The health policy pendulum: cost control vs. activity growth

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Introduction

On the 26th of February 2008 Sylvia Brustad, the Minister of Health, gave a clear signal to managers in Norwegian hospitals: “The time when overspending was allowed and followed by bailouts is over” (Dagens medisn 26.02.2008). This statement followed a period with large overspending, large deficits and central state bailouts in the Norwegian hospital sector (Tjerbo and Hagen 2009). About 5 years later, on the 12th of March 2013, the heading in Aftenposten, a leading Norwegian newspaper reads: “The conservatives will privatize the hospital sector no matter what costs”. When asked what the reform will cost, the deputy leader of the Conservative party, and later Minister of Health replies: “We will figure that out once we are in office” (Aftenposten 12.03.2013). It is hardly surprise that politicians from two different parties, and at two different points in time, send different political signals. We believe however, that the different messages illustrated by the two quotes above illustrate a fundamental feature of Norwegian hospital policy over the last decades, and that the importance this has for health care reform needs more attention.

The Norwegian public sector has been a moderate follower of New Public Management, and as a “laggard” in implementing NPM reforms (Christensen and Lægreid 2011). However this does not appear to be the case for the health care sector. Norway has implemented several health care reforms over the course of the last three decades. These reforms represent significant changes both in organization, governance and financing. Both the introduction of DRGs, the pursuit of cost-control and changes in the hospital structure has been described as containing elements of New Public Management (NPM) (Byrkjeflot and Neby, 2008, Pettersen, 2001, Lægreid et al., 2005). In general however, The Norwegian public sector has been a moderate follower of New Public Management, and as a “laggard” in implementing NPM reforms (Christensen and Lægreid 2011).

In this article we argue that NPM or other broader reform-trends do not give an accurate explanation of the reform or reform drivers. The main explanatory factor is an increasing awareness of the need for cost-control and the political consequences of achieving cost control. We argue that cost containment has been a major driver behind several of the key reforms of the Norwegian health care sector and that some policies aimed toward reducing cost growth appear to have been successful. However, successful periods have led to a later backlash. The reforms implemented reflect a policy pendulum that has swung between cost control and activity increases to reduce waiting lists. As cost control is achieved, waiting lists increase and new reforms are undertaken to increase activity. This, in turn, creates a new focus on cost control and reforms to improve the control of escalating costs. Improving cost control by reducing activity, primarily by increasing waiting times, comes at a high political cost such as an increasing number of dissatisfied voters.

The health policy literature is rich with comparative studies, but there is no clear theoretical “canon” (Wendt 2012). Some authors have focused on the role of institutions in explaining reforms or the lack of large-scale reforms. Important contributions here are Immergut (ref) work on the role of different interest groups, Wilsford (ref) work on path dependency and health care reform and Steinmo and Watts (ref) article on health care reform in the US. Tuohy (1992) made an important theoretical contribution towards understanding health governance. Both Tuohys and the mentioned institutional perspectives focus primarily on the development in single countries. Focusing on single countries over time allows a deeper investigation of “individual system logics, and the need to understand the dynamics of a system in its own right” (1999:130). Comparing cases naturally leads to a focus on what is common between

the cases. This can lead to an exaggeration of the relative importance of those elements that are common across cases, and overlooking important case-specific dynamics.

New Public Management (NPM) has been used as a defining characteristic of several reforms in the public sector since the nineties. More recent reforms are often described as representing reactions to earlier NPM reforms, or attempts to modify and correct deficiencies in NPM reforms. According to Christensen and Lægreid (2009) these “post-NPM” reforms are characterized by an increased focus on central capacity and coordination within and between sectors. Johan P Olsen (2008) has described this as “discovering the inherent strengths of bureaucratic organization after a period of marked based reforms” (quoted in Lodge 2011:143). Looking at Norwegian health policy as a case shows a more nuanced picture. Focusing on a single case over an extended time period allows a closer investigation of internal dynamics and the effect previous decisions has on later decisions.

Some of the reforms undertaken in the Norwegian health care sector do mirror similar reforms in other countries and can meaningfully be placed under the label of “NPM”. Looking at a single case such as this does however also show the limits of using general reform labels such as NPM or “post NPM” as explanatory perspectives. Rather than seeing a general trend towards NPM in one period, followed by a “rediscovery” of hierarchy after a period of NPM based organization, we see a recurring shifting between policies aimed towards cost control and activity increases. Understanding health policy reform in this perspective becomes a question of instrumental adaptations to the effects of earlier decisions. Policy makers try to improve on shortcomings in current policies. The fundamental health policy dilemmas are unsolvable, consequently what we observe is a health policy pendulum swinging between cost

control and activity growth. Policy makers are faced with a trade off between equity and cost-control that cannot be resolved with any finality, only balanced in either direction.

Methods

This is a case study of major health care reforms in Norway in the period from 1970 to 2014. We rely on expenditure data for descriptive purposes. Data on total health expenditure were taken from Statistics Norway. Data on actual and planned activity growth were taken from annual reports on hospital economy from SAMDATA¹. The main data sources are qualitative and consist of policy documents. We use quotes from newspaper articles for illustrative purposes.

Results

We identified four different phases during the period from 1980 until today: two phases during which activity increases have been at the forefront of the agenda and two phases during which cost control was the most important goal.

¹ Reports from 2009 to 2014 can be found at the Directorate for Health's website: <https://helsedirektoratet.no/statistikk-og-analyse/samdata>. Earlier reports are found here: <http://www.sintef.no/Projectweb/Startsiden/>. For this article, we have updated data used in Tjerbo and Hagen (2009).

Cost control I: 1980–1996

From the mid-1970s, the focus shifted toward cost containment, and this shift was mirrored in other developed countries and was driven by two factors. First, the energy crisis in the mid-1970s made the need for controlling costs salient. Second, conservative governments came into power, which ushered in an era in which conservative cabinets in different countries actively sought to reduce the size of the public sector. Naturally, this also affected health care reforms and health policy.

To some extent, the increased focus on cost control from the mid-1970s reflected a general trend shift across different countries. Developments such as the energy crisis and power achieved by conservatives changed the focus in health policy from expansion to cost control. This shift may also be seen as a response to the expansive politics of the post-World War II era (Cutler, 2002).

In 1980, Norway followed many other countries and introduced a block grant system. The expansion of the health care sector started to take its toll financially in most OECD countries (Cutler, 2002), and, as a consequence, policy makers emphasized more control over expenses. The introduction of a block grant system effectively placed the risk for variations in costs and activity on the provider (Figure 1), which stalled the growth in health expenditure in Norway and improved cost control significantly. The flipside, however, was that waiting times increased. Achieving cost control came at the cost of reduced growth in activity, increased waiting times, and dissatisfaction among voters and users.

The first attempts to handle this increase occurred through regulative measures and, most importantly, a legal waiting-time guarantee was implemented in 1990. According to this legislation, county councils were to assume full responsibility for offering treatment within 6 months to patients who had been given the guarantee, and available capacity in other counties was used when needed. However, this strategy proved unsuccessful for several reasons. First,

there were widespread concerns about inequality between the counties in the application of this guarantee. The guarantee was introduced in 1990, and the minister of health at the time — Wenche Frogn Sellæg — viewed it as legally binding on the counties (VG, 1993). The counties did not appear to share this view and argued that the lack of resources made it impossible to fulfil this guarantee imposed by the central state. When the social democrats took over, they stated that the guarantee was not a legal guarantee (VG 08.06.1993). In effect, the guarantee was a political guarantee made by central state politicians, and it was the responsibility of the county politicians to follow up on this guarantee.

Eleven years after the conservative minority cabinet of Jan Peder Syse introduced the guarantee, in which patients were given the rights of having their health situation assessed within 30 days and receiving necessary health care within individual medical limits. The new *Patient Rights Act of 2001* also gave most patients the right to choose a provider from throughout Norway. However, the regulatory and organizational changes did not solve the problem with the waiting lists because the solution had been found four years earlier when the financing system for the hospitals was changed once more. The move toward block grant financing in 1980 appeared to solve the problem of poor cost control, but it also created a problem with waiting lists. Solving the problem of waiting lists meant changing the financing system once again.

Activity increase II: 1997–2005

Activity-based financing (ABF) was implemented in the Norwegian hospital sector from July 1, 1997. A fraction of the block grant from the state to the county councils was replaced by a matching grant that depended on the number and composition of hospital treatments. Variations in demand and costs were adjusted through the block grant, and the remaining activity-based component was based on national average costs per diagnosis-related group

(DRG). At first, 30% of the DRG-based cost of a treatment was refunded from the state. This percentage was increased to 40% from January 1, 1998, and to 50% from January 1, 1999 (Biørn et al., 2003).

Introduction of ABF switched the risk for uncontrolled variation in activity and therefore, the costs back to the central state, but only partially this time. Consequently, hospitals (regional health authorities, RHAs) whose activity exceeds the agreed upon level will not be fully reimbursed. Furthermore, because the price is based on national averages, providers that do not use the resources efficiently are also punished. The combined model can be seen as an attempt to balance the need for increased activity with the need for maintaining cost control. The share of ABF from 1998 has varied between 40% and 60%.

The motivation behind the introduction of DRGs varies between different countries (O'Reilly et al., 2012). The main argument for introducing DRGs depends on the type of health care system. For example, in the USA, DRGs were introduced to improve cost control, whereas the main goal in the UK NHS was to improve productivity (Schmid et al., 2010). In general, the use of DRGs seems to be related to lower health expenditures (O'Reilly et al., 2012), although in the Norwegian case, the lack of clear budget setting by the central state combined with incentives to increase activity led to higher expenditure.

Figure 1 Gross operating expenses of somatic hospitals, 1970–2000 (in 1999 billion kroner).

Source: Statistics Norway

Figure 1 shows the changes in gross operating expenses for the somatic hospital sector in the period 1974–2000. This figure shows clearly the effects of the changes in 1980 and 1997 on the total running costs. Theoretically, this may be interpreted as showing the effects of changes in the way risk is shared between the central state and the hospitals. Clearly, understanding the changes in financing is important for understanding the changes in costs and activity in the period. However, it seems that achieving all goals simultaneously is notoriously difficult. The combined block grant and DRG-based financing system served its purpose, and the waiting lists declined sharply after 1997.

By making the hospital income partially based on activity, the central state was able to reduce waiting lists, but controlling costs soon became a problem once again. Although reducing waiting times was achieved, at the same time, control over the costs in the sector was reduced primarily because of the greater incentive to increase activity under a partially

ABF system. In the block grant period, the central state was able to create hard budget constraints. This ability weakened during the 1990s, and the introduction of ABF was the final blow to budget setting (Hagen and Kaarboe, 2006).

The shift to a partially ABF system in 1997 encouraged increases in activity. However, the ABF component did not cover the marginal costs of increasing the activity. The ABF component varied between 40% and 60%, and the remainder of the costs had to be covered through the block grant, which was independent of activity. It soon became apparent that there was a growing mismatch between the expected level of activity (set by the central state) and the actual activity levels in the hospital sector. Similar to the other financing models used, ABF solved some problems but also created new ones. In this case, the increased activity created deficits at the county level, and a “blame-game” developed between the counties and the central state. In this period, the central state was unable to create hard budgetary constraints, and the counties had good reasons to expect a bail out if their costs exceeded the budget. Soft budgetary constraints became a major problem during this period (Tjerbo and Hagen, 2009).

This is the background onto which the hospital reform of 2002 was introduced. The major change was that the counties were stripped of the ownership of the hospitals, and the central state took over. The central state’s role was strengthened, and local politicians were removed from the decision-making processes locally and regionally. The expectation was that, when both ownership and the responsibility for financing were placed with the central state, budgetary discipline would improve.

Two changes were of particular importance in the reform. First, the central state took over ownership and, second, five RHAs were formed and were given the responsibility for managing hospitals and hospital services in their region. These RHAs soon faced important choices. They had to decide how to organize the relationships between the RHAs and the

hospitals within their catchment area. They also had to decide between whether the hospitals should be an integrated part of the RHAs to be managed and governed primarily through hierarchical governing instruments or whether the providers should compete for contracts with the RHAs. The first option (hospitals integrated within the RHAs), is consistent with the traditional governance model used in the Norwegian hospital sector, whereas the second option (providers competing with the RHAs) closely resembles the NPM model. Choosing a model based on competition and contracting would improve that the owner's ability to provide incentives for quality and efficiency through competition. The RHAs could now identify those hospitals that performed best on the criteria used and reward them with contracts. On the other hand, the traditional model with larger (horizontally) integrated hospitals meant that coordination and scale benefits were prioritized before competition (Nerland, 2007).

Cost control II: 2005–2014

In 2002, the largest public sector reform ever undertaken in Norway occurred when the central state took over ownership of the hospitals. One of the key motivations behind the reform was to improve cost control by mending the fiscal imbalance caused by the separation of the responsibility for production and financing between the counties and the state. The attempt was unsuccessful. The introduction of ABF in 1997 had created strong incentives to increase activity; however, the activity-based component based on DRGs did not cover the marginal costs of increasing activity. Consequently, increased activity also meant increasing costs and deficits. In the years following, the central state takeover of the deficits in the sector was even higher than in the period of county ownership of the hospitals (Tjerbo and Hagen 2009). As in the attempt to use waiting time guarantees in the 1990s, balancing the inherent trade-off between cost control and activity growth through the use of instruments outside the financing system did not work.

The problem was more political than organizational. The minority situation created a situation with soft budgetary constraints (Tjerbo and Hagen, 2009). Because of the minority situation in parliament, the RHAs had valid reasons to expect a bail out when in need. The shift to a majority cabinet in 2005 hardened the budgetary constraints. The central state now had both the will and the ability to be credible. The first health minister in the new Stoltenberg cabinet sent clear signals to the RHAs.

One of the reasons we are in this situation is that one has spent more money than one has. This has to stop! ... She says that the days when the hospitals were allocated more money after being unable to stick to their budgets are gone, and characterizes it as undemocratic to demand more money than what the elected representatives in parliament already has appropriated. (VG. 26.02.08)

The center of power had shifted from parliament to the cabinet, and the signals sent by the minister were credible. Figure 2 shows that the change in wording coincided with a significant change in budgetary discipline. There was a discrepancy between the planned growth (from the national budget) and the actual growth in activity. In the first period, the actual activity was far higher than what the central state wanted, which created deficits. In the years following 2005, the situation changed dramatically so that growth was actually lower than that planned for several years.

Figure 2 Discrepancy between planned and actual activity growth in the Norwegian hospital sector 1999–2013. Sources: Annual Samdata and BUS-reports.

Clearly, the RHAs now listened and, consequently, the growth in expenditure decreased (Figure 3) and bailouts were no longer necessary.

Figure 3. Hospital expenditure 1997–2013 in 2013 million kroner calculated as the sum of categories HC1.1, HC1.2, and HC R1. Source: Statistics Norway table 05369

In the period from 1980 to 1997, cost control was achieved by formal changes in the financing system that reallocated risk between the central state and the providers. All though the Stoltenberg cabinet did not change the financing system, the same basic mechanism was effective in this period. Establishing a hard budgetary constraint is, in effect, a matter of allocating risk. Put differently, soft budgetary constraints arise because the provider or agency does not have to bear the risks associated with poor budgetary discipline. The main difference here was that the central state achieved this through the use of hierarchical steering mechanisms and not through formal changes in the financing system. The financing system in place during the years of the Stoltenberg cabinet was effectively a block grant system. Because activity above a predefined level was not tolerated and a strict hierarchal regime of following up on the RHAs and the activity level was created, the RHAs were effectively operating within a block grant system. Consequently, the same development in expenditure growth occurred as that in the period preceding the introduction of ABF in 1997. Hierarchical steering was made possible because of the majority situation. In the years of minority rule, other ministers attempted to reduce the activity growth but were unable to do so because of the minority situation (Tjerbo and Hagen, 2009).

Another major reform that focused on cost control — the Coordination reform — was also introduced during this period. This reform has counterparts in several other countries, in particular the Danish structural reform. The goal of the reform was to reduce spending on specialist care by motivating the municipalities to invest more in preventive care and the development of alternatives to specialist care situated at the primary care level. The prime motivation behind the reform was to control costs and, as in other reforms, the allocation of financial risk was a key instrument. The main elements in the reform were municipal co-financing, municipal emergency wards, and discharge arrangements. The reform is an

example of budget shifting (Mossialos and Le Grand, 1999). The central state wanted to shift more of the costs to the primary care sector based on the idea that providing care is less costly in that sector.

As in the earlier periods, achieving cost control came at a price. Users and employees voiced their dissatisfaction with the system, and increased waiting lists were perceived as a problem. In 2013, Stoltenberg lost in the election, and a new minority coalition between the Conservative and Progress parties came into power. The signals from the new coalition partners were clear: the waiting lists had to be reduced significantly. Once again, the pendulum has swung back.

Activity increase II: 2014–?

On October 7, 2013, the Conservative and the Progress parties presented their political platform. Under the title “Health policy,” they stated:

It is a challenge that so many patients are forced to wait unnecessarily long before receiving treatment, even for services where there is free capacity among private providers. In order to reduce waiting times and health queues, the government will include all good forces in the treatment of patients.

The intentions here were clear. Waiting lists were to be reduced, and this was to be achieved through an increased use of private providers. Patients were now to be given the opportunity to choose freely among private and public providers where possible, and the cap of reimbursement for private providers was to be removed. Increased use of private providers is a recurrent theme in Norwegian health policy. The conservative Syse cabinet (1989–1990) wanted to increase the use of private providers to reduce waiting lists, as has other Conservative politicians. The Social Democratic party, however, has remained skeptical about

the use of private providers. This skepticism has been reduced somewhat in the past decade or so, and there is more use of private providers now than there was in the 1980s and 1990s.

Both the problem and the proposed solution by the Solberg cabinet are not new. However, transforming the intention into policy turned out to be difficult. The proposal was criticized by a wide array of actors. It was feared that removing the cap for private providers would lead to escalating costs and less equality in access to health care. Private providers operate under contracts with RHAs, and these RHAs are partially financed through a block grant. Removing the cap for private providers would increase the price for this activity, which would have to be paid by the RHAs. This could lead to escalating costs and could potentially affect the prioritization between different patient groups.

Conclusion

Cost containment has been a permanent and primary health policy goal in most industrialized countries since the end of the “golden age” around 1970 (Cutler, 2002). In recent years, many countries have managed to slow the growth in health expenditure, but there are large variations between countries (OECD, 2013). The implementation and strategies chosen to achieve cost control also vary between and within countries, and over time (Mossialos and Le Grand, 1999, Stabile et al., 2013). In the Norwegian case, there is a clear tendency toward pendulum swings or circularity in health care reforms. The reforms have alternated between pursuing cost control and attempting to solve problems related to waiting lists that arise because of the pursuit of cost control. In this way, the effects of previous decisions become important explanatory variables for current decisions. At the same time, neither the focus on cost control nor the solutions sought are independent of choices made in other countries. Both the introduction of block grants in the 1980s and the focus on patient rights in the early 2000s mirror similar developments in other countries at that time. In other areas, such as the use of

competition and separation, Norwegian reformers have been more reluctant. Overall, major structural changes to the health care system are rare. The fundamental features of the Norwegian health care system have not changed dramatically in the period after World War II discussed in this paper. Most importantly, the focus on equality and access remain as fundamental to Norwegian health policy today as it was 50 years ago, and there is a clear reluctance toward undertaking major reforms that may affect this goal.

This reluctance toward major changes could be related to the growth in GDP. Norwegian economic development based on the income from petroleum activity in the North Sea has been formidable since the 1990s. In addition to affecting the perceived need for reform, this economic boom may be an important driver for the shift between cost control and activity growth that we have described here. The most important predictor of spending on health care is GDP; consequently, the large growth in GDP in Norway during this period may make Norway the odd one out internationally. One could argue that this makes the Norwegian case a special case for studying the effect of high GDP growth on cost containment policies. If so, the question arises as to what, if any, lessons can be learned from the Norwegian case.

We believe that there are several. First, the policy processes described can be characterized as pendulum swings or circular. They do not follow a linear path but instead comprise attempts to alter and adapt to problems that arise because of earlier decisions. In this respect, our conclusion is similar to that of Toth (2010) in so far as the circularity of health care reform is concerned. However, our argument and case clearly illustrate the need to focus on country-based internal processes and not on international reform trends or other exogenous variables. More importantly, we believe that the cyclic nature of health care reform illustrated here shows important features of health *politics* to universal health care systems. Cost control is challenging because its pursuit is unpopular and because it may undermine fundamental values relating to equity and access. Pursuing cost control comes at a political cost, and

increasing activity creates political benefits. This is one of the main causes of the cyclic nature of health care policy described in this article. However, the general financial situation does constitute an intermediate variable.

Second, understanding how policies for cost containment and/or activity increase the cost of a national health care system usually requires an understanding of how the financial system allocates risk between the central state and the main providers of health care (Jegers et al., 2002). In the periods analyzed here, the financial system has reallocated risk several times. The effects on both cost containment and activity increases have been remarkable. In particular, the introduction of global budgets around 1980 and the introduction of activity limits in 2005 placed greater risk on the providers and eased the pressure on the central state.

Third, a policy or reform can be implemented to achieve different goals, and there is not necessarily a one-to-one match between policy solutions and problems. As Stabile et al. (2013) also acknowledge, strategies may have multiple goals. For instance, they find that several countries have introduced ABF. Activity based financing is usually based on DRGs. While introducing DRG-based financing can be seen as an example of price setting (the price is set *ex ante*), the motivation for introducing DRGs may vary between different health care systems based on fundamental features of the health care system “type” (Schmid et al., 2010). While introducing DRGs in the US was motivated by a need for increased hierarchical cost control, this was not the case in Germany and in the UK. Also in the Norwegian case, DRGs were introduced as a tool for activity increase not cost control (cf. Street et al., 2011).

Our main conclusion is that policy makers are faced with a dilemma that cannot be resolved with finality but can only be balanced in one direction at a given time. Although single reforms or reform trends over a shorter time span can be described as trends or “waves” (Toth, 2010), in the long run, health policy reflects a pendulum that swings between cost control and activity growth. One could argue that Norwegian policy makers have had the

opportunity to focus on activity growth after periods of activity decline (cost control) because of the general financial situation. However, cost control is no less important as a policy driver in Norway than in other countries. Achieving cost control is also politically difficult in other countries with a less beneficial financial situation. We therefore believe that the features described in this article reflect a fundamental feature of universal health care systems. Health politics involve trying to maximize different goals that are impossible to maximize simultaneously. Pursuing both equity and quality comes at a high economic cost. Reducing and controlling the cost gives rise to political costs because of the increasing waiting times and public dissatisfaction. The empirical consequence of this dilemma, at least in the Norwegian case, is a pendulum that swings back and forth between cost control and activity growth.

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