og støtter personer som ønsker å endre levevaner knyttet til fysisk aktivitet, kosthold eller tobakk, gjennom individuelle samtaler og gruppebaserte tilbud. Man trenger ikke å ha en diagnose eller være syk for å delta på en frisklivssentral.

Frisklivssamtalen er individuell og bygger på prinsip- per for motiverende samtale, en metode som er dokumentert å være effektiv for endring av vaner.

Kommunene har i varierende grad tilbud innenfor følgende områder:

Frisklivstrening i gruppe kan foregå både innendørs og ute i naturen. Nivået er tilpasset deltakerne og har varierende innhold, for eksempel: gåtur, vannaktivitet, ballspill, intervalltrening, styrketrening, spinning, pilates og trening i sal til musikk.

Bra mat er et inspirasjonskurs hvor det er fokus på å øke motivasjon til å oppnå et varig sunnere kosthold. Man får blant annet praktiske råd i forhold til kosthold i hverdagen, utveksler erfaringer med andre deltakere og lærer å lese varedeklarasjon.

Røykfri sammen er et tilbud til deg som ønsker å slutte å røyke. Mange opplever at det er lettere å bli røykfrie sammen med andre.

Kurs i depresjonsmestring er et kurs hvor man jobber for å endre tanke- og handlingsmønsteret som ved- likeholder og forsterker nedstemtheten/depresjonen.

Temaundervisning skal gi motivasjon og inspirasjon til endring av levevaner.

”Det gjør så godt å være sammen med andre – jeg glemmer det som er slitsomt”.

Deltaker på frisklivssentralen

Hvem kan delta på frisklivssentralen?
Lege, annet helsepersonell eller NAV kan henvise deltakere til frisklivssentralen gjennom frisklivsresepten, men man kan også kontakte oss på eget initiativ.

Oppfølgingen starter med en strukturert samtale, hvor vi ser på muligheter og mål for perioden. Etter tre måneder gjennomføres en ny samtale hvor vi oppsummerer erfaringer og planlegger veien videre. Frisklivssentralen følger opp deltakere gjennom individuelle samtaler og gruppebaserte tilbud i inntil 12 måneder.

En norsk studie viser at frisklivsresepten kan gi bedret fysisk form, redusert vekt og økt selvopplevd helse.

De som ønsker hjelp til å endre levevaner kan ta kontakt med oss, uansett om man ønsker å delta på gruppetilbudene ved frisklivssentralen eller ikke. Frisklivssentralen har god oversikt over hva som finnes av tilbud i lokalmiljøet, og kan gi deg opplysninger om hvor du kan finne aktiviteter og tilbud i kommunen.

”Jeg ville først ikke være med på dette da jeg fikk resepten av legen. Nå skjønner jeg at det er det beste som har skjedd meg”.
Deltaker på frisklivssentralen

9.3 Appendix 3

Questionnaire for CHLs

1. Organisering

Navn på kommune	
Antall innbyggere i kommune	
Oppstartsår Frisklivssentral	
Organisatorisk plassering i kommunen	
Forankring i kommunen, prosjekt? Ev. varighet	
Interkommunalt samarbeid	
Økonomiske rammer 2012, støtte from hvem?	
Hvilken instans/person tok initiativ til å starte sentralen? Kommune/Fylke/Organisasjon/Enkeltperson	

2. Ansatte og andre bidragsytere per desember 2012

Ansatte (Yrkesgruppe/kompetanseområde)	Antall ansatte	Årsverk

Andre bidragsytere	Antall	Bidragsområde/hvordan bidrar de til sentralen
Eksterne instruktører/kursledere		
Frivillige		

3. **Henvendelser 2012**

Hvem henviser	
Antall henvist med frisklivsresept	
Antall andre henvendelser (møtt selv)	
Antall helsesamtale 1	
Antall gjennomførte frisklivsresepter (møtt til avsluttende helsesamtale)	
Antall som gjentar frisklivsresepten	
5 hyppigste henvisningsårsaker	

4. Aktiviteter/kurs

Tilbud/Aktivitet	Hyppighet/Hvor ofte arrangeres det?	Antall deltakere		Gj.snittsalder
		Kvinner	Menn	
Kurs				

5. Samarbeidspartnere

Samarbeidspartner Spesifiser offentlig/private/frivillig	Hvilke tilbud/hva samarbeides det om?	Samarbeidsform/tilknytning/avtale

6. Deltakere frisklivsresept

Status på deltaker	Antall
Grunnskole som høyeste utdanning	
Ev. annen informasjon om utdanning	
Er i jobb	
Er sykmeldt	
Ev. annen informasjon om arbeidssituasjon	

7. Suksessfaktorer

Hvordan vil du si at sentralen fungerer, og hvorfor/hvorfor ikke?	
Hva er viktig for at sentralen skal fungere?	
Hvis du skulle starte en ny sentral i dag nevn 5 elementer du ville vektlagt?	

9.4 Appendix 4

Description of calculations and methods used to compare the results in the questionnaires.

Respondents

Table 8

Total sample	Buskerud	13	Nordland	17	sum	30
Respondents	Buskerud	8	Nordland	13	sum	21

I plotted answers manually into Excel where I organized them into regular spreadsheets. I made pie charts and tables in the automatic tools. On questions where responses consisted of text such as “Length of project” (permanent/trial) I calculated the frequency of each response using basic formulas for percent. (When I refer to calculation of percent or frequency later in this paper I have used this formula.)

On employment I counted and summarized exact figures for man-years for each group rather than calculating the frequency. This was because there turned out to be great variation in regard to the size of a position; one place had one employee in 40 percent of fulltime, while another had four fulltime employees. Counting the frequency of the employees would give misleading results because one physiotherapist at one center was not necessarily equal to one at another center. In any case, once I had summarized the size of the positions I calculated the frequency of each professional group.

In order to see if there was a correlation between two events, such as “Organizational position in the municipality” and “Who took the initiative to start the center” I paired responses to the different questions, and counted how many were organized under the same unit that took the initiation so start the center.

In referrals I first compared how many people who were referred to the CHL, and how many ht1 and ht2 they performed. To investigate the correlation between the number of inhabitants in the municipality and the number of referrals I organized centers according to the size of the population. I detected the median, and distinguished between those who were above and below it as relatively “larger” or “smaller”. I used the same procedure on the number of prescriptions (in order) to differentiate between those who receive “more” and “less” prescriptions. Then, I compared how many “larger” centers received “more” prescriptions and

consequently “smaller” and “less”. I used this procedure to check the correlation between how many referrals they receive and how many complete and repeat the program.

To get the frequency of how many complete the program (have HT1 once they have had HT2) I divided the number of HT1 by the number of HT2.

I primarily used median as a comparative tool in my analysis because extreme outliers tended to influence the average. However, under gender and age I calculated the average since the variation across the sample was negligible.