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Implementing a health care reform through inter-municipal-cooperation: Adapting and implementing the Norwegian Cooperation-reform in three inter-municipal health regions

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Abstract

In this explorative article we will try to identify some issues and questions about how the Norwegian municipalities are preparing to implement the Cooperation reform and the new health care legislation. Our main focus is on examples of measures municipalities in three Norwegian inter-municipality regions so far have developed with respect to the Cooperation reform which will be implemented from spring 2012. By comparing and contrasting this three regions, with different history and adjustment patterns, our aim is to investigate inter-municipal cooperation as an suitable organizational solutions the municipalities can use in their struggle to prepare for their new extended role as health care providers. We will also explore factors that could explain why some inter-municipality regions have progressed better than others in their collaborative efforts to adapt to the future health challenges.

Introduction

The proposed health care reform legislation (St. meld. No. 47, 2008-2009) and a newly proposed health care act (Prop. 91 L, 2010-2011) will probably cause a substantial reorganization and the emergence of new roles between the hospital sector and the municipalities in Norwegian healthcare.[1] The discussion about organizing the relationship between primary health care and specialist health care is by no means a new discussion in Norway. In the 1970s, the Norwegian Parliament advocated that district health services should be a municipal responsibility. The transfer of management responsibility from the state district physicians at that time to the municipalities faced heavy opposition. The leading public physicians believed that the district health services and the specialist health services (hospitals) should be housed at the same administrative level, namely at the county-municipalities (Heløe and Ånestad 2007). However, this did not happen when the Municipality Health Care Law came in 1982. The primary health care became a municipality responsibility and the hospitals continued to be owned and operated by the county-municipalities. The Norwegian health care system is still facing many of the same coordination and competence problems that where under debate in the Seventies and. Once again, the discussion about coordination and competence is a central issue in the new

[1] https://fremtidenshelsetjeneste.regjeringen.no/last-ned-sammendragene-som-pdf/

Cooperation reform (St.meld. nr. 47 2008-2009). When the discussion in Parliament on the reform first time took place in April 2010, many representatives from both the opposition and the ruling parties were doubtful about the economic incentives in the reform (Innst. S nr. 212, 2009-2010). They argued that it was unrealistic to introduce municipal co-payment for hospital services and to make the municipalities more responsible for care after patients are discharged from the hospitals (Romøren 2010).[2] The Cooperation reform and the new health legislation passed in the Norwegian Storting (parliament) in June. The new Norwegian health reform are planned to be implemented in the Norwegian municipality sector during 2012. A "heavy burden" of health service delivery will then be handed over from the state owned health enterprises to the municipalities.[3] Due to the fact that many Norwegian municipalities are small, there will probably be a substantial need for restructuring in the Norwegian municipality sector if the municipalities are to be able to deliver sufficient specialized care. [4] However, the majority of the population is against merger of Norwegian municipalities and local identities and the power of the Norwegian periphery are still strong (Baldersheim and Rose 2010). Therefore inter-municipal cooperation could be an alternative to unpopular radical merger of Norwegian municipalities. At moment many municipalities are in an unclear implementation situation: where the future distribution of roles and the economic framework between the hospital sector and the municipal health care sector are changing. Most of the 430 Norwegian municipalities had already on voluntary initiatives close collaboration with specialist health care (hospitals), and most of the municipalities have designed agreements with the state owned health enterprises on transferring of patients and sharing of resources between the two sectors.[5] Inter-municipal cooperation are quite common, but will probably increase as the many small Norwegian municipalities adapt to the national reform. In collaborative efforts together with the state owned hospital sector are many Norwegian municipalities preparing to for their new extended responsibilities. Local medical centres seems to be "the new decentralized health care concept" in Norway, a concept

[2] The reform will make them responsible for 20 percent of the funding of specialist health care for all medical patients and for all medical patients discharged from the hospitals.
[3] The state took over the ownership of the hospitals from the county-municipalities and organized the hospitals as health enterprises in 2002.
[4] As many as 240 of the 430 Norwegian municipalities have less then 5,000 inhabitants, 90 municipalities have a population between 5,000 and 10,000 inhabitants, 57 between 10,000 and 20,000 and 33 between 20,000 and 50,000. Only ten municipalities in Norway have a population with more than 50,000 inhabitants.
[5] As much as 48 percent of Norwegian hospitals run education program for the staffs in primary health care and 64 percent of the hospitals do have ambulant teams in primary health care in 2009 (Kjekshus og Bernstrøm 2010).

which has much in common with the Swedish "Local Care-concept". (Romøren, Torjesen and Landmark 2011).

In this explorative article we will try to identify some issues and questions about how the Norwegian municipalities are preparing to implement the Cooperation reform and the new health care legislation. Our main focus is on examples of measures municipalities in three Norwegian inter-municipality regions so far have developed with respect to the Cooperation reform. By comparing and contrasting this three regions, with different history and adjustment patterns, our aim is to investigate inter-municipal cooperation as an suitable organizational solutions the municipalities can use in their struggle to prepare for their new extended role as health care providers. We will also explore factors that could explain why some inter-municipality regions have progressed better than others in their collaborative efforts to adapt to the future health challenges.

The article consists of five parts. In Part One, we discuss some of the advantages and problems related to inter-municipality cooperation. In Parts Two and Three, we provide an overview of our methodology and describe our three cases. In Part Four, we discuss different adoption patterns and some of the common problems and challenges our municipalities face in preparing for the implementation of the newly parliamentary passed health care reform (Storting June 2011). We conclude by offering some final thoughts and lessons from these three cases/regions.

More about the Challenges the Norwegian Municipalities are facing in the Wake of the Reform

The Coordination reform is not a reform in the usual sense. The Norwegian health authorities say the reform can be characterized as a development process that will gradually be implemented *"as a new direction-reform"* in health care (Innst. S. nr. 212 2009-2010) and in the new legal regulation it is stressed that the municipality will have so-called "*responsibility facilitation*" (Prop. 91 L, 2010-2011). Simultaneously, the municipality will keep their own autonomy and still find their own organizational solutions for delivering extended health care. In many ways, the reform follows the decentralized tradition in the Norwegian health care system. The central

government has usually provided the framework for health policy through legislation and funding, but when it comes to organization, have the municipalities been quit free to interpret the content of the policy (Romøren 2001).

At the moment we can observe that enthusiasm for the reform initiatives is growing. For example, the Association of the Norwegian Municipalities concluded already in their hearing comment that, "*The Cooperation reform requires a policy that in practice demonstrates that the next decade belongs to the municipal health service — as the first decade of this century definitely has been decade for the specialist health and hospitals for decades"* (Norwegian Association of Municipalities hearing: 03.12. 2010).

Central health authorities encourage by soft means adoption and implementation of the reform, i.e. distributing project money to the municipalities and regions that experiments with different organizational partnership solutions (collaboration laboratories). At moment the Government have allocated 580 million Kroner in 2011 to 115 different projects: most of which are experiments with local medical centres. However, the future financial responsibility for the many new health tasks in the municipalities are uncertain and it could be risky to develop new services based on short time project money from the state (Romøren 2010b). In addition the reform consequences represent an extra burden for the municipalities that are already in a stressful economic situation. In the end, it could result in lower service quality for the patient. In many municipalities are the nursing home sector under economic pressure (Rasmussen 2010) and the medical expertise is inadequate in many rural areas (Andersen 2010). We can also expect that the challenges will vary among the municipalities. In small municipalities with fewer economic resources and health care competencies and districts with scattered settlements and long travel distances, we can expect greater health challenges compared to areas of the country where people live in concentrated population centres close to health services where the municipalities have greater competencies and resources.

Inter-municipality Cooperation

A very strong local political autonomy tradition can in Norway be traced back to municipality act in 1837 (Formannskapsloven). In harmony with Norwegian traditions and culture could then

inter-municipality cooperation fit well to organize and keep up strong decentralized health care. It is evident elsewhere in Europe that inter-municipality cooperation can give more efficient and competent service delivery at the same time as local democracy, autonomy and competences is safeguarded (Hulst and Montfort 2007). Regional network governance or inter-municipal service solutions can then be an alternative to radical municipality merger that the population can accept. The model has for a long time been used in Norwegian municipalities (i.e. in the communication sector, in business development and for common water and sewage cleaning services). Inter-municipality cooperation is relatively easy to customize to new challenges, tasks, and services. The model has many advantages — especially when partnerships from other sectors already exists, it can allow for spin-offs, which makes it easier to start up new cooperation in new fields of service delivery. Transaction costs will then be lower if one is able to build on old networks and cooperation. With respect to health care, there are probably scale benefits at a certain population level. The government has recommended that the optimal sufficient size for service delivery in health care is an average population of 30,000 (St. meld. No. 47, 2008-2009).

Inter-municipal collaborations can be thought of as networks. Linden (2002, p. 9) maintains that collaboration becomes more important as society moves from "mechanistic models to more organic ones." Networks often form because one organization lacks the resources to provide a good or service on its own. Networks allow organizations to pool their resources in order to provide a good or service (O'Toole, 1997; Kickert, et al., 1997), deal with complex or "wicked" policy problems (O'Toole, 1997), and as a response to changes in the role of government from a direct service provider to one of contracting, steering, and collaborating (Kooiman, 2003). Many claim that inter-municipal collaboration can reduce fragmentation by allowing organizations to share their diverse resources and facilitating the development of innovative solutions to policy problems by encouraging broad stakeholder groups to participate in decision-making about service delivery (Powell, 1990; Alter & Hage, 1993; Jones, Hesterly, & Borgatti, 1997).

As McGuire and Agranoff (2007, p. 14) note, "Working collaboratively through networks often times connotes images of some interactive nirvana, where nothing but 'love and kisses' prevail in a sort of a soothing hot tub atmosphere." Experience proves otherwise, and scholars have documented and classified barriers to collaboration in many instances (Jennings & Krane, 1994;

Bardach, 1998; Linden, 2002; Agranoff, 2007). Jennings and Krane (1994), for example, interviewed state officials involved in coordinating service delivery for the Job Opportunities and Basic Skills (JOBS) program in order to identify barriers to collaboration. They outline three broad types of barriers: organizational (e.g., differing missions, professional orientations, agency structure and processes, etc.), legal/technical (e.g., conflicting regulations and reporting requirements, legal restrictions on the use of funds, technological capacities of organizations, etc.), and political barriers (e.g., turf protection, support of leaders, environmental dynamics, etc.). Other challenges include a lack of democracy and informal governance structures outside the formal democratic institutions is often reported to be a problem (Andersen 2010). Politicians can lack information, and decisions about inter-municipal cooperation can be made administratively outside of political budget control. On the other hand, previous case studies in Norway also illustrate that it is the local politicians who in the end have the power and determine the scope and content of collaborative solutions. Putting a lot of effort and resources into building interim inter-municipality solutions can in the end be canceled-out when politicians have made their decisions. In addition, a positive experience with inter-municipality collaborative efforts does not automatically provide more regional integration. In the end, this means that the municipality will not be less important than the region as a reference and source of identity. In this way previous studies from Norway tells us that inter-municipal governance can fall short and challenge local autonomy when encroaching upon the core jurisdiction and domain of the municipalities (Andersen 2010).

Inter-municipal Cooperation as Path Dependent

The inter-municipal cooperation we are studying can be interpreted as dependent on the previous history. The three regions follow old routes as the inter-municipal cooperation become more and more institutionalized. Historical institutionalism tells us that institutions are built upon historical experiences and that policy-making and institutional change is path dependent (Steinmo et. al. 1992). At certain points in time when a critical juncture occurs (i.e., a new health reform), there is a break with the past and an opening for system transformation in which new forms of organizing and ideas can emerge (Campell 2004). The regions we are observing can then be considered as institutions: that have a different constituting history, with their different development paths and different conflict- and integration history.

Methodology

We have collected data in in three inter-municipality cooperation regions in health care by conducting in-depth, open-ended interviews, examining written documents, and observing several meetings.

Interviews

Six interviews with middle and top managers informed this research. We developed an initial interview guide that covered topics such as the history of collaboration in the municipalities, the current state of health care delivery in the municipalities, and the proposed health reform legislation. The interviews occurred in person during 2010. Each interview lasted approximately one to two hours.

Written Documents

We also examined written documents related to the health networks in the three regions, including Power Point presentations, legislation, and meeting agendas and briefing materials. The interviews were used in tandem with the documents to determine whether they supported one another (Caudle, 1994).

Observation

One of the authors also attended and observed network meetings in the three inter-municipal regions (a total of six meetings during 2010 and 2011). Doing so gave us an opportunity to observe first-hand how the municipalities discuss and plan adoptions to the reform initiatives. Second, it gave us insight about which issues the regions are discussing and how decisions regarding the health care networks are made. Third, this fieldwork has enabled us to meet people and question them more informally about the health care issues. Finally, this has allowed us access to written materials, including meeting reports, that have allowed us to stay up-to-date on the various issues affecting the health care networks due to their planning to implement the reform initiative.

The Three Cases

We have chosen three contrasting critical cases (Flyvbjerg 1993). The cases will hopefully shed light on how inter-municipal cooperation and integrative processes is handled in three contrasting critical cases/ regions. Two of the cases can be considered to be pioneers, as they have long traditions (history of cooperation) of inter-municipal cooperation in health care. The third case/region have in contrast another more problematic conflicting history of cooperation where collaborative efforts in health care is just starting up.

The first case is *Region South* (total population 125,000) comprise of eight municipalities—where seven are small with a population less than 12000 inhabitants. The many small municipalities surround one large town municipality (81.500 inhabitants). The *Region Sout* is closely linked to a specialist healthcare-hospital located in the town municipality which are a division in the Health Enterprise South (state owned enterprise). The travelling distance between the single municipalities and the hospital is short. The Region South has for a long period developed inter-municipality collaboration and joined-up services in many areas: health, transportation, handling of refugees, handling of drug addicts, economic development, etc. The region appears in many ways to be well integrated, with a common identity and a well institutionalized contractual relationship to the hospital. The region has great ambitions and aims to be "the best region in health care cooperation". The first inter-municipality health network projects started in 2007 and in 2008 the region started collaborating in public health. The region has a common nursing home education center for all municipalities and the "big brother" the major town municipality has the teaching responsibility (host function) for the home health services, refugees, and immigrants. There are professional networks in addiction and geriatrics. The small municipalities in the partnership "lean on the shoulder" to the largest town municipality, which has more resources, competence, administrative capacity, and facilities in health care. These assets provide a more balanced relationship in negotiations and agreements with the more highly competent specialist health care in the health enterprise (hospital) where health professionals from municipality health care in *Region South* also are placed physically in the hospital in combined positions where they work part time for the health enterprise and part time in municipality health care.

The second inter-municipality region, *Region West*, is located the western part of southern Norway and it constitutes a population of about 35,000 in eight small municipalities where all have less than 10,000 inhabitants. The region has close ties to the local hospital—a division of Southern Local Health Enterprise — located in a small town (8,853 inhabitants). The *Region West* has a quit strong historical common identity caused by a common labour and service marked that has emerged after a new road connected the three small municipalities more closely to each other. In health care the region has already inter-municipality collaboration in rehabilitation, geriatrics, palliative care, psychiatric services. The different health networks have been closely developed in collaboration with the local hospital: supported by strong professional competencies from the specialist health care. In the region there is a strong commitment to protect and further develop the local hospital. By using a successful recruitment strategy, where the hospital have recruited physicians from Germany and Holland, the hospital have secured resources and competences. In contrast to many other local hospitals in Norway there is sufficient physician staff in the hospital which has also been an important competence asset for the entire *Region West*.

Our third case is the *Fjord Region*, which constitutes half (50,000) of the population in a county in the fjord-district of Norway. The inter-municipality health region is comprised of 12 mostly very small municipalities (less than 3,000 inhabitants). In specialist health care the region is served by a local hospital located in the largest municipality (11,000 inhabitants). Transportation has been problematic but a new road project is connecting more of the region together. However, ferry transport is still needed and the travelling time and can be long to the hospital. Historically the region is not well integrated with many disputes among the municipalities about localization questions of services, and previously about closing down the local hospital in the little town in favour of the remaining hospital. Previously there has been some form of institutionalized industrial development cooperation between the municipalities but the municipalities have struggled for a long time to find consensus when it comes to inter-municipality collaboration in business and commerce. Especially with regard to localization of inter-municipal services it has been problematic to find solutions that could satisfy all municipal partners. In health care, the municipalities have slowly started collaboration measures with respect to develop a common

district medical centre in collaboration with the local hospital. Before the new national health reform initiatives came, a binding contractual cooperation between the single municipalities and the health enterprise already existed. This previously developed partnership with the hospital seems to be a good starting point for promoting integrated healthcare in the region.

Comparative Discussion

How far have the three regions gone in attempting to meet the reform challenges? There seems to be no alternative to respond. As one interviewee put it: "The Cooperation reform must be implemented; because of demographic changes (such as a growing elderly population), there is no alternative." However, how these three regions have prepared for and met the most recent reform challenges varies.

In the *Region West* it looks like they have been progressing well. Since 2008 has the region established ten projects with nine employees and a overall administrative network structure has been established. They are well organized and hold frequent meetings. The project manager is constantly looking for new opportunities and resources (e.g. what the reform could bring in of state project funding money). There seems to be now competence problems since the expansion of the project portfolio happens all the time in close partnership with the local hospital, which provides considerable expertise. Much of the inter-municipal cooperation is spin-off from a long-lasting tradition of competence crossover between municipalities and the hospital. This well-functioning consensus based partnership is probably the key to the success in integrated health care in the *Region West*. The partnership can be described as a form of balanced exchange: where the municipalities are committed to the hospital, and where the municipalities get competence in return, and where a more seamless healthcare is the payoff to the patients in the region.

In contrast, the *Fjord Region* has slowly started to create administrative and political support for the reform. It has taken long time to establish a forum for discussing inter-municipal cooperation effort among the many (12) small municipalities. The initiatives have mainly been driven from the largest municipality constituting of few managers and politicians. Backed by the National

Association of Municipalities, the county administration, and the local health enterprise are the region is scrutinizing the areas of health care where patients in the region could benefit from cooperation and inter-municipal services. Currently, the region has recruited three new project managers funded by state reform money. The new project managers are responsible for initiating specific inter-municipal cooperation project in the region, i.e. propose and establish collaborative forums and inter-municipal institutions in rehabilitation, public preventive services / environmental health.

In our third region, *Region South*, inter-municipal cooperation in healthcare can be traced back to 2007 — long before the Cooperation reform initiatives came from the national authorities. In many senses, the collaboration in health care was built on old institutionalized structures and functions, described as a form of path dependent development. The region's "big brother", the large major town, had for a long time strong ambitions to become the regional capital and the region wants to "win the Norwegian championship" in health care collaboration. These ambitions have generated more resources and competences also in health care which all the small neighbour partners (municipalities) can draw advantages from. So far the attitude and commitment has been to share the "common" resources. The major town municipalities (80.000 inhabitants —with its prosperity and growing competencies in health care — so fare show generosity and willingness to sharing its resources and are doing many services for the small surrounding municipalities. The integrative helping each other attitude process probably also stimulate for a further development of a common regional identity. The partnership between *Region South* and the local health enterprise play a significant role in promoting a collaborative health network and a more seamless health care between specialist- and municipality health care in the region. The main focus areas include interaction with other health care services providers, common cooperated professional competence development, e-health and development of local medical center.

Contrasting discussion in the Light of historical Institutionalism

The *Region West* is following an old path to protect and support their local hospital. Based on the region's historical experiences cooperation and integration develops along the old routes where new collaborating- and network efforts are being build up around and in close relationship with

the local hospital. As the management in *Region West* shared with us: "We do not need a new physical location for a district medical centre, since we already have our hospital." This strategy is also made possible after the new road came in the region some years ago. The new road binds the region closer together by shortening down the travel distance between the municipalities. As a consequence a previous long-standing conflicts among competing municipalities in health care has been reduced. At moment it seems that all inhabitants in the region are committed to one local hospital serving the entire region and to develop common inter-municipal health care services.

In the *Fjord Region* we find another form of path dependency. The traditional geographical and administrative boundaries are still present. The many small municipalities are located in several informal regions. It seems like the inter-municipal cooperation in health care might drag along with some of the old controversies between informal districts in the region.[6] The many municipalities are connected to old district identities, and unlike *Region West*, they do not have a common local identity and "ownership" to the local hospital. However, there seems to be a new climate and will to integrate. Since the municipalities are small and lack competencies and resources they have to find new solutions in the wake of the national reform. Stimulated by new ideas in health care and project money from the government and in partnership with the local hospital are the region scrutinising opportunities and there is a momentum to meet common extended responsibilities they can't handle as single small municipalities. In the light of historical institutionalism, "a critical juncture" as a consequence of the national Cooperation reform has got foothold in the region. There could be a break with the old path as more emphasis is gradually put on new ideas of organizing municipality healthcare, policy learning, and the transfer of concepts happens (Campell 2004; Byrkjeflot and Torjesen 2010). Complementary to the need in the inter-municipal development process in the *Fjord Region* there is a parallel change in the localization strategy in the health enterprise. The health enterprise in the *Fjord Region* is planning to convert two of the existing local hospitals to local medical centres and concentrate more advanced specialist health care to one in one more advanced remaining hospital. However, it is not certain that the new local hospital-concept will be accepted by the

[6] The old administrative districts in the region were based on Danish administrative bodies/fogderier still present in the populations' minds and local belongings.

public as a substitute for the two previous local hospitals. The inhabitants in the Norwegian periphery still want to their local hospitals. Local hospitals represent important jobs, values of closeness and security in health care and local identities (Kvåle og Torjesen 2010). In addition, there is the question of whether the establishment of the new medical centres will lead to a resurrection of the old localization struggle between municipalities in the region. From what we have witnessed, it seems that this debate and de-integrating conflicts among the many small municipalities rapidly could be revitalized in the *Fjord Region*.[7]

Common Challenges

Many of the challenges the municipalities face is similar in the three regions. These include funding uncertainty and the ability of the municipalities to gain the competence needed to serve their populations. How the region should handle the cooperation with the general practitioners (GPs) in providing services are of great importance if the regions should succeed in their effort to promote integrated health service. In this section, we draw upon our empirical data to discuss these issues.

Funding Problems: The Short-Term Project Funding Problem

The question of what the reform will mean in terms of funding is creating much uncertainty and muted expectations. One interviewee eloquently summarizes these fears: "We are well prepared, but it will depend on funding. If we get funding can we recruit more qualified professionals, we can take more responsibility. What I am afraid of is whether we have the responsibility and not the financing."

Another question that brings uncertainty and ambiguity for decision-making and planning is the short-term funding the regions receives from the central health authorities. Most of the funding

[7] In Norway, there has historical been considerable resistance in the population against closing down local hospitals. During the fall of 2010 there have been many demonstrations in local communities and towns and a heavy social movement pressure in the population against the sitting governments health policy. In the government's instructions to the health enterprises for 2011 it is stated "that no local hospitals should be closed". In this way the Norwegian local hospitals with emergency functions and maternity wards once again have been protected. Reducing the service ore convert the local hospital to local medical centers would probably be a conflicting issue in Norwegian health policy in the coming years.

to developing local medical centres is based on voluntary initiative from the regions, financed by short-term project money. Most of the initiated projects in the regions have a time horizon of between one and four years. As one of the managers puts it: "The problem is the day-to-day budgeting."

The Competence Problem

Gaining the competencies needed to serve their populations is another challenges the interviewees in the three municipalities discussed. According to one interviewee, "The region has not a capacity problem with the beds but the need for competence." Furthermore, a chief municipality doctor points to the main difference between the specialist health care and primary care:

> "The most common difference between a nursing department in a nursing home and a hospital is that in the hospital there are fifty times as many doctors and twenty times as many nurse hours per day. If we can reduce this difference, we may well take over more of the work, but not the intensive diagnostic work. There may be a good solution with a division in which hospitals do what they can do best (i.e., diagnosis)."

The GP Problem

Many of the problems in the municipalities can be traced back to the Eighties. At that time, the Municipal Health Law, which was signed into law in 1982, resulted in significant changes with regard to primary care in the Norwegian municipalities. In the same law regulations came the previous state district doctors on the payroll to the municipalities and where then regulated by the municipal political boards and administration in such a way that they lost much of their previous status and autonomy (Berg 1997). The handover of the district doctor responsibility from the state to municipalities created conflicts and difficulties still present in the Norwegian municipal health service (Heløe og Ånstad 2007). Norwegian municipalities had little control over the GPs, they are first of all private oriented in their attitude (Berg 1997). The GPs run their own practices. They are partly funded from the municipality as contractors (approximately one-third of their funding) for being a family doctor with a fixed number of patients (approximately

1000-1500 patients on average) and also receive one-third of their funding in the form of patient co-payments and one-third in refunding from the state welfare agency.

According to one interviewee, "The important thing is that they run their own business, they rent their offices, they purchase their own equipment, employ their own staff. They are only responsible businessmen before they attempt to become a doctor."

In the *Region West* they have so far tried to involve the GPs more actively by building a inter-municipal network among all the doctors, but the problem is how to involve them more actively in implementing the new reform initiatives. As one interviewee puts it, "A doctor stated that the reform is the stupidest reform ever, it will fall on its own stupidity. The doctors have low expectations."

However, the GPs differ in their willingness to be involved in municipality healthcare planning activities. Some are more enthusiastic than others, but the municipality cannot dictate how the GPs should spend their time. For example, one of the interviewee states, "If you take a doctor out of the office for a meeting, you must pay him for participating in the meeting (to make up for the money they lose because they are not able to serve patients). You cannot arrange meeting in this way. It does something to the attitude when you are self-employed."

Concluding Discussion

In this paper we have explored how some inter-municipality regions have progressed better than others in their collaborative efforts to adapt to the new extended health challenges in the wake of the Norwegian Cooperation reform. What are the lesions that can be learned from these three cases?

First, when more responsibility for health services is handed over from the hospitals to the municipalities, inter-municipal collaboration may be the only way for the many small Norwegian municipalities that lack sufficient resources to meet the reform challenges. The only way they will be able to do this is through close cooperation with the local hospitals. From the *Region West*, we have learned that this strategy can be the key to success.

Second, it looks obvious that should municipalities succeed in their struggle for better health care, it is important that they develop the ability to steer and regulate the "privately oriented" GPs. The collaboration with the GPs will largely determine the success or failure of the new reform initiatives. This seems to be a common problem in all three regions and these "privately committed" doctors, hesitating to be steered and regulated by public municipality health care, will most likely have a strong impact on whether the reform will succeed or fail.

Third, much of the argument in favour of the Norwegian Cooperation reform has been to create a more seamless, patient-friendly health services. Here we can ask how smart it would be to reduce patient care in hospitals and transfer responsibility for the patients to the municipalities. As other observers have stated, it is not sure that this handover necessarily be less expensive if the same patient quality should be maintained (Romøren 2010b).

Fourth, much is still unclear about the future responsibilities of the Norwegian health service in the municipality sector. However, the local authorities we have studied are greeting the challenge with great enthusiasm. A plausible explanation may be that employees in the health care service are getting more exciting and challenging tasks. Project work can be more exciting than ordinary routine duties in the municipal health service. It provides growth, access to new jobs, careers, and opportunities for competence building to the individual employee (Berg 1995). Municipalities that are initiating project based on inter-municipal cooperation are probably also running for state funding. Politicians in the regions we have studied are also driven by competition with other regions. They are striving to create integrated and attractive employment and settlement areas - where a well-developed health care system is key. To build up health services based on current state project funds to the new regional medical centres may also be a seductive strategy.

Fifth, a future scenario can be that it is conceivable that the municipalities will be left without sufficient economic and quality carrying capacity when the economic impact of the Cooperation reform is determined and more patients are transferred to municipalities. If this is the case, the patients will be the ultimate losers. The Norwegian health reform of 2002 offers some strong

parallels and possible lessons. First, there was great optimism for the reform in the beginning, but it turned out that the government tightened its grip and financial management of the hospital sector (Torjesen 1998, Byrkjeflot and Neby 2009). If we look closer to the Norwegian municipalities they have little economic autonomy, since they are only able to decide a tiny portion of the tax level (i.e. compared to Danish municipalities) and largely dependent on government transfers. If the municipalities take over more of the responsibility for health care, they will have to rely even more on state funding. The result, therefore, may be that the state gets a stronger hold on municipal health services because: those who are funding usually want to control how the money is spent. The economic situation for the Norwegian municipalities in the future when they become more advanced health care providers and from 2012 are economic responsible for co-funding 20 per cent of their medical patients belonging to the municipality. Municipality Co-payment for specialist health care are in many ways adapted from Denmark which introduced the incentive-model in connection with the Danish structural reform in 2007. The Danish experiences tell that this policy may lead to more fragmentation rather than promoting integrating health care between the hospital sector and the municipal health care sector (Vinge and Kjellberg 2009, Romøren, Torjesen and Landmark 2011).

Another definite question is how the reform will proceed (or succeed) if the Norwegian municipalities could achieve more control over the GPs and commit them to municipal and state health planning. Much of the answer to how the Cooperation reform will succeed will be found precisely here.

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