Health Policy 121 (2017) 134–140

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Competition policy for health care provision in Norway☆

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ARTICLE INFO

Article history:
Received 27 June 2016
Received in revised form 21 October 2016
Accepted 16 November 2016

Keywords:
Health care
Competition policy
Norway

ABSTRACT

Competition policy has played a very limited role for health care provision in Norway. The main reason is that Norway has a National Health Service (NHS) with extensive public provision and a wide set of sector-specific regulations that limit the scope for competition. However, the last two decades, several reforms have deregulated health care provision and opened up for provider competition along some dimensions. For specialised care, the government has introduced patient choice and (partly) activity (DRG) based funding, but also corporatised public hospitals and allowed for more private provision. For primary care, a reform changed the payment scheme to capitation and (a higher share of) fee-for-service, inducing almost all GPs on fixed salary contracts to become self-employed. While these reforms have the potential for generating competition in the Norwegian NHS, the empirical evidence is quite limited and the findings are mixed. We identify a set of possible caveats that may weaken the incentives for provider competition – such as the partial implementation of DRG pricing, the dual purchaser–provider role of regional health authorities, and the extensive consolidation of public hospitals – and argue that there is great scope for competition policy measures that could stimulate provider competition within the Norwegian NHS.

1. Introduction

Health expenditures in Norway are escalating at a faster rate than the GDP. According to Statistics Norway, the total health expenditures in 2015 amounted to NOK 311 (approx. £ 25) billions in total, NOK 60 000 (approx. £ 7200) per capita, and 10% of total GDP (12% of mainland GDP excluding oil production). Public health expenditures account for more than 85% of the total health expenditures. According to the OECD Health at a Glance 2015 report, Norway is third in the ranking – after the United States and Switzerland – in terms of total per capita spending on health (measured in US dollars and adjusted for purchasing power) and at the very top in terms of public per capita spending on health. Despite high health expenditures, waiting times for treatment are long. However, Norway scores well on a wide set of quality indicators compared to other OECD countries.

The Norwegian health care system is a National Health Service (NHS) based on mandatory social insurance financed mainly through general taxation. The role of competition in the Norwegian NHS has traditionally been

☆ This research is supported by the Health Foundation, an independent charity committed to bringing about better health and health care for people in the UK. The views expressed in this paper and in the case studies are those of the authors and do not necessarily reflect the views of the funders. The paper has benefited from comment by Martin Chalkley, Are Forbord, Hugh Gravelle, Tor Iversen, Sara Martin, Luigi Siciliani, Emma Spencelayh and an anonymous referee. The usual disclaimer applies.

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http://dx.doi.org/10.1016/j.healthpol.2016.11.013
0168-8510/

very limited, as in most countries with an NHS, and is still quite restricted along many dimensions. Health insurance is nationalised and provided by the government, and thus not subject to competition. This was also the case for health care provision. However, in the last two decades several government reforms have deregulated the health care provision and increased the scope for provider competition within the NHS.

The purpose of this paper is to review competition policy for health care provision in Norway and to derive some key lessons from the Norwegian experience. As in most countries with an NHS, the scope for standard competition policy (e.g., merger control) is limited, implying that competition policy is mainly indirect related to deregulation of the public monopoly provision of health care. A key focus is therefore on the government reforms that have opened up for provider competition within the Norwegian NHS, and the effects of such competition on performance measures such as quality, waiting times, and cost efficiency. We focus particularly on reforms in the secondary care market introducing competition between hospitals, but consider also reforms in the primary care market opening for competition among general practitioners (GPs).

The rest of the paper is organised as follows. Section 2 describes the key policy reforms of the Norwegian NHS. Section 3 reviews the competition policies in the Norwegian NHS. Finally, Section 4 presents key lessons from the Norwegian experience and discusses possible implications for future design of competition policy for health care provision in Norway.

2. Institutional set-up

The national health insurance in Norway is comprehensive. It covers a wide set of medical treatments and offers high insurance coverage with limited demand-side cost sharing. Patient may top-up with private health insurance, but the market is small due to the comprehensive national health insurance. The out-of-pocket payments for health care within the NHS are low. For in-patient hospital care, patients are usually not charged any co-payments. For primary care and out-patient specialist care, there are in principle significant co-payments. However, in practice the co-payments paid by the patients are de facto very low due to an annual expenditure cap per patient (at around £ 200). Once the expenditure cap is reached, patients receive 100% coverage for any additional health expenditures within the NHS. This limits the scope for using co-payments, and possibly price competition, to allocate demand across health care providers, and implies that demand for health care is highly price inelastic. Thus, competition between health care providers within the NHS is mainly on non-price variables such as quality and waiting times. In the next two sub-sections, we describe the institutional set-up of the Norwegian NHS, focusing on the provision of primary and secondary care.

2.1. Secondary care provision

Until the end of the 1990s, specialist care was provided by public hospitals which were local monopolists in their catchment area. Patients could not choose hospital, but were administratively allocated to the closest one. The counties were responsible for the provision of specialist care, and had ownership to the public hospitals which were under direct governance of the local administration and politicians. The hospital funding was based on global budgets to ensure cost control. However, most of the funding came from central state transfers, which created an agency problem where the counties (who controlled the provision of specialist care) had weak incentives to enforce hard hospital budgets. In the last two decades, the secondary care provision in the Norwegian NHS has changed drastically due to several government reforms. In particular, there have been four major reforms that have opened up for provider competition in the secondary care market. Below we describe these reforms in chronological order.

2.1.1. Activity based funding reform (1997)

In 1997, Norway introduced, as one of the first countries in Europe, activity based funding for hospital care based on the diagnosis related group (DRG) system. The purpose of this reform was to increase hospital productivity and reduce waiting times, which had escalated in the years with hospital funding based on global budgets; see, for instance, Biørn et al. for a more detailed description [1]. However, the Norwegian government decided to implement a hybrid payment system that combined activity based funding (DRG pricing) with global budgets. The share of activity based funding was initially set to only 30% of the total hospital budgets, which in practice implied a 70% cut in the DRG price. Thus, hospitals received only 30% of the full DRG price per treated patient. The share of activity based funding was increased to 40% in 1998 and has since fluctuated between 40% and 60%. Today the share is 50% activity based funding and 50% global budgets. The DRG pricing scheme covered initially only inpatient somatic care. Mental care was (and is still) not covered by DRG pricing but a part of the global budget. Outpatient care was mainly based on fee-for-service, but became a part of the DRG pricing scheme in 2010.

2.1.2. Patient choice reform (2001)

Patient choice for secondary care was introduced in 2001 by a new legislation that entitled patients the right to freely choose hospital for elective (non-acute) care within the NHS. This reform replaced a scheme of administrative allocation, where patients were usually referred to the closest hospital that offered the relevant treatment, which could be either a local, a central or a university hospital depending on the illness of the patient. While hospitals could not compete for patients, they could "compete" for the right to provide certain services. However, the patient choice reform opened up for competition to attract (or avoid losing) patients. The reform was extensive in the sense that patients can choose among *any* hospital within the NHS and entitled the patients to reimbursement of travel costs from the national health insurance (net of some deductibles).

The reform faced two key challenges at the start. First, hospitals could turn down patients from other counties if they were capacity constrained, which was indeed the