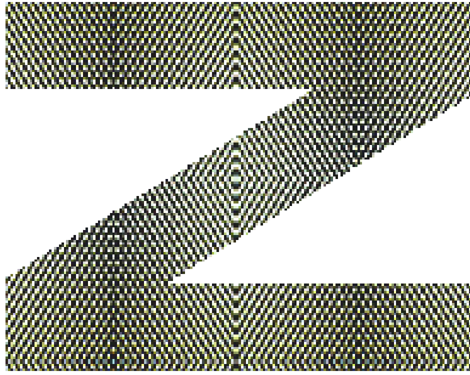
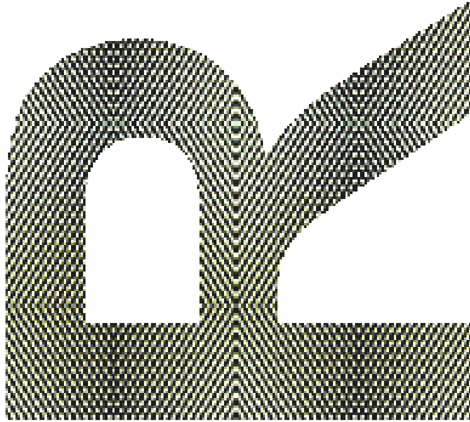
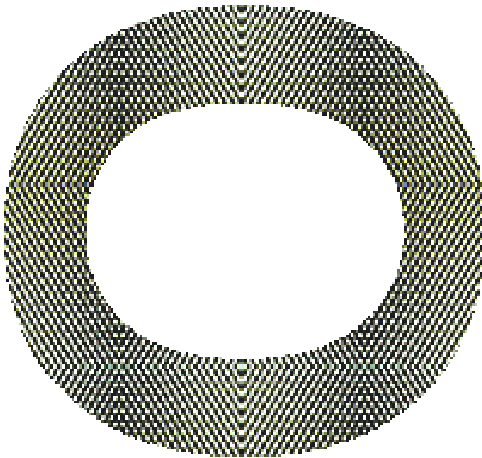
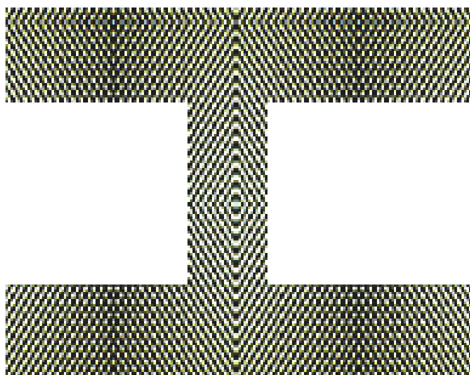

The Norwegian Hospital Reform of 2002: Central government takes over ownership of public hospitals

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HEALTH ORGANIZATION RESEARCH NORWAY - HORN

Working paper 2004 : 1

UNIVERSITY OF OSLO
Department of Health Management
and Health Economics

The Norwegian Hospital Reform of 2002: Central government takes over ownership of public hospitals[1]

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This version: 16th February 2004

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[1] An early version of the paper was presented at the 24th Nordic Health Economists' Study Group Meeting (NHESG 2003) in Bergen, 15th - 16th of August 2003. Thanks to seminar participants for comments and suggestions. Financial support from the Norwegian Research Council (grant no. 153074/530) to the Health Organization Research Program Norway (HORN) is acknowledged (Hagen).

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Health Organization Research Norway (HORN)
Financial support from Th eResearch Council of Norway is acknowledged.
ISSN-0808-7857

Abstract

From January 2002 the central government took over the responsibility for, and ownership of, all public hospital in Norway. This hospital reform represents the latest attempt by the central government to resolve what are meant to be the main problems of the Norwegian health care system. In this paper we describe the recent reforms, and the problems they are intended to remedy. We also indicate further proposals that we believe need to be accomplished to ensure that the reforms become successful. We conclude by indicating some lessons that can be learned for the Norwegian experiment.

Keywords: Public hospital, hospital reform, financing, fiscal federalism, Norway

1 Introduction

From January 2002 the central government took over the responsibility for, and ownership of, all public hospital in Norway. The reform represents the latest attempt by the central government to resolve what is meant to be the main problems of the Norwegian health care system: long waiting lists for elective treatment, lack of equity in the supply of hospital services, and a lack of financial responsibility and transparency that led to a blaming-game between the counties, which were the former hospital owners, and the central government. The reform also touches upon the problem of lack of legitimacy of county governments.

The health care sector in the Scandinavian countries is often characterized as a decentralized NHS-model (Rice and Smith 2002); funding is tax based, main actors are public, and compared to the centralized British NHS, local and county governments have an important role in allocation decisions. By the takeover-reform the Norwegian model changes from a decentralized to semi-centralized NHS-model. In this paper we address four questions related to the reform: First, what is the background and reasons for the transfer of hospital ownership from the county councils to the central government in Norway? Second, what are the main elements of the new Norwegian model? Third, how should the hospital reimbursement system be aligned to the current institutional structure? Fourth, what can be learned from the Norwegian experience?

In this paper we first give a short historical review over the period where the counties were responsible for the institutional health services in Norway. This period lasted from 1970 to 2002. In the review we emphasize the relationship between the hospital funding system and the incentives it is created for important actors in the health sector. This is done since analysis, see e.g. (Biørn, Hagen et al. 2003) and (Iversen and Luras 2000), have showed that actors in the Norwegian health care sector do respond to economic incentives. Our analysis is thus built on the belief that to understand the performance of

the health care sector it is important to analyze how reimbursement systems affect important actors' behaviour.[1]

We show that the hospital funding has varied largely in the time period 1970-2002, thereby giving important actors changing incentives. Furthermore, proposed changes in the funding system were often results of the problems that the current funding systems were creating. During the time period we also observe that the central authorities to an ever-increasing extent have intervened with the decisions taken at the county level regarding the specialist care. The interventions have taken the form of both increased financial responsibility and of political-oriented initiatives like the introduction of a waiting time guarantee and the introduction of free choice of hospital. As a result of these interventions, central authorities become partly responsible for the outcomes that were produced in the health care sector. The joint responsibility of the state and the county councils started a blaming game between these parties were both county councils and the state tried to make the other part responsible for the sector's inability to reach central goals. In the end, and by the 2001 Hospital Act, the state decided to quit the game by claiming full and complete responsibility for all specialist health care.

The takeover (non-) debate and the 2001 Hospital Act are then described. The takeover proposal from the minority Labour-government came as surprise to most political observers. However, the proposal passed the Parliament with an overwhelming majority, and without much debate, tanks to support from the right wing Progressive party and the Conservatives. The reform is however not only an ownership reform. It is also a reform that includes a new way of organizing and managing hospitals as these institutions now are organized as enterprises. This means that they have become separate legal subjects – enterprises – and thus not an integrated part of the central government administration, although ownership still is public. Principal health policy objectives and frameworks are determined by central government and will form the basis for management of the enterprises. The day-to-day running of the enterprises are however clearly the

[1]The fact that actors in the health care sector do respond to economic incentives is not exceptional for Norway. See e.g. Croxson, B., C. Propper, et al. (2001) and Le Grand, J. (1999) for two other studies that show similar results.

responsibility of the general manager and the executive board. In this way the reform is also about decentralization of the management process. It is hoped that one through decentralization will achieve less bureaucracy, an improved ability to manage care and enhances user-information.

By the 2002 hospital reform the central government changed the ownership, the structure (i.e., the number of regional actors) and the form of attachment, but not the financing system (which was still aligned to the former decentralized NHS-model). The central authorities did however signal that a special commission should be appointed to look more closely into the financing issues. This commission was appointed in February 2003, and delivered its report (NOU 2003: 1) in December the same year. In 2002 and 2003 the financing system did however mimicked the one that were used prior to the hospital reform. In section 4 we describe this financing system and argue that since the financing system was unchanged, many of the problems that the hospital reform was intended to solve still are present. Furthermore we discuss changes in the financing system that are implemented from 2004.

Finally, in section 5 we conclude by indicating some lessons that can be learned from the Norwegian experience, and we draw some parallels to experience and the debate in other Scandinavian countries. To us, it seems like the central government's interventions have lead to lack of transparency and blaming games in the Norwegian health care sector. A reform was necessary to tackle these problems. Some of the problems underlying the Norwegian reform are common to the Nordic countries. However, they have been tackled in different ways in different countries: While Norway chose central government takeover of hospitals, Sweden has developed their regional, county-based model. Denmark has currently put on their think cap. A royal commission with a mandate to recommend reforms in hospital and county management delivered its report in January 2004.

2 Historical Review 1970-2001

Norway is divided into nineteen counties, with an average of 237,000 inhabitants (2001), ranging from 74,000 to 509,000. The counties were assigned responsibility for institutional health services by the introduction of the 1970 Hospital Act. However, most hospitals were owned and managed by county councils also before this legal formalization. Since 1970, and until 2001, each of the Norwegian 19 counties has assumed the responsibility for the planning and operation of the local hospital sector (including both somatic and psychiatric institutions) as well as other specialized medical services, such as laboratory, radiographic and ambulance service, special care for alcohol and drug addicts and dental care for adults. The only exception was that the state owned some highly specialized university hospitals including Rikshospitalet (the National Hospital) and Radiumhospitalet (The Norwegian Radium Hospital).

Responsibility for primary care shifted from state to local government in 1984. Consequently, and contrary to other Nordic countries, the responsibility for primary and secondary care has been divided between different governmental levels.

Each county council, which is directly elected for a four years term, organized hospital services within its territory according to its own priorities within the overall national objectives. Thus, the counties were legally obliged to submit plans for their health services on a regular basis for approval to the Ministry of Health and Social Affairs. During this time period, central authorities have put stronger emphasize on their role in authorizing construction or substantial expansion of hospitals.

The funding of the county hospital system (including most university hospitals and hospitals owned by none-profit organizations) has come from four sources in the time period from 1970 to 2001:

- County councils provide basic hospital financing. County councils revenues come from local taxes and block grants received from the central government. Contrary to other Scandinavian countries, taxes are fixed by the central government implying a centralized system of county finance.
- Earmarked grants are provided by the central government to counties targeting specific activities to reflect national policy objectives (e.g. research, education and specific patient groups).
- Contributions from the National Insurance Scheme (NIS) have been used to finance ambulatory (outpatient) care as well as private specialists, laboratories and radiotherapy. In periods NIS has also financed in-patients.
- A minor patient fee has existed for ambulatory care.

Even though the funding of the hospital system has been four-tired in the whole period, its composition has varied largely in different sub-period. As a result the incentives for county councils and hospitals have varied too.

1970 – 1980: The Era of Per Diem Reimbursement

Like in many other European countries, hospital financing in the 70s were based upon a per diem reimbursement system (Nerland 2001). The combination of decentralized responsibility and per diem funding from the state gave strong incentives for the counties to increase both the existing hospitals' activity and to invest in hospital buildings and equipment. As expected, hospital costs increased strongly reaching a yearly average of nearly 10% in years after 1970, see Table 1 below. In addition, the decentralized responsibility resulted in an increased geographical difference in adequacy and equity in access to health care, in particular in the access to specialized medicine.

To resolve these problems, the present government put forward a 1974 White Paper (St meld nr 9 (1974-75), suggesting that the 19 counties should be grouped into five health regions with one university hospital in each region. Regional health committees headed the health regions. Cooperation was, however, based on voluntary participation from the counties. In addition the government suggested that hospital costs should be reimbursed by means of annual block grants instead of on a per diem basis.

The Norwegian Parliament approved the creation of the five health regions from 1974, but decided to keep the per diem reimbursement of hospital costs. These costs thus continued to rise, and more than doubled (in fixed prices) in the years from 1970 to 1980 (NOU 2003: 1).

1980 – 1997: The Era of Block Grant Financing

The present Labour government decided to reform the hospital funding system in 1980 - approximately at the same time as similar reforms in other European countries (OECD 1987; Mossialos and Le Grand 1999). The central government now gave fixed annual block grants to the county councils for funding of hospitals and other activities (e.g. secondary schools, culture and transportation). The grants were set according to a set of criteria such as counties tax revenues, the age composition of the population and population density. Contrary to other Nordic countries, tax rates were fixed by the central government implying a centralized system of county finance (Rattsø 1998). The counties, in turn, provided their hospitals with an annual budget, from which most of the specialist physicians and other staffs were paid salaries according to a national pay scale. Major capital spendings were budgeted separately on an ad hoc basis. The central government reimbursement of outpatient clinics through the National Insurance Scheme (NIS), sustained. In addition to cost containment, the main reason for the block grant reform at the county level was to allocate more resources to primary care. In this way, the funding reform can be seen as part of a new health policy, placing more emphasis on preventive care.

The change in funding changed the incentives to contain costs, and as county councils become responsible for the total costs in the hospital sector, more emphasize were put on cost containment. As a result, the annual cost increase in the hospital sector decreased dramatically; the cost increase in the 1980s was on average less than 1 % per year, (see Table 1). The low growth rate should however be seen as result of more that the reform in the funding system. First, Norway was in a recession following the collapse in the oil price in 1986. Second, the growth rate in primary care was substantial in the first part of the 80s. This could have reduced demand for hospital care.

Table 1. Percentage cost increase in the hospital sector in the period 1971-2000

Years	Per cent
1971-1975	40
1975-1980	31
1980-1985	7
1985-1990	3
1990-1995	9
1995-2000	30

Source: Adapted from Figure 3.1 in NOU 2003:1

The county councils' incentives to contain hospital costs resulted in an insufficient ability of both general and psychiatric hospitals to absorb patient inflow, see e.g. NOU 1985:25. This followed even though the present Centre-right government modified the block grant system from mid 80s by introducing earmarked grants to county councils in order to stimulate hospital activity. The intervention did not follow from a comprehensive evaluation of the funding system but were ad hoc measures introduced to dampen the growing criticism against the central government for neglecting the health care sector (Carlsen 1994). Later on, the persistence of long waiting lists prompted the central authorities to introduce national standards for admission priorities. This measure was supplemented in 1990 with the introduction of a legal waiting time guarantee. According to this legislation, the county councils should assume full responsibility for offering treatment to patients, who have been given a waiting time-guarantee, within six months, making use of available capacity in other counties if needed.

The introduction of the waiting time guarantee did however not bring down the number of patients on waiting lists, even though the central government compensated the counties with increased funding. On of the reasons for this was that the county councils responded to the increased funding by reducing their own expenditures to specialised health care: While the total real expenditures to specialised health care increased by 6.3% from 1991

to 1994, the county councils share of the expenditure was reduced by 1 %, (White paper 44 (1995-96)). Furthermore, as Table 2 shows, the number of violations of waiting times guarantees increased sharply, and the proportion of patients granted such a guarantee varied both between and within counties, pointing to differences in interpretations of the criteria for giving a guarantee.

In 2001, the Parliament decided to change the law by providing patients with the right of having their health situation assessed within 30 days, and a right to receive necessary health care within individual medical limits. At the same time, the Parliament approved a law that gave (most) patient the right to choose provider within the whole of Norway. Hence, and even though the waiting time guarantee cannot be evaluated as successful in bringing down the number of patients on waiting lists, it can be seen as the starting point of a trend that has reinforced the patients' position in the Norwegian health sector.

Table 2: Number of violations of the waiting time guarantee.

White Paper /at the turn of the year	**Number of violations**[1)]	**Comments**
Nr. 50 (1993-94)	Not available	94 % of WT[2)]-patients treated within 6 months. Expressed need to increase capacity.
Nr. 44 (1995-96)	1993: 5000 (6,5 %) 1995: 10 000 (10 %)	ABF[3)] suggested, 3 months WT-guarantee implemented, 30 days first opinion guarantee.
Nr. 24 (1996-97)	Aug. 1996: 17 000	Bad quality of the waiting list is said to be a great problem. large variations in the proportion of patients granted a guarantee.
1997/1998	25 000	Whereof 8000 violations of the 3 months guarantee.
1998/1999	7 100	Only the 3 months guarantee.
1999/2000	5 700	

[1)] Till the turn of the year 1997/98: violation of the 6 months waiting time guarantee

[2)] Waiting time

[3)] Activity based financing

In the so-called White Paper on Health of 1994, (St.meld. nr. 50 (1993-94)), the present minority Labour government invited the Parliament to discuss several major health issues that turned out to be important in the next decade. These were:

- Cooperation and division of labour within the five health regions. The recommendation was better coordination achieved through regional health plans and that the Ministry of Health was given a position of hands on control of the plans with the ability to initiate reforms in the division of labour between hospitals, finance such reforms, and approve regional plans.
- The financing system for the specialist care. The government discussed alternatives to the block grant system, first and foremost DRG-based[2] piece rate financing, but concluded with the recommendation of status quo.
- Strengthening of patients' rights. The government recommended a separate law on patient rights including rights to assessment and second opinion, rights to treatments, and a right of free choice of providers (hospitals).
- Ownership of hospitals. The government touched upon this question but without suggesting changes.

The Parliament accepted the main recommendations from the government, including continued county ownership of hospitals. However, the Parliament raised the question of ownership to university hospitals and the government appointed a special commission to evaluate this question in the spring of 1996. A further discussion of the ownerships question follows in part 3.

The role and responsibilities of the regional health committees was further discussed in a 1997 White Paper (St meld nr 24 (1996-97)) that formed the basis for the introduction of new legislation to regulate the role and responsibility of the regional health committees. The aim of the reform was to improve both national and regional planning, and to ensure cooperation and the division of labour among counties. According to the new regulation, the regional health committees were responsible for the development of regional health plans in accordance with national guidelines. National areas of high priority, determined by the central authorities, were to be included in the plans. Furthermore, the regional health plans had to be evaluated and approved by county councils prior to authorization by the Ministry of Health and Social Affairs. If the counties failed to agree on vital

[2] Diagnostic related groups or DRGs.

issues, or if the plan was not made in accordance with national guidelines, the central authorities were entitled to make changes in the regional health plans.

July 1997 – present: The Era of Activity Based Financing

Less than two years after the debate over the White paper on Health, the present Labour government decided to change the hospital financing system, (St meld nr 24 (1996-97)). From July 1st 1997 a fraction of the block grant from the central government to the county councils was replaced by a matching grant depending upon the number of patients treated, the patients' DRGs, and a national standardized cost per treatment. The government used several arguments for the introduction of activity based financing (ABF). First, an increase in the number of elective treatments was considered needed in order to fulfill the waiting list guarantee adopted by the Parliament. Second, an increase in the central government block grant to the county councils was assumed to be insufficient because of the leakage to other sectors for which the county councils are responsible, in particular secondary schools and transportation. Third, block grants (without any activity measures) to hospitals were seen as an inefficient way of financing due to the former experience of crowding out. As a consequence, a reform of the financing mechanism was sought for. By introducing a matching grant to the county councils, the government intended to influence the county councils' cost of hospital treatment relative to other services, and hence, shift the county councils' priorities in the direction of hospitals. In addition, and to ensure that the county councils increased their share of the hospital funding, the activity-based component was set below the marginal cost of producing a DRG-point. The intention was also that the ABF should be implemented as activity-based contracts between a county council and its hospitals. However, the county councils were free to decide the kind of funding mechanism they would use.

It turned out that 15 of Norway's 19 county councils introduced ABF in 1997, another two introduced ABF from 1 January 1998, another one from 1 January 1999 and the last one from 1 January 2000 (Biørn, Hagen et al, 2003). Initially set at 30 percent in 1997, the activity-based component in 2001 accounted for 50 percent. In 2002 and 2003 the activity-based component was further increased to respectively 55 and 60 percent of the

expected cost per treatment. By initially setting the activity component relative low it was believed the block grant component still would the main determinant of the activity level. As the same time as activity-based financing of somatic care was introduced, central authorities decided to earmark large proportions of the funding of psychiatric health services. The reason was a concern by central authorities that county councils would put less emphasize on these highly prioritised services that were financed through block grant. Again we see an example of stronger involvement by central authorities in county councils' priorities.

The introduction of ABF is followed by a substantial increase in the number of cases treated and a reduction in waiting time: From 1997 to 2001 the yearly average increase in the number of treated somatic inpatients was about 2.2 per cent, an increase from the yearly average growth of about 1 per cent in the time period 1990 to 1997 (Biørn, Hagen et al. 2003). The increase in activity should however be seen as a result of several factors: First, Biørn, Hagen et al (2003) find a 2% increase in technical efficiency as a result of the reform.[3] Second, financial resources to the hospital sector increased both as a result of ordinary central government and county councils budget decisions. Parts of increase in counties' spendings were financed by increased deficits ((Bjørnenak, Hagen et al. 2000). Third, and partly as a result of higher deficits, the central government provided the counties and thereby the hospitals with supplementary funding during the fiscal years. Fourth, the problem with lack of key personnel was partly reduced from mid 90s, in particular for physicians. However, the increased demand for labour nevertheless contributed to tight labour markets, which resulted in high wage inflation. Simultaneous to the increase in technical efficiency, one can therefore observe a reduction in cost efficiency.[4]

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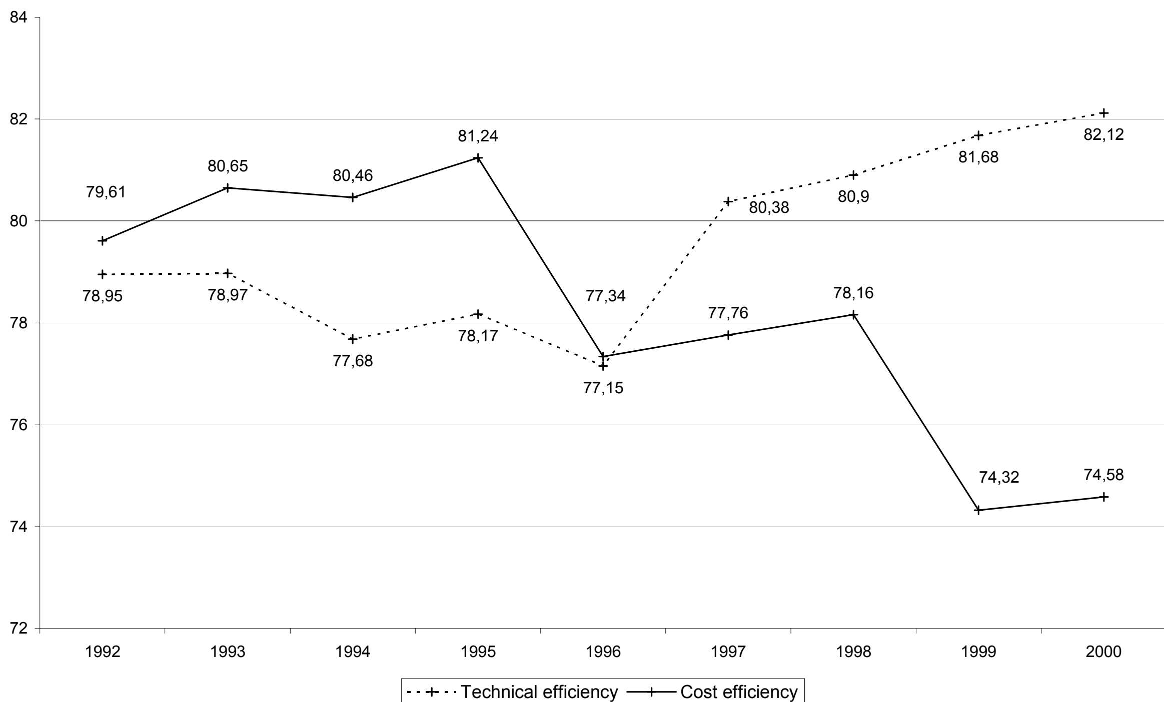
[3] An increase in technical efficiency means that the hospitals are able to produce more output with the same amount of inputs.

[4] Cost efficiency is measured as inputs in costs. A reduction is cost efficiency means that the costs of producing the same level of outputs have increased.

Figure 1 summarizes the development of technical- and cost efficiency during the 1990s. The efficiency analyses are done by Data Envelopment Analysis and are further described in Biørn, Hagen, et al., 2003.

Figure 1: Average levels of efficiency 1992-2000. Two different input/output specifications.

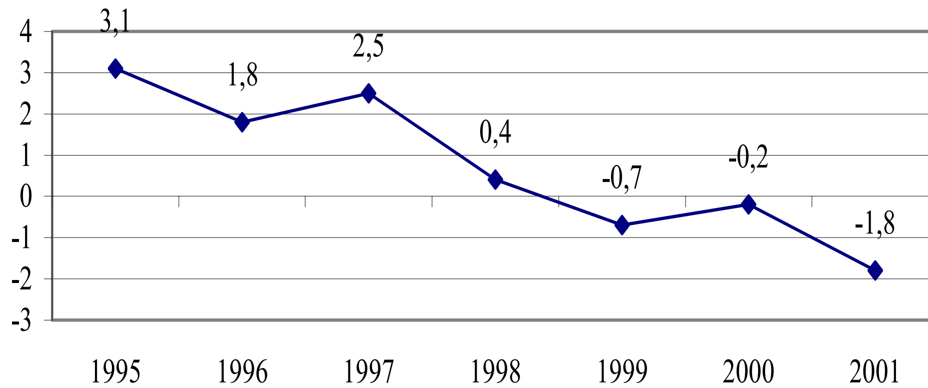


Source:(Biørn, Hagen, et al, 2003)

In consequence, the activity-based financing reform had both desired and undesired effects. The intended increase in treatment of patients is realized. However, waiting lists were nevertheless long. At the same time we observe three effects that probably are dysfunctional to the steering system of the health care sector: First, county councils became more financial dependent by the central government as the share of the county councils own spending on somatic hospital services decreased from more than 72% in 1996 till less than 44% in 2001. Second, the combination of increased activity and

increased use of expensive labour resulted in large deficits in the hospital sector. As depicted in Figure 2 below, the *deficit* as share of county revenues increased from a 3.1 percent surplus in 1995 to a 1.8 percent deficit in 2001.

Figure 2: Net operating surplus as share of revenues (counties, except Oslo)



Source: Statistics Norway, March 2002.

These deficits were to some extent covered by supplementary funds from the state to the county council. In Table 3 supplementary funds are classified into two groups: Funds that explicitly are given as a result of unplanned activity-increase, and supplementary funds with another background (for example cost increases). As also can be seen from the table, supplementary funding has not been reduced after the reform. We'll return to this later.

Table 3 Supplementary fund from the state to the county councils 1997–2001, and state and regional health enterprises (2002-2003).

Year	Supplementary funds in mill Nkr		Aim	Document
	Unplanned activity increase	General financial situation		
1997		300	Problematic economic situation in county council hospital partly due to high salary increases for physicians.	St.prp. nr. 83 (1996-1997)
2000	1 018	710	To finance unforeseen activity increase in county hospitals	St.prp. nr. 47 (1999-2000) Innst. S. nr. 241 (1999-2000)
2001	330	231	Unplanned activity and problematic economic situation with the regional hospitals.	St.prp. nr. 22 (2001-2002) Innst.S.nr.57 (2001-2002)
2002	651	1500	Finance unplanned increase the activity level, and compensate for the economic deficits the regional health enterprises inherited from the county councils	St.prp. nr. 59 (2001-2002) Innst. S. nr. 243 (2001-2002)
2003	1 970		To compensate the hospitals for realizing a higher activity level in both 2002 and 2003 that assumed by the Parliament.	St. prp. nr. 21 (2003-04) Innst.S.nr.88 (2003-2004)

County councils and hospitals probably interpreted the supplementary funds as a signal of softer budget constraints. Finally, the increased involvement of central authorities resulted in a blaming game between the county councils and the central government were both parties tried to make the other part responsible for the sector's inability to reach

central goals – as reduced waiting time for elective patients, higher cost efficiency and cost control. This eroded the trust between central authorities and the county councils.

3 The Takeover (Non-) Debate and the 2002 Hospital Act

The mandate for the special commission that was set up to discuss ownership of university clinics in 1995 -96 was expanded after one of the commission's first meetings to include recommendations regarding ownership of all hospitals as well as other parts of specialist care. The commission's recommendations were unanimous in respect of every point it had been asked to consider, except for the question of ownership (NOU 1996:5). At this point the 12-member commission was divided into three equal fractions: One voted in favour of continued county ownership of the hospitals. Another fraction supported a model characterized by two main elements: First, hospitals are owned and governed by a regional enterprise were the counties within each health region are the shareholders. Second, county councils are seen as purchasers of services from the regional enterprises. The third fraction supported central government takeover and management of hospitals through a NHS-like national directorate with regional offices. The commission's report did not lead to changes in the central governments policy as far as ownership is regarded, but in line with the recommendations from the report, from the 1994 White paper on health and as described above, new guidelines for regional cooperation were developed.

The difficult economic situation in the hospital sector at the end of the 90s and the endless dispute of who was to blame for long waiting lists and increasing deficits, led the present minority Centre government to try re-focusing the debate. The government appointed a special commission to look more closely into the hospitals forms of attachments to county councils. The commission's report (NOU 1996:5), investigated the advantages and disadvantages of various agency models like the traditional hierarchical model, more enterprise oriented attachments, and various forms of state- and county corporations. The commission was unanimous in its recommendation that hospitals must be given more autonomy. A majority of the commission argued that hospitals could be

organized either as state enterprises (the two state hospitals) or municipal/county enterprises. This suggestion was forwarded by the Ministry of Health and Social Affairs in a 1999 Act (Ot prp nr 25 (1999-2000)), and later on approved by the Norwegian Parliament. Basically the new form of attachment meant that hospitals could be organized as separate legal subjects that were not an integrated part of the county council administrations. It was also suggested that the county enterprises should have their own board, and that the county councils only exercised its authority through a general meeting, and should not interfere in the day-to-day issues. On the other hand, the county councils as owners would still determine principal health policy objectives and frameworks. Furthermore, hospitals were still publicly financed, and the county councils stood surety for the hospitals, i.e. hospitals could not go bankrupt.

Simultaneous to the "attachment"-debate another special commission was appointed to go into the allocation of task and responsibilities between the different governmental levels (state, counties and municipalities). The commission with its particular focus on reforms of the county level delivered its report in the beginning of July 2000 (NOU 2000:22). The commission recommended several changes in the allocation of tasks between the governmental levels and a structural reform at county level that included mergers and reduction in the number of county units. Problems in the hospital sector generated by a fragmented structure were used as one of the commission's main arguments for the structural reform. Following the commissions report several actors raised the question of relaxing the central government control over counties tax rates.

However, the minority Labour government that came into power in March 2000, after a vote of confidence had led to resignation of the minority Centre government (Christian Democratic Party, Agrear Party and Liberal Party), never pushed the debate over structural reforms at the county level any further. Instead, the newly elected Prime Minister Stoltenberg hinted already by the beginning of June 2000 that a more comprehensive hospital reform was on its way. By the end of summer 2000 the government took the consequence of the increased financial involvement of central

authorities in hospital financing, the ongoing blaming game, and decided to quit the game by claiming full and complete responsibility for all specialist health care.

The proposal of central government takeover was politically disputed. But both the Conservative Party and the right-wing Progressive Party had for a long time favoured central government takeover of hospitals. For them, central government takeover was seen as part of a strategy to get rid of a county level with low political legitimacy, partly as the result of problems in the hospital sector, and with tasks that easily could be handed over to the state or local governments. Both parties also favoured activity based funding directly from the state to the hospitals.

Following the inauguration, the Labour government launched an ambitious program for modernization of the public sector, very much in the tradition of the modernization program of the Blair government in Great Britain. However, it came as a surprise to most political observers that the key reform in the program showed to be central government takeover of hospitals. The Labour Party can be seen as the main architect of the post world war public sector in Norway. It has initiated both direct elections to county councils and proposals leading to decentralization of tasks to counties and local governments. Parts of the party were also strongly associated with rhetoric of direct democratic involvement in the government of the public sector. In spite of internal political struggles over the proposal the Labour party managed to agree upon the reform. With both the Conservatives and the Progressive Party backing the proposal in Parliament, the reform passed with an overwhelming majority and without relevant alternatives seriously considered. Most central media favoured the proposal.

The 2001 Hospital Act

There were four main elements in the 2001 Hospital Act. First, central governments took over responsibility for all somatic and psychiatric hospitals, and other parts of specialist care. As a result approximately 100 000 employees or 60 000 man-years and a bit less that 60% of county councils budget were transferred from the counties to the state. Secondly, the central government kept the five health regions that were established in 1974 as the organizational unit for coordination and steering. This implied that the new

organization could start out with up-to-date descriptions of supply side and demand side factors, and with already made plans for restructuring. All five regions were set up with a university hospital. Third, both the health regions and the hospitals were organised as health enterprises as outlined by the special commission of 1999 (NOU 1999: 15). Five regional health enterprises were established covering each of the five health regions. The regional health enterprises have statutory responsibility for ensuring the provision of health services to inhabitants in their geographical area. Below the regional health enterprises the 70-80 hospitals and a number of smaller institutions were first (2002) organized as approximately 45 health enterprises, later (2003) reduced to approximately 25 health enterprises. Each regional enterprise is set up with an executive board appointed by the Ministry of Health Affairs and a general management led by a chief executive officer. The same model applies for health enterprises. The regional board appoints the board at this level. Fourthly, the Minister of Health Affairs, as the general assembly for the regional health enterprises, is responsible for overall general management of specialist care.

4 The Need for a New Reimbursement System

By the 2002 hospital reform the central government changed the ownership, the structure (i.e., the number of regional actors) and the form of attachment, but not the financing system. The central authorities did however signal that a special commission should be appointed to look more closely into the financing issues. This commission was appointed in February 2003, and delivered its report (NOU 2003: 1) in December the same year. The proposal for a new reimbursement system (St.meld. nr 5 (2003-2004)) passed the parliament in December 2004.

The Reimbursement System in 2002 and 2003

The main feature of the reimbursement system in 2002 and 2003 is that it mimicked the reimbursement system that existed since 1997. That is that somatic inpatient care is financed with a combination of a block grant and a matching grant depending upon the number of patients treated, their diagnostic related group (DRGs), and a national standardized cost per treatment. In 2003 the matching grant was 60% of the standardized

national cost per treatment. Other hospital services like psychiatric inpatient care, research, and teaching activities are financed through a block grant, where large proportions of the funding are earmarked to reflect national policy objectives. Investments are also financed though block grants, but there are no earmarking on these money. The only new element was that these funding were directed to the regional health enterprises, instead of to the counties.

Ambulatory (outpatient) care as well as private specialists, laboratories and radiotherapy are funded through contributions from the National Insurance Scheme (NIS) as well as through block grants from the regional enterprises. The contributions from the NIS are given directly to the hospitals, and not through the regional health enterprises.

The two next figures show the structure and the size of the different types of funding in the Norwegian health care sector in 2003.

(See the Appendix for the figures.)

Since the reimbursement system in 2002 and 2003 to a large extent mimicked the one in the years before the hospital reform, it gave the hospitals no incentives to change their behaviour, even though the ownership structure had changed. As a result, many of the problems that the hospital act was meant to solve are still present:

- The Parliament's habit of rewarding increased hospital activity by supplementary funds still gives the hospitals no incentives to adjust their activity level according the signals sent by central government. (By now it seems like the activity level in 2003 is going to exceed the target by about 5 % (St prp nr 21 (2003-2004)).
- Since the marginal income of somatic care is 60 % higher for somatic care compared with psychiatric care, the former type of care is consuming a larger and larger share of the total resources. The growth in total expenditure from 2001 to 2002 for somatic and psychiatric care was 13 % and 8 % respectively (SSB 2002).

- The hospital sector is still running with deficits: The aggregate deficit of 2002 and 2003 is estimated to NOK 3,5-4,0 billions based on preliminary accounting results.

The pleasant part of the story is that the hospital managers, in the same way as the chairman of the county councils the two last year they were responsible, can report on shorter waiting times for elective treatment and a reduced number of patients on the waiting lists.

The Debate over a New Financing System

The commission that was appointed to look into the question of hospital financing delivered its report in December 2002. The commission suggested two main reforms in the financing system. The first reform touches upon the role of the regional health enterprises. The second reform treats the way central government should finance the regional health enterprises.

The commission was unanimous in its recommendation that it is necessary to strengthen the regional health enterprises role since they are both the bodies that are responsible for procuring specialized health services for their populations, and the owner of most health care providers. The commission therefore suggested that all health care providers, both private and publicly owned, should have the regional health enterprises as their contract partner, and that the regional bodies are free to chose whatever type of funding they like for the health care providers. That is, the regional health enterprises can decide which types of contract (block grants of fixed prices, etc) they will offer for the different services they procure. In addition the commission suggested that all types of funding should go through the regional health enterprises, and not directly to health care providers. The first part of the reform was approved by the government and the Parliament. However, these bodies did not follow the commission's suggestions that all types of funding should go through the regional health enterprises but decided to let approximately 40% of expected revenues (down from approximately 60%) to private specialists, and private laboratories and radiology come as reimbursement directly from the NIS to these actors.

The second reform related to the funding of the regional health enterprises. In this regard the commission was divided. A small minority (3 out of 11) held the view that the current combination of (earmarked) block grants and activity-based financing (ABF) of somatic in-patient care should be maintained based on the argument that the problematic economic situation for hospitals is not related to the current reimbursement system, but rather to internal conditions within hospitals. The majority however argued that the current reimbursement system, with its combination of (earmarked) grants and ABF, would be inappropriate to solve the problems in the hospital sector of the following reasons. First, since the ABF of somatic inpatient care only covers about 60 percent of the standardized national cost of treatment, it is necessary for central authorities to earmark grant for other highly prioritised hospital services like e.g. psychiatric care to make sure that money for these services do not end up in the somatic sector.[5] This will lead to bureaucratisation of the regional health enterprises, which again can limit these bodies legitimacy. Second, the combination of block grants and ABF implies that central authorities do not need to be clear and transparent on the level of activity they procure. The majority of the commission argued that the unclear message from central politicians and central authorities on which activity level the current budget was meant to finance was one of the main reasons for the large hospital deficits the latter years. Third, the current reimbursement system does not reflect local cost conditions since the ABF is based on the standardized national cost per treatment As a result it is difficult to equalize the use of resources among the regions if the current reimbursement system is maintained. The majority argued that such equalization is necessary to erase the historical effects of local (political) prioritisations and differences in local tax revenues. Finally, the majority of the commission argued that the combination of ABF and earmarked grant makes it likely that the cost containment in the sector will continue to be poor. Again this argument hinges upon the facts the ABF-part covers less that the full cost of treatment, that hospitals have poor information about costs, and that central politicians often have chosen to respond to hospital deficits by providing supplementary funding.

[5] That is, the relative cost of using one Norwegian krone on somatic care is, from the regional health enterprises view less than one, since the central authorities pay back 60 percent of the money used on somatic inpatient care.

To solve the above-mentioned problems, the majority of the commission suggested the following funding model. First, the Parliament decides the total budget for specialized health care sector. The total budget is then allocated to the regional health enterprises according to a need-based capitation model. Based on the regional budgets, there is a dialog between each regional health enterprise and the central government about which activity level the budget is meant to finance. This process is supported by information about regional activity and cost levels documented by an independent permanent expert group.[6] In addition the following mechanism for risk-sharing between the central government and the regional health enterprises applies. If it turns out that the realized activity level is up to two percent higher that decided upon, the central government covers 60 % of the standardized national cost, but all activities above this level must be completely financed by the regional health enterprise. In the same vein, if a regional health enterprise does not fulfil its required activity level, its budget will be adjusted downward by 60 % of the regional cost times the difference between the realized and the preset activity level.

It is the majority of the commission's view that this funding model is the most appropriate model given the institutional structure of the Norwegian health care system for the following reasons. First, the model reduces the worry that activities that are difficult to measure will be prioritised downwards. This follows since there are caps on the funding of measurable activities. Second, the model forces the central authorities to be transparent on the level of activity they believe the current budget can finance. In addition the model has some build-in incentives for both the central authorities and the boards of the regional enterprises to reach agreements on which activity level the current budget can produce. This follows since the boards can decide to step down if they feel that the conditions given by the state with the budget, if the dialogue breaks down, are impossible to live with. It is however natural to believe that the boards wish to do the job they have agreed upon when accepting being at the board. This will discipline the boards' wish to signal to the media and central politicians that the central authority's proposals are impossible to fulfil. Of equal importance is however the fact that it is a transparent

[6] If the parties do not reach an agreement, the central government decides the activity level.

signal to the central politicians that the central authorities under-finance the activity level they procure if the regional boards repeatedly decide to step down. This again will discipline the central authorities' demands in the dialogue, again providing incentives that improve upon the parties' possibilities to reach an agreement. Furthermore, when an agreement is reached, the regional bodies have strong incentives to fulfil it, since it has (voluntary) accepted the conditions behind the agreement. In addition, the construction the independent expert body will further discipline the process of reaching agreements by providing independent information about regional costs and activities. Third, the cost containment in the sector is likely to be improved both since the Parliament decides upon the total budget before the activity-level dialogue, and since the extra funding which follows higher-than-planned activity stops at a certain level. Finally, regional differences in costs will to a larger extent be reflected in the central funding-system. This follows since regional activity levels will reflect regional cost differences that are related to factors beyond the regional enterprises control, like e.g. population density.

In addition several members of the commission felt that the majority's suggested model would be more political stable that a block grant capitation model. This argument is based on the fact that the element of risk-sharing between the central government and the regional health enterprises also implies that the latter part cannot argue that increased activity is not followed by extra funding be the state. Furthermore, the element of risk-sharing should increase the likelihood of activity-based financing between the regional level and health care providers such that cost-efficient hospitals have incentives to increase their activity.

The government and the Parliament did not approve this reform. The arguments were mainly that it would be too demanding to set regional activity levels, and a worry that the regional health enterprises should respond to the model by funding health care providers with block grants. In stead the government and the Parliament adopted the model suggested by the minority. This model is basically a continuation of the current model with its combination of block grants and DRG-based financing of somatic in-patient care. However, the share of piece rate financing was reduced from 60 to 40 percent and the

block grant increased correspondingly. There were three main arguments for the modification, better cost control, a fear for reduced allocative efficiency since highly priorities hospital services like psychiatric care are financed through block grants, and a growing fear that the relatively high reimbursement rate had led hospitals to increase treatment of “profitable” diagnosis.

6 Conclusions

What can be learned from the Norwegian experiment? The analysis shows that over the last 15-20 years there has been a growing tension between the regional (county level) and the central authorities on the performance of the health care sector. Furthermore the analysis indicates that central actors in the health sector do respond to the economic incentives that are contained in the funding system. The analysis also shows that central authorities often responded to it’s dissatisfaction on the performance of the health care system by introducing national standards (e.g. admission priorities, waiting time guarantees and other patient rights) or action plans (e.g. for heart, cancer and psychiatric patients) that often were associated with increased funding. As a result, the central authorities’ expectations on health care results were raised, and at the same time, the county councils become more financial dependent by the central government. The interdependency led to a blaming game over finances, activity and responsibility in the hospital sector and in 2000 the newly elected Labour government decided to quit the game by claiming full and complete state responsibility for all specialist health care.

The main lesson to be learned from Norwegian experience in this setting is thus that central government involvement in local and county government decision-making can lead to unclear responsibilities and lack of transparency. In particular when central government involvement implies shared responsibilities for financing of particular services this seems to be a problem.

The above mentioned lesson can be put into a broader perspective by confronting the literature about fiscal federalism (Oates 1998); (Rattsø 1998). In this literature the stability of a decentralized system is said to be contingent upon the balance and degree of

overlap between the political, economic and administrative/operative dimensions of the system. The basic argument is that a system in which the responsibility for these dimensions is spread among actors at different hierarchical levels has a build in destabilizing features. In Norway for example, prior the hospital reform, the regional level (i.e., the county councils) were responsible for the running of the hospitals, but the central government provided more than 50 % of the funding for these institutions. In this sense there were some destabilizing features build into the Norwegian model thereby creating a drive for a change.

Some of the problems underlying the Norwegian reform are common to the Nordic countries. However, they have been tackled in different ways in different countries: While Norway chose central government takeover of hospitals, Sweden continues to develop their regional, county-based model. During the 1990s, the Swedish health care system has undergone several major structural changes. Responsibilities were gradually transferred to county councils and municipalities, and new organizational and management schemes were introduced. County councils took over regulation of the private health care market in 1995. In 1998 a pharmaceutical reform was implemented. This reform's aim was to gradually give the county councils full (including financial) responsibility for pharmaceuticals, after a transition period during which the social insurance system continues to subsidize pharmaceuticals. Hence in Sweden it seems like the recent reforms are consistent in the sense that they are transferring more and more of the responsibility for health care to one hierarchical level and one political body, namely the county councils. Furthermore, a number of mergers between county councils have taken place during the last years. This development has been driven by increased pressure on county councils to contain costs and to increase efficiency. By merging smaller counties into larger regions, it is believed that these objectives will be easier to meet, and in the same time maintain the decentralized NHS-model.

In Denmark most health care is funded and provided by the counties, but take place within a national regulatory frame and a set of agreements between the central government and the counties. Denmark has however currently put on their think cap as a

royal commission with a mandate to recommend reforms in hospital and county management will deliver its report in 2004. Contrary to Sweden, the central government in Denmark has showed an increased involvement in the health care sector. This is due to several reasons. First, the central government has increasingly used the annual budget negotiations between itself and the Association of Counties as a means of influencing the direction of the health care system the last 5-7 years. This is done by highlighting priority areas like cardiac surgery, cancer treatment of waiting times. Second, the central government has made available earmarked grants to assist the counties in achieving some of the targets, (Møller Pedersen 2002); (Vallgårda, Krasnik et al. 2002). Third, in the 2002 budget negotiation the central government set apart funds to cover additional treatment of patients in 2002-2004, given that the hospitals' activity level reaches certain (predetermined) levels. Fourth, from July 2002, the central government gave most patients the right to seek treatment at a private or foreign hospital if treatment has not been offered by the county hospital system with a period of two mounts. Finally, there seems to be a shift in the national political thinking, which seems to have less faith in the decentralized political management than before, (Vrangbæk and Beck 2004).

It is thus not surprising that one of the proposed models of the royal commission is a "state-model" where the counties are dismantled. However, and according to the commission, this model's main drawback is the centralization of the hospital sector which implies a risk of weaker cost-containment. The commission's main proposal is thus variants of county models with re-allocations of tasks between the governmental levels and a structural reform at the county level that include mergers and reductions in the number of county units. While no decisions are taken yet, it seems like Denmark is restoring the Scandinavian model with lager units at the county level.

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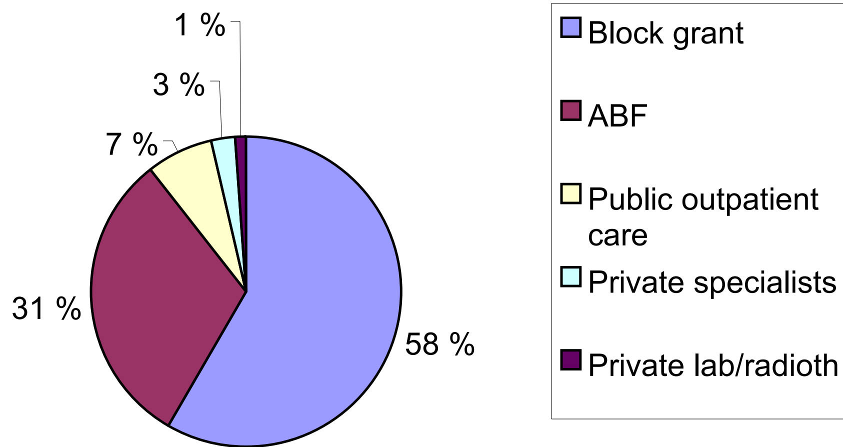
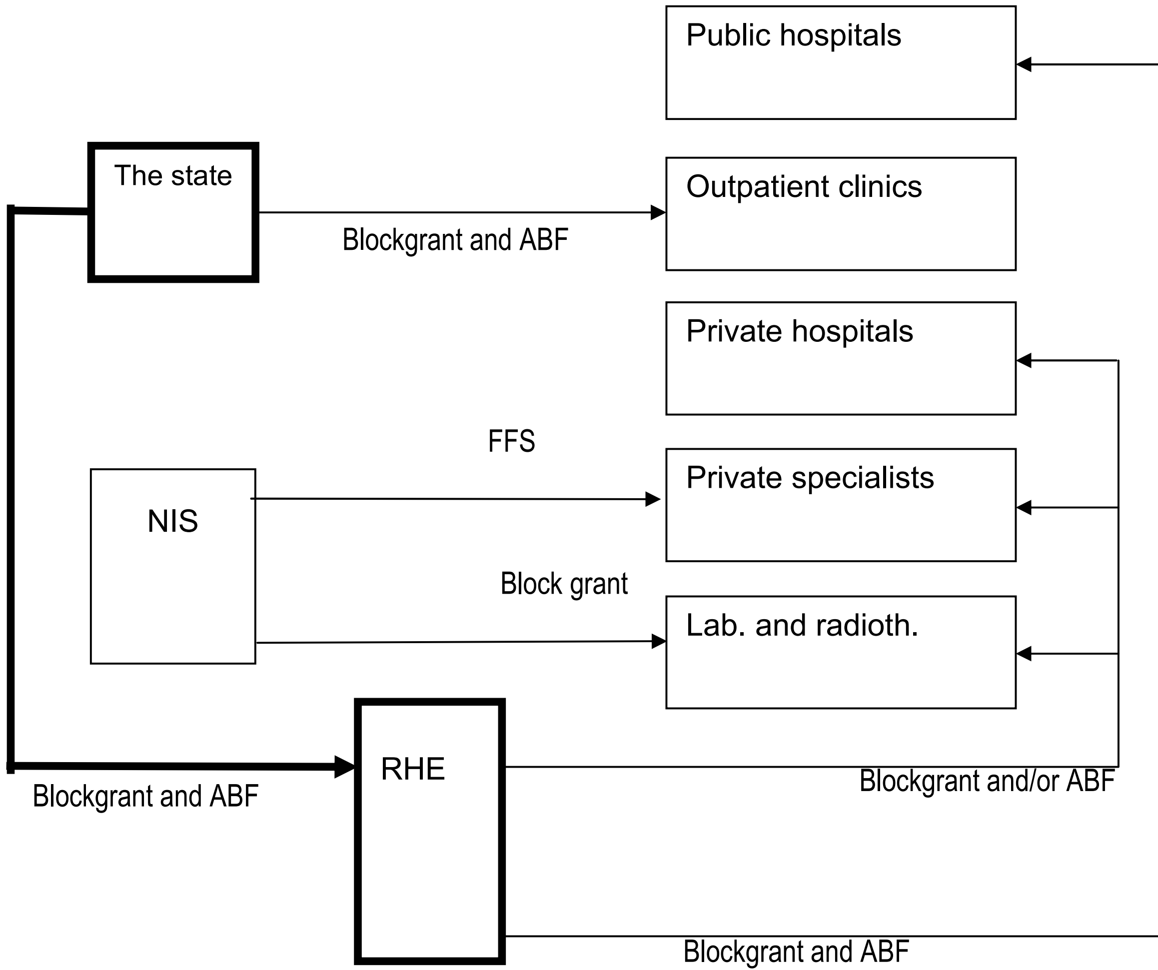
Appendix




Public hospitals
The state
Outpatient clinics
Blockgrant and ABF
Private hospitals
FFS
NIS
Private specialists
Block grant
Lab. and radioth.
RHE
Blockgrant and ABF
Blockgrant and/or ABF
Blockgrant and ABF