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The Norwegian hospital reform of 2002: Central government takes over ownership of public hospitals

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Abstract

Starting in January 2002, the majority of the Norwegian Parliament transferred the ownership of all public hospitals from the county governments to the central state. This round of reforms represents the most recent attempt by the central government to resolve major problems in the Norwegian health care system. In this paper, we describe these 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. The main lesson to be learned from the Norwegian experiment is that central government involvement in local and county government decision-making can lead to ambiguous responsibilities and a lack of transparency. This appears to be particularly the case when central government involvement implies shared responsibilities for the financing of particular services.

Keywords: Public hospital; Hospital reform; Financing; Soft budget constraint; Waiting time; Efficiency; Norway

1. Introduction

Beginning in January 2002, the Norwegian central government took over all public hospitals and other specialist care institutions from the various county governments. Hospitals were then reorganized within five regional health enterprises (RHEs) as local enterprises or trusts. This reform process represents the latest attempt by the central government to resolve what are viewed as major problems in the Norwegian health care system: namely 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, as the former owners and the central government. The reforms also touch upon problems associated with a lack of legitimacy in county governments.

The health care sector in Scandinavian countries is often characterized as a decentralized NHS-model [1]: that is, while funding is tax-based and the main actors are public, when compared to the centralized British NHS, local and county governments have an important

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role in decision-making process. Through the recent takeover reforms, the Norwegian model moved from a decentralized to a semi-centralized NHS-model. In this, responsibility for primary care will remain at the local (municipality) level also after the reforms in specialist care.

In this paper, we address several important issues related to the recent round of ownership reform. What is the background for the transfer of hospital ownership from the county councils to the central government in Norway, and what are the main elements of the new organizational model for specialist care? We respond to these questions in Section 2 by briefly describing the institutional and financial structure of the former regime and some of the problems related to these structures. Several earlier reforms were put into operation to resolve these problems during the 1990s before the implementation of the 'big bang' ownership reform. Some of these reforms had the intended effect, such as the introduction of activity-based financing (ABF) in 1997, which served to increase activity in acute care hospitals. However, the ABF reform also affected the distribution of fiscal responsibility between the counties and the central government. This distorted fiscal arrangements and triggered a blame game that led to the most recent ownership reform.

Similar structural reforms in the health care sector are discussed throughout Scandinavia. In Section 3, we contextualize the Norwegian changes by briefly present and discuss reform proposals related to the organization of specialist care in Sweden and Denmark.

How then are the reforms of the 1990s and the subsequent ownership reforms best explained? In Section 4, we outline some underlying mechanisms that can explain the organizational changes described in Section 2. While some organizational changes are often explained as 'fashion' or 'fake' [2,3], here we emphasize the incentive effects contained in different organizational and financial structures, and how such incentives generate problems that activate reform. For instance, the effects of the introduction of ABF on efficiency and activity are well understood within a principal–agent framework [4]. To rationalize the breakdown of fiscal responsibility and ownership reform we extend the basic principal–agent framework by including vote maximization in the principal's (central government's) goal function. In such cases, it can be difficult for the principal to maintain hard budget constraints. This seems to be particularly a problem in situations of minority government.

Is the change in ownership sufficient to resolve these problems? In Section 5, we present preliminary results from the first 2–3 years of the reform. These results suggest that some of the problems the hospital reform was intended to solve, in particular the problem of soft budget constraints, are still present. We discuss further steps that we believe must be taken if the hospital reform goals are to be obtained.

Finally, in Section 6, we outline the lessons learnt from the Norwegian experience. Our main conclusion is that central government involvement in local and county government decision-making can lead to unclear responsibilities and lack of transparency. This seems to be especially a problem when central government involvement implies shared responsibilities for the financing of particular services.

2. From county to central government responsibility

Norwegian counties can be classified as multipurpose governments, with responsibility for secondary education, transportation and culture in addition to specialist health care. The actual responsibility for planning and operating institutional health services was formalized by the introduction of the 1970 Hospital Act. At that time, counties had had an informal status as hospital owner for some time. However, in contrast to other Scandinavian countries, the county tax rate on individuals is fixed by parliament, implying a centralized financing system. The 19 Norwegian counties (including the capital Oslo) are also relatively small with an average of 237,000 inhabitants in 2001. Elections for county councils are held every fourth year.

2.1. Reforms of the 1970s, 1980s and 1990s

Norwegian specialist care has undergone several institutional and financial reforms before the 2002 central government takeover. These reforms are partly a consequence of both the small size of the counties and the centralized tax system:

- *Regionalization*: The country was divided into five health regions in 1974 with one university hospital