

Health care in Norway: Recentralization with a twist.

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Background

- Norway – population 4,7 million (“Colorado”)
- Area 1,3 of Colorado
- GDP/capita = \$ 53 450 PPP (1,15 of US - 2007)
- Government – coalition of social democrats, left wing socialists and centrist party – upcoming election fall 09
- Predominantly public provision of services
 - Education
 - Health care
 - Social services



Political governance

- **Central government**
- **Counties** – local elected councils (19)
 - Upper secondary school (11-13)
 - Regional development
- **Municipalities** – local elected councils (430)
 - Primary and lower secondary school (1-5, 6-8)
 - Nurseries/kindergarden
 - Primary health care / care for elderly and disabled
 - Social services
 - Municipal development

Fiscal governance

- Non discretionary local taxes
 - 21 % municipal income tax
 - 7 % county income tax
- Central grants in the form of
 - General purpose grants (tax equalization)
 - Earmarked grants
- Compared to Nordic neighbours - low share of unconditional central grants
- Thus higher level of fiscal centralization

Health care

- Universal coverage through a tax based system
- Public provision – small number of private hospitals + private physicians
- Expensive system
 - 8.7 % of GDP in 2005
 - \$ 4520 – behind only US and Switzerland
- Substantial growth from 1990, parallel to growth in GDP/capita

Health care

- No national health policy until 1969
 - Mix of private non-profit, municipal and county initiatives
- 1969: Law on hospital services
 - Specialised health services a County responsibility, regional co-operation
- Generous per diem financing from the central government led to rapid increase in costs and high level of investment

Health care: 1980-2002

- Period of decentralization
 - Specialised health care county responsibility
 - Primary health care a municipal responsibility
 - To curb costs – block grants
- In both cases a political decentralization to elected local bodies
- But limited autonomy, central supervision and control, central planning of capacity

Developing concerns

- Low levels of efficiency
 - Change from global budgets to activity based financing (1997) – meant higher share of funds coming from central government
- Large geographical variations in health care spending
 - But this was sort of the result of the decentralised model
- Competition for capacity between counties led to excess capacity and duplication of services
 - Regional mandatory health plans (2000)
- Deficits and a "blame game" between counties and state
 - Extra central funding – soft budgeting
- Note: Less focus on primary health care and care services

2002

- Recentralization of specialist health care
 - Ownership from 19 counties to the state.
 - From devolution to deconcentration; organize the sector in 5 regional health enterprises (RHE)
 - No politicians on the boards of the health enterprises
 - Funding is a combination of block and matching (activity based) grants to the RHEs

Why recentralize?

- Economic goals related to
 - Cost containment
 - the state decided to quit the blaming game
 - “one owner – one health policy”
 - Technical efficiency
 - Economics of scale and scope
 - Less duplication of services between regions/counties
- Management goals
 - A more professional management
 - Professional boards

Adjustments

- Politicians back on the boards (2006)
 - Strong concerns about "deficit of (local) democracy" in model with professional management/boards
 - But appointed – not elected
- Further centralization
 - RHEs reduced from 5 to 4 (2007)
 - Southeast (55%), West (20%), Middle (15%), North (10%)
 - Even the two state owned RHEs in the south east could not agree on capacity and localisation

Effects

- Higher levels of efficiency (but still substantially lower than e.g. Finland)
- Gradual restructuring – larger and more specialised units
- Growth in activity – against the explicit policy goals of the government
- Persistent deficits – with some exceptions in well managed enterprises
- Strong focus on regional equity

”New” challenges

- Deficits, activity growth seen as a (partly) result of lack of integration between primary and specialist health care
 - Too many admissions into hospitals of patients that could be treated in primary care
 - Too few discharges from hospitals of patients that could be treated in municipal care
- 2010 – new reform ”interaction”

”Interaction” reform

- Municipalities cover 20 % of the costs in regional health enterprises
 - Thus 20 % of the grants currently given to specialised health care will go to the municipalities
- More GPs – no growth in # of (hospital) specialists
- More funds to preventive care
- Municipalities must cooperate to increase the capacity of health centers that provide both primary and (less) specialised care

Comments

- How competent are municipalities as purchasers of specialised health care?
 - More than half of municip < 5000 inhab...
- "Political suicide" to enforce merging of municipalities
 - Thus hope of voluntary cooperation – optimistic at best, catastrophic at worst
- If primary care is not a substitute for specialised health care this will increase use of services and costs

Summary of experiences

- Recentralization
 - Efficiency is likely to improve
 - Hospital structure will be (in some sense) more optimal
 - Deficits can be avoided if politicians refrain from extra funding and management is good
- Payment
 - Activity based payments increases activity and costs
- Budgeting
 - Soft budgeting is likely to prevail when a) the country is wealthy and b) the government is weak
 - And – majority governments are only marginally better suited to enforce budget limits