Deficits, soft budget constraints, and bailouts: Budgeting after the Norwegian hospital reform*

Trond Tjerbo and Terje P. Hagen
Institute of Health Management and Health Economics, University of Oslo

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Corresponding author:
Terje P. Hagen
Institute of Health Management and Health Economics,
University of Oslo,
Box 1089 Blindern,
NO-0317 OSLO, Norway.
E-mails: t.p.hagen@medisin.uio.no

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Abstract

In the 1990s, the Norwegian hospital sector was characterized by soft budgetary constraints and increasing budget deficits. This was one of the main antecedents of the 2002 hospital reform, where the central state took over ownership of the hospitals from the counties. Arguably, the centralization of ownership, financing, and production would harden the budget constraints and increase the budgetary discipline. This analysis shows that this has not been accomplished. Instead, the production has been far above what was planned, and the deficits higher than ever. Two stages of the post-reform budget processes are analyzed: First, the stage where the central state set the budgets and sent signals of budgetary rules (whether the state sent signals of soft or hard budget constraints), and second, how the central state handled deficits in the hospital sector as they emerged (whether the hospitals was bailed out or not). The conclusion is that the central state neither set a hard budget constraint nor managed to stay firm as deficits turned up. We argue that three mechanisms explain the prevailing problems of managing the hospital sector: (1) uncertainty of the hospitals’ financial situation during the transition phase, (2) minority governments, and (3) specific features related to the organization of the budgetary process in the parliament.
1. Introduction

During the 1990s, the fiscal deficits of the Norwegian hospital sector were increasing. As a consequence, during the winter of 1999-2000, the Minister of Health Dagfinn Høybråten (Christian Democratic Party) sat down to evaluate the critical situation with a working group made up of the Ministry of Health and representatives of the counties, the hospital owners at that time. The working group proposed a supplementary grant of 2-2.5 billion NOK to be given to the counties during fiscal year 2000, resources meant to cover accumulated deficits from the period 1998 – 2000 (Ministry of Health and Care Services 2000). A few weeks later, the minority Centre government, made up of the Christian Democratic Party, The Center Party, and the Liberal Party, resigned after a no confidence vote, and a minority Labor government, with Tore Tønne as Minister of Health, came into power. The new minister accepted that a supplementary fund had to be granted and proposed a bill of 1.250 billion NOK to the Parliament. The Parliament increased the bill to 1.750 billion NOK when the budget for 2000 was revised during June 2000 (B. Innst. S. nr. II (1999 -2000)).

However, the deficits of the hospital sector and the blame game over the responsibility for hospital financing and production led the new minister to initiate a process where the ownership of hospitals became the issue (Hagen and Kaarbøe 2006). By early summer 2000, Prime Minister Stoltenberg (Labor Party) hinted that radical changes were under way (Adresseavisen 6th July 2000), and on the 22nd of August 2000, the central committee of the Labor Party approved the main elements of the 2002 hospital reform. These changes included moving the ownership of the hospitals from the 19 counties to the central government and organizing the hospitals as health enterprises within five Regional Health Authorities (RHAs), also organized as enterprises. The main argument for the reorganization was a desire to concentrate responsibility for ownership and financing in one place (Tønne 2001) and to thereby avoid the blame game over production and deficits between the different governmental levels. On the 13th of September 2000, the majority of the Labor Party’s National Convention voted in favor of the reform. The reform passed the parliament on the 6th of June 2001 with votes from the Labor Party and the right wing Progress Party (Innst. O. nr. 118 (2000-2001)), and was implemented starting 1st of January 2002.1

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1 The Conservative Party (Høyre) also voted for central government takeover of the hospitals, but proposed a slightly different model from that of the majority. The Christian Democratic Party (Kristelig Folkeparti), the Center Party (Senterpartiet), the Liberal Party (Venstre) and the Socialist Left Party (Sosialistisk Venstreparti) all voted against central government takeover of the hospitals.
Five years after the 2002 hospital reform, the fiscal challenges facing the hospital sector have become even larger than they were during the nineties. Production has been far higher than planned. By the end of 2006, the deficits accumulated to approximately 18 billion NOK or about 22 percent of the five RHAs’ yearly revenues (BUS 2007). Parliament has, with few exceptions, given supplementary funds to the RHAs each year after the transition.

The main aim of this paper is to explain the failure to reestablish budgetary discipline in the hospital sector in the period following the 2002 hospital reform, where budgetary discipline refers to the ability and will to balance budgets. Budgetary discipline is often related to problems of soft budget constraint (Kornai 1979, 1986), a situation that, according to Maskin (1996:125), “arises whenever a funding source finds it impossible to keep an enterprise to a fixed budget, i.e. whenever the enterprise can extract ex post a bigger subsidy or loan than would have been considered efficient ex ante.” An agent expecting soft budget constraints may have incentives to increase activity or costs above what is preferred by the principal, send the bill to the principal, and hope for bailouts.

The causes of the breakdown of fiscal discipline in the Norwegian hospital sector are interesting for a number of reasons. First, the outcomes were outcomes that none of the principal political players wanted initially. Although the organizational model chosen in 2002 was not recommended by governmental commissions that evaluated the organizational structure of the hospital sector (cf. NOU 1996:5; NOU 2000:22), the main purpose for hospital reform was to reduce or even eliminate the problem of soft budget constraints. Second, both the hospitals and the central state are worse off today than they were before the reform of 2002. The hospitals struggle with large deficits, and the central state struggles with a lack of legitimacy among hospital employees (Aasland et. al. 2007). Third, the breakdown of fiscal discipline emphasizes our deficient understanding of basic political processes, such as political parties’ inability to make enforceable agreements and understanding of information uncertainties.

We commence by describing the basic institutional features of the Norwegian health care system, presenting data on hospital performance, and surveying the budget literature with a focus on soft budget constraints and bailouts. We will argue that, in order to explain the breakdown of fiscal discipline, we have to consider the differences in goals and strategies within the central state, and in particular, between the government cabinet and Norwegian parliament, the Storting. Empirically, we concentrate our analysis to the first two years following the 2002 hospital reform.
2 The 2002 hospital reform - its prelude and sequels

The blame game

An awareness of three elements is necessary to understand the blame game that developed in the late 1990s. First, the costs of hospital services are, with some exceptions of minor out-of-pocket payments for outpatient visits, free of charge, meaning that the patients have no incentive to trade off costs vs. utility for the treatment. The demand for services is consequently high, and rationing is needed (Aaron et al. 2005, Mechanic 1995). Second, the financing system for the 19 counties, which were responsible for the hospital sector during the 1990s, was centralized. County revenues came initially as block grants from the central state and from local taxes, with the tax rate fixed by the central state. An activity based funding (ABF) system put into operation beginning July 1st 1997 implied that a fraction of the block grant from the state to the county councils was replaced by a matching grant depending on the number and composition of hospital treatments measured by the DRG²-system (Halsteinli et al. 2006). At first, 30 percent of the DRG-based cost of a treatment was refunded by the state. From 1 January 1998, the activity based component was increased to 40 percent of expected revenues. In the ensuing period, the ABF-component has fluctuated between 40 and 60 percent. The intent of the government and the parliament was that activity-based contracts between a county council and its hospitals should be implemented, which also turned out to be the case. Third, the introduction of ABF was followed by an activity increase in acute hospital. From 1997 to 2001, the average yearly activity increase was 2.2 percent, compared to only 1 percent in the years prior to 1997 (Biørn et al. 2003). Since the marginal ABF revenues were lower than marginal costs, the introduction of ABF led to increased demand for resources. As taxes were still fixed and other county services such as secondary schools were highly regulated, the counties ended up producing increasing deficits.

This system of vertical fiscal imbalance with low taxing autonomy (Rattsø 2003) led to the blame game. The counties could claim that the deficits were a result of insufficient funding and demanded additional transfers from the central state. The central state, which had encouraged hospitals to increase patient treatment and reduce number and duration of waits, was not able to resist demands for additional funding. The counties interpreted this as a signal of soft budgetary constraints, and the deficits grew further (Hagen and Kaarbøe 2006).

² The DRG system is a classification of different patient groups based on medical and financial criteria. These groups constitute the backbone of the activity-based part of the financing system. Each DRG is given a relative weight which reflects how costly this DRG group is compared to the average for all DRGs.
The reform

During fall of 2001 the hospital reform was implemented at a remarkable pace. 100 000 employees and 60 % of the county budgets were transferred to the central state. Five health regions, which had existed since the mid ‘70s as network organizations between the counties, were upgraded to regional health authorities (RHAs). The RHAs were organized as enterprises with the responsibility of providing hospital care to the inhabitants in their catchments area, either through the hospitals under their own ownership and control or through contracts with private providers (Ot. prp. nr. 66 (2000-2001)).

As the ownership of the hospitals was removed from the counties, politicians were removed from the day-to-day management of the hospitals. The Minister of Health became the general assembly of the RHAs, each with a board composed of professional members from business, academia, and the hospitals’ labor organizations. Decisions concerning administrative, organizational, and production issues were decentralized to the RHAs, or even further to the local hospital trusts, which were organized similarly to the RHAs and governed by boards composed of professional members.

The counties’ and the RHAs’ choices of activity and cost levels

Overall, there was a marked increase in activity levels in the period after the hospital reform (Huseby 2004). This is illustrated in figure 1, which depicts planned and actual growth, in DRG equivalents, in acute hospitals from 1999, the first year explicit targets were set, to 2006.

(Figure 1 about here)

For all years, the actual activity growth was higher than planned. This is particularly true for 2001, 2002, and 2003. The high growth in 2001 was mainly due to an activity increase in the second half-year following the decision to move the hospitals from the control of the counties to the central state (Huseby 2004). For psychiatric hospitals we also observe activity and cost increases, but this was planned increases that not translated into management problems. In addition to high activity growth, the wage increases in the hospital sector

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3 The datasources are BUS (2006, 2007) and various SAMDATA reports from the years prior to 2002. See: http://www.sintef.no/content/page13____7678.aspx
exceeded the rest of the Norwegian economy by approximately 4 percent in the period from 2001 to 2004 (BUS 2006).

Higher activity growth than planned, along with the leaps in salaries, created deficits and massive needs for organizational restructuring at the hospital level (Tjerbo, 2007). The restructuring plans led to turmoil and demand for supplementary funds. In figure 2, we depict two types of funds that were transferred to the counties or RHAs in addition to the funds allocated to hospitals by the Parliament’s approval of the State budget for the fiscal years 1997-2007:

1) Supplementary funds that imply increases in RHAs’ global budgets
2) Activity based financing that exceeds the production targets set for each consecutive year.

We estimated activity based funds that exceeded the production targets as: \[ \text{Produced DRG-equivalents in year } t-1 \times (\text{Actual activity growth measured in DRG-equivalents from } t-1 \text{ to } t \times \text{ unit price of the DRG-system in year } t \times \text{ share of ABF in year } t) \]. The two types of funds are not fully separable. For example, an increase in supplementary funds to improve the general financial situation can affect activity growth, thereby affecting funds related to unplanned activity.

(Figure 2 here)

As a consequence of higher than planned activity, both funds related to unplanned activity growth and also supplementary funds related to the general financial situation, continue to be high. Funds related to the general financial situation were allocated to the RHAs based on formula funding (mainly demographic and socioeconomic factors) in all years except for 2007. In 2007, the allocation was based on the actual size of the running deficits (St. prp. nr. 44 (2006-2007)).

Supplementary and activity based funds did not enable the hospitals and the RHAs to achieve budgetary balance. Even after the adjustment of budget balance requirements as depreciation costs were excluded from the total costs, the hospitals ran deficits in all years, as illustrated in Figure 3.

(Figure 3 about here)
The deficits were moderate in 2002 but came close to 2 billion NOK (or 3% of total revenues) in 2003 and 2004. The reduction in deficits from 2004 to 2005 is less than the supplementary grant given during 2005 (700 million NOK). The accumulated running deficits in the period from 2002 was approximately 8 billion NOK by the end of 2006. Including depreciation costs, the deficits totaled approximately 18 billion NOK or 20% of yearly revenues by the end of 2006 (BUS 2007). One of the RHAs, The Eastern Norway RHA, managed to break from the pack in all years following the reform and delivered balanced budgets (for an analysis, see Tjerbo and Hagen 2005).

3 Preferences, institutions and the soft budget constraints

We start out by presenting a simple sequential game model that structures our empirical discussions, and then add understandings of preferences, information problems, and institutional features.

A sequential model

Following Inman (2003), we assume that the default game consists of two main players: the principal, who in our model is the central state, and an agent, a Regional Health Authority (RHA). In the first move, nature determines the principal’s type, i.e. whether or not the central state is of a hard or soft type. Then, the principal sets the budget and signals its type. In the next move, the agent (the RHA) evaluates the principal’s signal, i.e., whether it is facing a situation of hard budgetary constraints or not, and makes decisions regarding activity and cost levels. If the agent views the principal’s signal of hard budget constraints as credible, and thus chooses to keep activity within budgetary limits (BAL), the game ends. If the principal is not viewed as credible or signals a soft budget constraint, the agent chooses to increase activity or costs beyond the level the principal has chosen. As the agent generates deficits (D), it tries to pressure the principal towards increasing the funding in the next stage. In the third stage, the principal has two options. Either it chooses to bail out (B) the agent by supplementary grants and/or postpone the demand for balance, or it chooses to stand firm (Not-B). Figure 4 depicts the game tree.

(Figure 4 here)
As the sequences of the moves are given, the solution of the game will depend upon the players’ preferences and their information partitions. If the costs of bailing out the agents are lower than the costs of standing firm, the principal will choose a bailout. Subsequently, the principal has revealed its type, and the agents will have even stronger incentives towards increasing their activity in the future.

The game in its simplest form has six different solutions (I-VI). In Inman’s set up, the most preferred solutions for the principal are solutions III and VI. Here, the agent balances his budget, there are no deficits to be covered, and the principal receives his best allocation of resources. In the setting of hospital reform, the principal did not end up in III or VI, but in I or IV.

**The actors’ motivation and information sets**

Several studies discuss the mechanisms that explain the principal’s choices in the different stages of a bail out situation. First, there are discussions of the actors’ motivations. Dewatripont and Maskin (1995), in what has come to be a standard reference, argue that the main reasons for the soft budget constraints are that politicians cannot distinguish bad projects from good ones *ex ante*, and cannot resist refinancing bad projects *ex post*. Given that a project is established, previous costs are sunk and the project will be financed as long as benefits cover marginal costs. As already stated by Robinson and Torvik (2006) however, the role of political motivation may also be important. Persistent soft budget constraints can serve the interests of politicians. Economically inefficient projects can be rational because they produce political sympathy and votes during elections.

More generally, it is desirable to derive preferences from general assumptions of politicians’ motives or objective functions. Three common and parsimonious motives are often assumed to be (Schlesinger 1991, Strøm 1990): Office-seeking, i.e., politicians and parties trying to maximize their numbers of seats in the cabinet government or other public positions; policy-seeking, i.e., politicians and parties seeking to maximize their impact on public policy; and vote-seeking, i.e., politicians and parties trying to maximize support in future elections.

Second, the choices will depend upon the actors’ information sets. The RHAs do not know what the central state payoffs are prior to making their move, and will have to base their choice on the expected utility of the different choices. However, the central state is also
uncertain of the financial situation of the hospital sector after the take-over, making it difficult to be credible when signaling budgetary constraint.

Institutional factors

Third, in addition to preferences and information available, the budget constraint and the choice between bailout or not, can be conditioned upon several institutional factors. Two strands of the literature are important here. One stream of papers focuses on how budgets are made. The papers of this “budget institutionalist” stream indicate that centralization of the budget process may increase the fiscal discipline (Alesina et al 1998, Hallerberg and von Hagen 1999). In 1997, the Norwegian Parliament passed a reform that centralized the Parliament’s budget process. Prior to 1997, the expenses were aggregated through a piecemeal process where the spending proposals of the committees were added up in the end, and the result made up the total budget expenses. This was a decentralized process with no initial limit on the expense side of the budget. Although preference dependent (Ferejohn and Krebibi 1987, Helland 2000), a centralized process can lead to lower budgets. However, a special feature of the budget reform of 1997 was that the centralized budget process was only implemented for the budget passage during the fall, and not when the budget was revised during late spring. This means that it is easier to increase the budget for specific purposes during the spring. As will become clear, this ambiguity in the parliaments’ budget process played an important role in understanding the principal’s signal of budget constraint.

Another stream of papers, those of the “electoral institutionalist” stream, focus on the effects of electoral systems. Their general finding is that plurality systems maintain tighter fiscal discipline than proportional representation systems (Person and Tabellini, 2003), mainly because of their ability to establish majority governments. Strøm et al (2005) describe how some distinctive features of the Norwegian parliamentary democracy, notably the lack of dissolution power and informal cabinet formation rules, have led to an increased probability of minority governments as the party system gradually became more fragmented. The increasingly fragile minority governments have problematic effects both as far as accountability and credibility is concerned (Strom et. al 2005). As shown by Roubini and Sachs (1989) and Edin and Ohlsson (1991) minority governments also produce greater debts and weaker fiscal discipline.

4 Changes in the budget can take in the revision during the spring or in the balancing in December.
4 The central state’s first move

Let us now open the “black box” of what we name the principal’s first move of the game depicted in figure 4. This is where the central state assigns a budget to the agent, establishes institutional rules, and signals its decisiveness over budget constraints. The principal’s first move is significant. Signaling a hard budget constraint is an obvious solution if the main goal is to increase the RHAs’ incentives to show budgetary discipline. A signal of a hard budget constraint from the cabinet government needs to be supported by a stable alliance in the parliament. We divide the analysis into two parts: analysis of the establishment of the institutional rules and analysis of the alliances behind the minority cabinet government in the parliament.

Institutional rules: The claim for budget balance

2001 was an election year, with the general election to the Storting taking place on the 10th of September. The two parties that had voted in favor of the hospital reform, the Labor Party and the Progressive Party, used the election campaign and the month following the election to drum up support for the new organizational model that was to be implemented beginning in January of the coming year. Labor’s Minister of Health, Tore Tønne, said he would resign if he was not able to fulfill Labor’s goal with the reform by the end of 2003. The goal stated goal was that: “Norwegian hospitals shall treat 100 000 more patients yearly than today. It shall not cost one additional crown” (Aftenposten Aften, 23rd August 2001). His alliance partner from the Progressive Party and the leader of the Parliament’s Committee of Social Affairs, Jon Alvheim, went even further, but seemed less preoccupied with the cost side of the issue: “The hospitals shall treat more patients, no matter what the costs” (Aftenposten, 19th November 2001). As a consequence of the signals from leading politicians, the hospitals increased their activity significantly during the last part of 2001. While the activity increase from 2001 to 2002 measured in DRG-equivalents was planned to be 1.5 percent, the actual increase was later calculated as 7.7 percent. In addition, prices in the hospital sector increased relative to the public sector in general as a result of wage increases and increases in pension premiums (St. prp. nr. 59 (2001-2002)).

The significant activity increase during late 2001 put the Ministry of Health and Care Services (MOHC) in a difficult position. At the time of the proposal of the State Budget for 2002 in early October 2001, the Ministry had incomplete information regarding the hospitals’
financial situation (St.prp. nr. 1 (2001-2002)). However, the MOHC got a second chance due to the election defeat of the Labor government and the establishment of the minority centre-right government made up by Liberals, Christian Democrats, and Conservatives, with Kjell Magne Bondevik (Christian Democrat) as Prime Minister and with Dagfinn Høybråten reinstated as Minister of Health and Care Services. Still, in an amendment to the State budget (St.prp. nr. 1 Tillegg nr. 4 (2001-2002)), the cabinet government had to admit that there was “uncertainty regarding the cost level of the specialist care by the beginning of 2002” and that “the cabinet government will return to the totality of hospital grants in the Revised National Budget” that by standard procedures are approved by the Storting at the end of each spring session.

The totality of the hospitals’ economic situation was then considered in a separate proposition to the Parliament by the beginning of May 2002 (St.prp. nr. 59 (2001-2002)). Here, the cabinet government estimated the deficit of the hospital sector as 2.6 billion NOK by the beginning of 2002, and proposed a supplementary bill of 1 475 mill NOK to partly cover it. The bill was increased to 1 825 mill NOK by the Parliament. The important signal, however, was that the cabinet government proposed that the remaining deficits should be covered by the end of 2003 through efficiency improvements. This implied that the general claim of balanced budgets inherent in the Health Enterprise Act (Ot. prp. 66 (2000-2001)) was postponed. For the first time in history, the hospitals were legally allowed to run deficits. The time limit for reaching balance was later the same year postponed from 2003 to 2004 for many of the same reasons cited above (St. prp. nr. 1 (2002-2003)). The central state started to pursue its goal of a hard budget constraint by institutionalizing a soft budget constraint.

The failure to establish a stable majority alliance

However, the unclear signals from the central state did not stop here. The Bondevik minority government that came into power after the 2001 parliamentary election needed support from either the Progress Party or the Labor Party to get a majority in the parliament.\(^5\)

We assume that the Cabinet Government moves first and decides whether or not to negotiate with the Progress Party. Since the Progress Party had contributed to the establishment of the center-right government, the cabinet government chose to go into budget negotiations with the Progress Party, both in 2002 and in 2003. The Progress Party could

\(^5\) It could also make a majority with the Socialist Left Party (SV). This happened only in a few cases.
accept the invitation and start negotiating the budget, or they could reject it. Accepting it would probably mean, because of the rules of the initial spending ceiling passed by parliament and in accordance with earlier experiences from this type of negotiations, that the room for manoeuvring was limited. Rejecting the invitation would mean that the Cabinet made a proposal of negotiations to the Labor Party, and the Progress Party would be left in the shadows. In other words, assuming that the Progress Party had policy or votes or both in mind, the payoffs were low in both cases. Could the payoffs be increased?

For the Progress Party, an agreement with the cabinet over the budget would make it possible to get some of their own policies passed, but it would not lead to the significant increase in expenditures on health care and hospitals that they had signalled to the voters. In order to achieve considerable increases, the Progress Party and the Cabinet Government had to cut other expenses, thereby creating a situation where the votes gained through increasing transfers in this area had to be weighed against the votes lost through similar reductions elsewhere. In the end, the Progress Party decided to form a deal with the cabinet. However, the Progress Party was disappointed with the compromise they had reached. The leader of the Parliament’s Committee of Health and Social Affairs and spokesman for the Progressive Party in health issues, Jon Alvheim, was clear-spoken and hinted that the centralized budget procedure of 1997 was the problem: “The present way of treating the committee budgets constitutes a repudiation of the committee’s competence. … after weeks of work the committee has only managed to move about 16 thousandths of the budget” (Stortinget 2002).

Then, immediately after the budget for 2003 was passed by parliament, came the opportunity to increase the payoff. As the parliament was preparing to adjust the budget for 2002, the Progress Party and the Centre Party proposed to increase the transfers to the hospital sector by 2 billion NOK. The bill was regarded as unusual as it had no chance of being passed, but the Progress Party was able to modify the signal they had just sent to the voters and the RHAs through the budget deal with the Cabinet Government. A prominent member of the Labor Party’s Committee of Health and Social Affairs from the Labor Party, Bjarne Håkon Hansen, commented on the Progress Party’s proposals and voting in this way: “This completely undermines the budget compromise they have just entered!” (Stortinget 2002). MP Olav Gunnar Ballo and the Socialist Left Party was of the same opinion: “This is double bookkeeping, pretending to oppose the same policy which they have created themselves...This is a way of courting the voters ... ” (Stortinget 2002). Although not supported by the other parties, this conveyed a clear signal and gave the RHAs valid reasons to expect a future bailout.
6 The central state’s second move

During the winter of 2002/2003, it was already clear that the RHAs would end in a difficult financial situation the coming fiscal year. The question was whether the RHAs would be granted supplementary funds by the end of the parliamentary spring session, as had been customary in previous years and as had already been discussed during the parliament’s fall session. The answer came extraordinarily early that year as the leading Norwegian newspaper, Aftenposten, notified its readers on the 13th of January that the minority Bondevik cabinet faced a majority coalition made up of the Labor Party and the Progress Party on a hospital bill. This was less than a month after the Progressive Party had backed the non-socialist cabinet government’s budget for 2003 (B. Innst. S. nr. II 2002 -2003). The argument from the Progressive party was straightforward: “We cannot sit and watch that patients are not receiving treatment” (Aftenposten, 13th of January 2003). The Progress party also stated their dissatisfaction with the budget deal they had made with the cabinet in the previous autumn (Aftenposten, 13th of January 2003).

Realizing both the difficult parliamentary situation and the difficult economic situation of the hospital and the RHAs, the cabinet chose a two-step strategy. First, to handle the difficult parliamentary situation, it was decided to deviate from the approved 2003 budget accepted by parliament in late autumn 2002 by proposing a supplementary bill of 265 million NOK by the end of the spring session (Innst. S. nr. 260 (2002-2003)). Second, to handle the fundamental financial problems of the hospitals which were related to production above the planned level, it decided to submit a revised planning document to the RHAs to make them comply with the production goals set in the 2003 budget (Ministry of health and Care Services 2003a). The revised planning document was sent June 25th, less than a week after Parliament had started its summer recess on Friday June 20th. While the first step can be regarded as a partial success, the second step ended with a threat of impeachment and total humiliation for the Minister of Health.

The supplementary bill

Consider first the game over the supplementary bill. The fact that hospital production in 2001-2003 was above planned levels (figure 1), and that wage increases during this period were above those of the rest of the economy, led to deficits and plans to restructure the hospital sector to cut costs and increase efficiency. During the spring of 2003, the restructuring plans
became evident to the public. Reactions came swiftly as massive popular protests rose, in particular in areas where the plans implied shutting down emergency rooms or maternity wards. We have already presented the strategy of the main opposition parties, the Progress Party and the Labor Party. The two other opposition parties, The Socialist Left Party and the Center Party, signaled similar responses, and a supplementary bill to the hospitals by the end of the spring session was to be expected. If the Cabinet did not take the initiative, the parliament would.

For the minority government, therefore, the alternatives at the end of the parliament’s spring session were 1) to stay firm on the approved 2003 budget, not bailout the hospitals, and take the blame from the voters or 2) to bailout the RHAs by proposing a supplementary bill and receive some sympathy from the voters. The opposition on the other hand had the option of trying to increase the transfers or not increase the transfers to the hospitals. The game tree is presented in Figure 5 under assumptions of perfect and complete information. The equilibrium concept is subgame perfect Nash and the solution of the game can be found by backward induction.

(Figure 5 here)

The opposition had already committed itself to bailout the hospitals by a supplementary bill. Consequently, they would prefer all other alternatives to IV. We assume that the opposition will rank the alternatives in the following way III>II>I>IV, based on an intent to show the voters that they want to increase the transfers to the hospitals and that they are “better” at this then the cabinet. The cabinet government’s payoff will be ordered IV>II>I>III. The Cabinet therefore wants to avoid a bail out, but depends on support from the opposition in order to achieve this. The worst outcome for the cabinet is III, as this means that the opposition is given the opportunity to present themselves to the voters as saving the hospitals, while the cabinet can be portrayed as having tried the opposite.

By backward solution we end up at I, where the cabinet bailout the hospitals, and the opposition choose to increase this bill. This outcome rests on the assumption that both players want to reap the electoral benefits of being the party which increases spending on health care. The Cabinet prefers outcome I to outcome III since it does not want the opposition to be perceived as the only party which cares about the grant level to hospitals. This means that we stipulate that the players seek relative gains. Each player is also interested in not leaving the
other player in a position where voters are likely to reward him or her with votes. The cabinet proposed a bill of 265 million NOK, where 300 mill NOK was related to an estimated increase in the activity based part of the DRG-based financing, and minus 35 mill NOK to an estimated decrease in outpatient treatment (St. prp. nr 65 (2002-2003)). The cabinet government did not increase the global budget. However, the opposition parties did not agree on an amendment to the Cabinet’s proposal. The Socialist Left Party, the Centre Party, and the Progressive Party all put forward amendments to the Cabinet’s proposal. But the Cabinet’s proposal was accepted by the parliament with votes from the three ruling parties and the Labor Party (Innst. S. nr. 260 (2002-2003)). Contrary to our prediction, we ended up at solution II.

Or did we? Although the bill passed the parliament June 20th, the last day of the spring session, the endgame didn’t end here.

The revision of the planning document and a threat of impeachment

Consider now the revision of the planning documents from the Ministry of Health and Care Services (MOHC) to the RHAs. The revised planning document (Ministry of health and care services 2003a), dated the 25th of June, became public just five days after the parliament had started their summer recess. Based on the bill approved on the last day of the spring session, the MOHC demanded forcefully that the RHAs should keep hospital activity at the levels initially planned for 2003, which was equal to the hospitals’ activity level at the end of 2002. The planning document further emphasized one important feature of the financing system (Ministry of Health and Care Services 2003b) which was also emphasized as the ABF system was introduced in 1997. Since the global budget and the activity based component together make up the hospitals’ budgets, and the activity based components on the margin do not cover costs, it is the global budget that defines the activity level.

Both the RHAs and the political opposition responded with shock and outrage to the document. In the official protocol from the board meeting in the Eastern Norway RHA (Helse Øst 2003), it is stated that: “The board regrets to see that the revised budget for 2003 leads to significant changes in the external conditions and the rules of the games for the hospitals.” And further, “The board acknowledges that this means that parts of the patient services will have to be closed.” And as a conclusion, “The consequence of this is that the waiting lists will increase.... ” However, the strongest reaction came from the political opposition. The former prime minister, and at that time the leader of the Labor Party, Jens Stoltenberg, said that “The
cabinet must withdraw the steering document at once...we would not have been in this situation if our proposal of 500 million more (our comment: proposed during the parliament’s decision of the National budget during the fall) had been accepted” (NTB 2003a). The leader of the Progressive party, Carl I. Hagen, went even further and threatened the Minister of Health, Dagfinn Høybråten, with impeachment if the revised planning document was not immediately withdrawn. The responses from the Cabinet Government came swiftly. The Minister of Finance told the press that Høybråten had done nothing but follow up on Parliament’s approval of the Revised National Budget (NTB 2003b). The Prime Minister, Kjell Magne Bondevik, followed up by saying that Hagen’s remarks were nothing but a populist attempt to make a political offensive and that “if this is so serious that he is threatening with impeachment, he should at least come home from Spain’s Costa del Sol” (NTB 2003c).

However, Bondevik’s minority government had to comply with the opposition’s wishes. Already on June the 30th, the MOHC submitted a letter to the RHAs inviting them to a meeting with the Ministry in the beginning of August to discuss budgets and activity levels (Ministry of Health and Care Services 2003b). Although the formulations were vague, the letter could be interpreted in only one way, as a withdrawal of the revised planning document. The consequences were dramatic from a fiscal policy standpoint. The RHAs did nothing to reduce activity growth, which became about five percent higher than the parliament had planned a year earlier. The central state had to increase the activity based funding by approximately 1.4 billion by the end of the year. Furthermore, Parliament decided not to follow the MOHC in lowering the unit cost per DRG⁶. However, since the DRG price did not cover marginal costs, the extra funding did not prevent the hospitals from running deficits, this year by 2 billion NOK or approximately 3 percent of total revenues.

Consider once again figure 5. The bailout of the hospitals through the supplementary bill proposed by the Government was approved by the Parliament with votes from the three governing parties and the Social Democrats. However, as the proposal was about to be implemented, the Social Democrats jumped off and demanded higher spending. There can be several reasons for this change of strategy. Most likely, the harsh reactions from the RHAs made the Social Democrats reassess the trade-off between policy and votes in the upcoming local elections and that the cabinet government miscalculated this reaction. This is also how

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⁶ Lowering the unit cost per DRG means that the per capita based part of the financing system becomes more important. This also reduces the incentives to increase activity since a larger part of the RHAs income will be based on the activity level.
the Minister of Health, Dagfinn Høybråten, later interpreted the Labor party’s behavior: “The Labor Party complained about soft budget constraints .... then initiated the hospital reform. Coming in opposition they forgot about everything they had said and fueled the fire as the hospitals started their crises description” (Høybråten 2006).

7 Discussion

We’ve investigated into the effects of a radical reform with ambitious goals. The main argument for the transferal of the ownership of the hospitals from the counties to the central state was lack of transparency and a blame game between the counties and the central state. So far, the story tells us that a new blame game has replaced the old one and as stated by the former Minister of Health, Dagfinn Høybråten: “… the hospital reform has provided many of the benefits we wanted, but it has not delivered as far as budget steering is concerned” (Høybråten 2006).

Two institutional factors are important for understanding the problems of governance. First, the Cabinet Government’s minority situation made the decision making process in the Parliament difficult. It neither managed to signal a hard budget constraints nor to stay firm as the hospitals produced deficits. Second, the decentralized nature of the budget process surrounding the revision of the budget in the parliament each spring made replays easy. Any signal sent through the national budget during the fall is up for revision during the spring. A temporary problem adds to these two structural weaknesses as the signals of activity level sent during and after the election campaign of 2001 made the transition phase difficult for the Ministry of Health and Care Services. The experiences from the Norwegian hospital sector after the central state took over ownership shows how politics at the central level undermined the budgetary discipline. In a way we can say that soft budgets constraints serves the short term interests of politicians.

Once a soft budgetary constraint is established, there are no simple ways of harden it. Nevertheless, three types of reforms should be considered. The first potential reform is a reform in the formation rules of cabinet governments. Minority governments have dominated Norwegian politics since 1971 (Strom et al 2000). The notion that minority governments have a negative effect on fiscal performance is also supported by empirical studies (Roubini and Sachs 1989, Edin and Olsson 1991). In the Norwegian case, both dissolution power and stricter cabinet formation rules would probably increase the probability of majority
governments. However, Norway do currently (2007) have a majority cabinet, and this does not seem to have had any effect. The deficits are still present and high.

A different solution is to place more of the risk for excess activity on the RHAs. This was basically the idea proposed by a royal commission delivering its proposal during the fall of 2002 (NOU 2003:1). The commission concluded that the current system was unable to control the activity level. To solve the problem, the majority of the commission suggested the following funding model. First, the Parliament decides the total budget for the specialized health care sector. The total budget is then allocated to the regional health enterprises according to a need-based capitation model. In addition, the following mechanisms for risk-sharing between the central government and the regional health enterprises apply. If it turns out that the actual activity level is up to two percent higher than 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. The problem with this solution is that it relies on the central states ability to enforce it, and as we have seen, relying on this may be unrealistic.

A third possible solution is to reverse the reform of 2002 and decentralize the hospital sector to regional governments but this time with elements of taxing autonomy (cf. Oates 2005). If local residents were more directly exposed to the costs of the increased expenditure on health, this could give stronger incentives to maintaining cost control for regional political decision makers. Thus, decentralization of the responsibility for both the financing and the production of hospital services to a regional elected assembly could potentially have a positive effect on budgetary discipline. This solution could, however, create problems of horizontal inequality and thereby challenge one of the main ideological pillars of the Norwegian health care sector.
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Figure 1 Planned and actual growth in DRG-based activity, 1999-2006
Figure 2 Supplementary funds (1997-2006) and estimated funds related to unplanned activity growth (1999-2006).
Figure 3 Running deficits (current prices) in million NOK (left axis) and percent of total revenues (rights axis), 2002-2006.
Figure 4 A sequential model of a bailout game
Figure 5 Illustration of the game between the opposition and the cabinet in spring 2003.