What costs has the Coordination Reform so far incurred for the municipalities?

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Summary

This survey is conducted on behalf of KS, and aims to answer the following questions:

- What measures have municipalities implemented locally in connection with the Coordination Reform?
- What costs have municipalities incurred in this effort?

Costs incurred in 2010 and 2011
Through the reporting of results we can reveal the extent to which municipalities in our sample have had costs in the various areas we have examined, and then the size of these costs.

Our study shows that the 86 municipalities surveyed had total costs as they relate to the Reform Coordination of 119.9 million NOK in 2010 and 186.1 million NOK in 2011. Most of the municipalities' costs are listed as carrying costs. This is mainly operating costs and less investment costs. In 2010, 83% of the total cost was carrying costs. The corresponding figure for 2011 was 79%. Based on the 86 municipalities' cost reports, we estimated costs on a national basis. Our two alternative estimates vary between 600 and 657 million NOK for 2010, and between 931 and 992 million NOK for 2011. We emphasise that the figures reported from both the 86 municipalities and the numbers we have aggregated to a national basis are uncertain.

The largest cost items in our survey, in 2010, were costs to 1) replace hospitalisation, 2) for prevention and health promotion, and 3) competence and skills upgrading. In 2011 the ranking of the most costly activities was to 1) replace hospitalisation, 2) patients ready for discharge, and 3) prevention and health promotion.

Costs in 2012
In the case of 2012, we sought to identify some of the upcoming costs as they emerged in the spring, almost half way through the year. There is obviously considerable uncertainty associated with these costs. We did not ask about the same costs as in 2010 and 2011, so the figures for 2012 are not directly comparable with the figures for 2010 and 2011. The costs that we have sought to obtain an overview of amounted to 88 million NOK in the 86 municipalities surveyed. We estimate costs on the national level to be between 440 and 467 million NOK. This estimate does not include spending on measures to replace hospital services, nor any expenses incurred for the establishment of FLS.

The largest cost items identified in this study in 2012 were 1) patients ready for discharge, 2) competence and skills upgrading, and 3) the establishment of emergency beds.

The study has mainly a retrospective perspective, since we have primarily aimed to identify the costs incurred in 2010 and 2011. It has certainly been a challenge for the municipalities to recover the costs they can relate to the Coordination Reform. It is difficult, if not impossible, in retrospect, to fully isolate the preparation and early implementation of the Coordination Reform from other operations. The costs reported for 2010 and 2011 are covered within regular budgets without additional transfers from state authorities. This means that there has been a significant restructuring of economic priorities in this field in the municipalities in recent years. When it comes to costs surveyed in 2012, these are largely new costs arising as a direct result of the implementation of the Coordination Reform on January 1st 2012.

Recurring and non-recurring costs

Of the costs which have been mapped, there are some typical non-recurring costs, while some are recurring. Typical non-recurring costs are costs associated with the legal agreements and costs of familiarizing with the reform and prepare procedures for the implementation of it. The recurring costs are typically cost for alternatives to hospital services, for skills development, and for prevention and health promotion. On the basis of the estimates for 2011 and 2012, we have calculated a recurring annual expense as a result of the Coordination reform, of between 662 and 705 million NOK. The non-recurring cost of the Cooperation Reform for 2011 and 2012 is estimated to be between 709 and 754 million NOK. Municipalities are currently only compensated for the costs of co-financing hospital services and for costs related with patents ready for discharge. If the municipalities in the long term should come out in economic balance, there must be a reduction in local government spending on hospital services corresponding to the recurring costs.

Motivation for new measures and attitudes towards the Coordination Reform

We also sought to ascertain the motivation for municipalities developing new offerings. Do the local authorities develop new measures because they consider that they will eventually provide health and economic gains, or do they develop new measures because they anticipate that they will be funded by state budgets rather than the municipality's budget? We have also obtained information about the municipalities' attitudes toward the Coordination Reform in general and to public health work in particular. These factors were identified in the survey using statements where respondents could indicate the degree of disagreement/agreement, and sought elaboration in the qualitative interviews.

Our findings suggest that the Coordination Reform is a much welcomed reform, in the sense that it provides functions that the municipalities wish to attend, and in some cases already have come a long way in developing. It is generally agreed that the Coordination Reform first and foremost aims to improve people's health. It certainly gives a good deal of attention to the notion that the reform is all about money transfers - understood to mean that the co-financing is all about the health enterprises sending money to the municipality that the municipality, in turn, generally sends in return. Generally, the service development and capacity building that takes place in the municipalities is perceived as a step toward better healthcare. The municipalities seem generally to have faith in their ability to make good assessments and see which solution is best for the individual. The municipalities do seem to prioritise based on what they think is best for their citizens and, to a lesser extent, on the

basis of how the state will reimburse their efforts. These priorities seem largely to be in line with the Coordination Reform objectives.

We would also point out that the project portfolio profile of the state-funded Collaboration Projects indicates that state management direction means a great deal. A large proportion of these projects involve the establishment of local medical centres. We have also seen that an increasing proportion of the projects are aimed at health prevention. Public health and prevention is clearly something that the municipalities want to prioritise regardless of state signals. This is supported by experience gained from the interviews. The municipalities are, however, disappointed that so far little funds have been given to support an increased focus on public health work, even though improved public health is one of the main objectives of the reform.

Future costs

We will conclude by drawing some findings from the survey, which we regard as particularly significant in terms of future costs. The first concerns the preventive and health promotion work that local authorities now prioritise differently than before. We believe that it will be important to achieve a strong link between prevention and research in the municipal sector. This is because the local authorities so far seem to be somewhat perplexed as to which good measures work. Based on the findings in our study, we assume that the approach to prevention and health promotion will be instrumental in the sense that measures will be aimed at the prevention of hospital admissions for specific groups, where one will be able to read the economic effects relatively quickly. Without additional funding to this field, we believe the municipalities will downgrade general population-oriented health promotion and preventive measures.

We have detected signals in some municipalities that the health enterprises seem to be planning to withdraw their share of funding for collaborative initiatives that are currently well established. This means higher costs for the municipalities. It would be a paradox if health enterprises find that they no longer benefit from these measures. It is premature to conclude what the outcome will be in these cases, but what we have observed can be interpreted as signs that the economic incentives in the system can have unintended effects. The authorities should focus on this in particular.

The last aspect we would like to mention relates to the lack of electronic interaction. Our study shows that about 40% of the municipalities do not yet have a system for electronic interaction. They are also not informed about what costs it will entail to get this in place. We have also uncovered evidence that, in terms of communication concerning patients who are ready for discharge, little is done electronically. There is no doubt that the Coordination Reform would be more effectively implemented if a good system for electronic communications around patients were in place. Our study reveals that future costs must be expected to put systems for electronic patient communication in place.

The data collection

The municipalities are the objects of study here, and we have collected data about and from them. To illuminate the study questions we have chosen dual data collection. First, a quantitative survey was conducted, where 86 municipalities participated. The survey was

sent to chief municipal executives in each municipality or to the one he/she believed to be the right person to answer our questions. Data collection was conducted electronically in the period from 7th of May to the 22nd of June 2012. The second part of the data collection was a qualitative study of eight, selected case communities conducted in order to validate and expand on the findings of the survey. Interviews in the municipalities were carried out in the period from 16th of May to the 13th of June in 2012.

The study focuses on costs incurred for the years 2010 and 2011, but we also investigated some costs in 2012. The costs are associated with various administrative measures (particularly the statutory appointment system, and management of the co-financing and patients ready for discharge), prevention and health promotion measures, and measures to replace hospital services. We also asked specifically about the cost of increasing competence and skills. Costs related to the co-funding of hospital services, which represent the largest single cost in the Coordination Reform, are not part of this investigation.

In the survey, we asked about the municipality's net cost. That is, costs that the municipality does not get reimbursed from the state governments, health authorities or others. To the extent that the costs are booked as expenditure figures the municipalities were asked to provide these. Alternatively or additionally, the use of resources could be given as an estimate of work time spent. In our communication with the municipalities, we made it clear both verbally and in writing that we understand that it would be difficult for them to give us exact numbers, but we asked for their best judgment.