

Chapter 1

Welfare services in Norwegian local governments: has decentralisation come to an end?

Lars-Erik Borge^{10 11}

Abstract

During the last three decades of the 20th century, local government consumption in Norway increased steadily as a share of GDP. Local responsibility for welfare services or social expenditures was an important driving force. The hospital reform in 2002 reduced the importance of the local public sector as a provider of welfare services, but the degree of decentralisation (measured as the ratio of local to central government consumption) has been on decline since the mid-1980s. Recent trends in earmarking, regulation, and service organisation point towards even more centralisation. This triggers the question of whether decentralisation has come to an end. It is argued that the ongoing process of municipal amalgamations is crucial in answering this question.

1.1. Introduction

The organisation and financing of the local public sector in Norway attempt at combining local democracy with an agency role in welfare services. Local governments are an integrated part of the welfare state and run about half of public service production. Since equalisation of ser-

¹⁰ Norwegian University of Science and Technology.

¹¹ I am grateful for comments from the participants, and in particular from my discussants Ludwig Strohner and Wouter Vermeulen.

vices is a central goal of the welfare state, service provision and financing are subject to central regulation. The local governments have been integrated in the welfare state by national laws, and the legal and financial framework established for the local public sector must be understood in this context.

With the establishment of the welfare state after World War II, a quite clear division of labour between central and local government emerged. The central government took over most municipal transfer schemes for the poor and the elderly and established a national social security system, while welfare services (education, health and social services) remained local responsibilities. Expansion and equal access to welfare services were cornerstones in the construction of the welfare state. It became a central government responsibility to provide sufficient funding, and the expansion of welfare services were largely financed by matching grants. Equalisation was achieved through fiscal equalisation and legal regulation of the services.

Major changes in financing and regulation were implemented in the 1980s and 1990s. First, in 1986 a major grant reform was implemented. Most matching grants were consolidated into a general purpose grant scheme where fiscal equalisation is achieved through tax and spending needs equalisation. In 1992 a new Local Government Act was implemented and gave local governments more freedom with respect to organisation of the political system and service production. The purpose of these reforms was to promote local democracy, local accountability and efficiency.

This paper discusses the current responsibilities of municipal and county governments in Norway (Section 2), the development of the degree of decentralisation (section 3), and some recent experiences of earmarking and central government regulation (Section 4). The paper ends (Section 5) with a brief discussion of whether the era of decentralisation has come to an end.

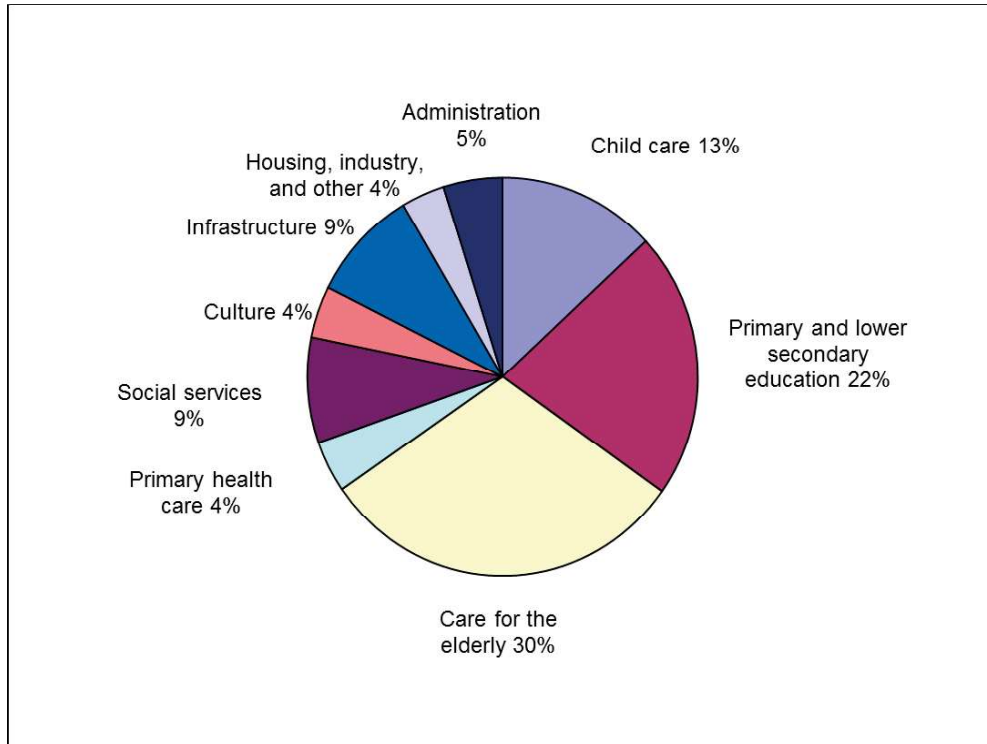
1.2. Current local government responsibilities

Norway is quite large in terms of area, but small in terms of population. By January 2015, the population size was 5.2 million. The public sector is divided into three tiers: the central government, the county governments and the municipal governments. The 18 counties and the 428

municipalities constitute the local public sector.¹² More than half of the municipalities have less than 5000 inhabitants. The municipalities and the counties have the same administrative status, whereas the central government has the overriding authority. Both municipalities and counties are mainly financed by taxes and grants from the central government. As in the other Nordic countries, the local public sector is an important provider of welfare services. The sector accounts for nearly 50 percent of government consumption and their revenues make up nearly 20 percent of (mainland) GDP. Close to 20 percent of the workforce is employed in the local public sector.

¹² The capital, Oslo, is a municipality that also has county responsibilities.

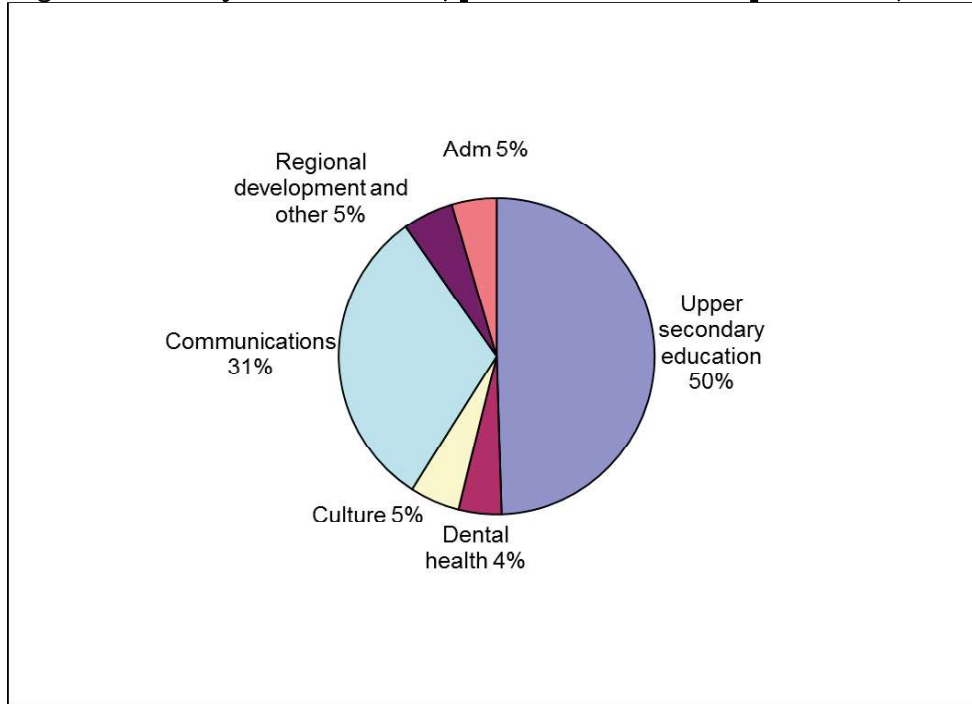
Figure 1: Municipal service sectors, percent of current expenditures, 2014



Source: Local Government Accounts, Statistics Norway

The main responsibilities of the counties are shown in Figure 2. After the national government took over the responsibility for the hospitals in 2002, upper secondary education (general and vocational) is the largest task for the counties. It amounts to around half of the total budget. The second largest service sector is communications (roads and public transport), which accounts for $\frac{1}{4}$ of the budget. The remaining services are dental health (mainly for the young and residents in nursing homes), culture (libraries, museums, sports facilities, etc.), and regional development (planning and business development). Together, the welfare services upper secondary education and dental health make up around 55 percent of county expenditures. However, if we consider county transport as part of a national infrastructure, this share increases to 85 percent.

Figure 2: County service sectors, per cent of current expenditures, 2014

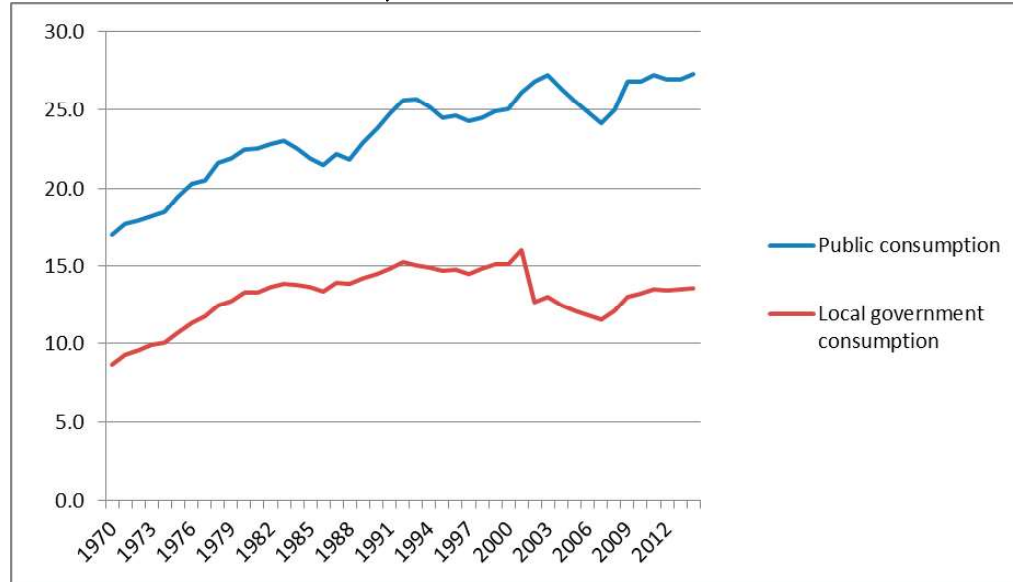


Source: Local Government Accounts, Statistics Norway

1.3. The development of public consumption since 1970

In the Norwegian welfare state, local governments (municipalities and counties) are important providers of public welfare services within education, health and social services. Figure 3 shows the development of public consumption (local and central) and local government consumption as share of Mainland GDP for the period 1970-2014. Until 2001 both public consumption and local government consumption increased steadily as a share of GDP. However, the growth was higher for local government consumption than for public consumption in total. While local government consumption amounted to around 50 percent of public consumption in 1970, it increased to around 60 percent by the turn of the century. On average, the real annual growth rates from 1970 to 2001 were 4.1 percent for local public consumption and 3.3 percent for central government consumption.

Figure 3: Public consumption and local government consumption as share of Mainland GDP (%), 1970-2014

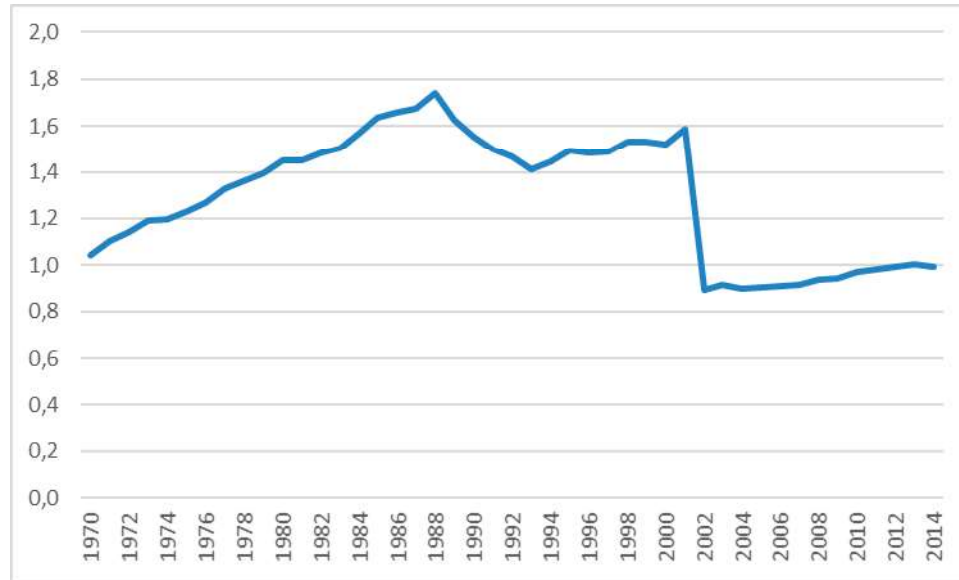


Source: National accounts, Statistics Norway

From 2001 to 2002 local government consumption was sharply reduced, from 16 percent of GDP to less than 13 percent of GDP. This reflects that the central government took over the responsibility for hospitals, and as a consequence, the share of local public consumption in total public consumption dropped from 61 to 47 percent. Since 2002 local public consumption has again grown faster than central government consumption and has since 2011 made up around 50 percent of total government consumption.¹³

¹³ The average annual growth rates were respectively 2.2 and 1.8 percent.

Figure 4: The ratio of local to central government consumption, 1970-2014



Source: National accounts, Statistics Norway

The ratio of local to central government consumption, displayed in Figure 4, can be interpreted as an indicator of the degree of decentralisation of public services. It appears that the degree of decentralisation increased steadily during the 1970s and most of the 1980s, but has been on decline since then. The hospital reform in 2002 was a substantial contributor to increased centralisation, but the process started already in the late 1980s.

Table 1 shows the breakdown of local government consumption by COFOG functions for 5-year intervals from 1970 to 2010. The COFOG classification separates between (i) education, (ii) social protection, (iii) health, (iv) housing, (v) economic, (vi) general, and (vii) other. To better understand the figures in Table 1, it is necessary to clarify the link between the COFOG functions and the actual services provided by municipalities and counties. The service sectors in the COFOG function education is primary and lower secondary education (municipalities) and upper secondary education (counties). Nearly 90 percent of the COFOG social protection function is home-based elderly care (municipalities) and child care (municipalities). Finally, the COFOG health function in-

cludes nursing homes (municipalities), primary health care (municipalities) and dental health (counties). Before the central government takeover in 2002, it also included hospitals (counties). It is interesting to notice that the care for the elderly sector is split between social protection (home based care) and health (nursing homes).

Table 1: Local government consumption by COFOG functions 1970-2010, percent

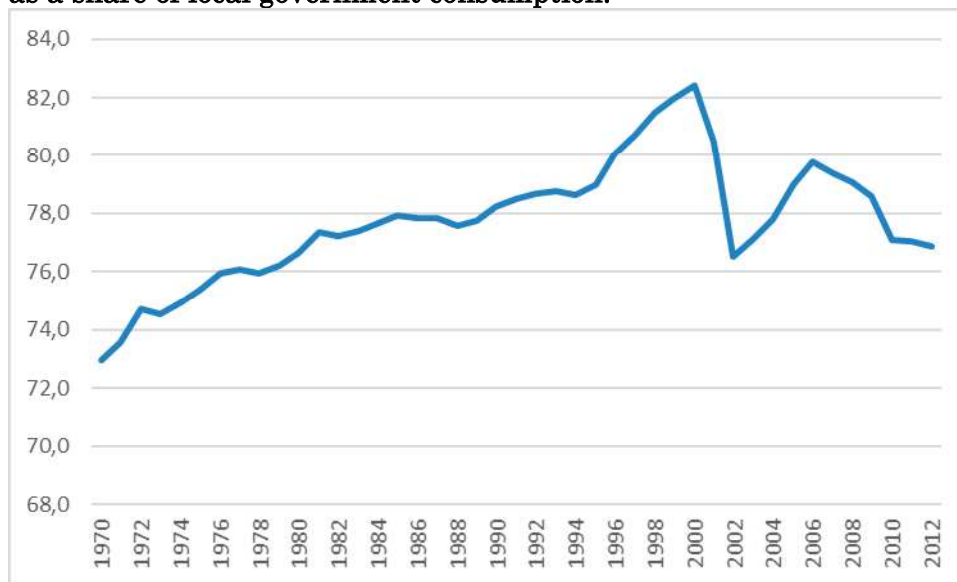
Year	Education	Social protection	Health	Housing	Economic	General	Other	Sum
1970	44.2	11.8	17.0	3.9	8.2	8.5	6.4	100.0
1975	37.4	16.6	21.4	3.5	7.3	7.7	6.1	100.0
1980	33.9	19.4	23.4	3.1	6.2	7.6	6.4	100.0
1985	32.0	21.1	24.9	2.7	5.3	8.1	6.0	100.1
1990	30.8	23.6	23.9	2.6	4.2	9.2	5.7	100.0
1991	29.8	15.1	33.6	1.6	3.7	8.7	7.5	100.0
1995	27.7	17.3	33.9	2.4	3.5	8.1	7.0	99.9
2000	28.0	17.3	37.0	1.3	2.7	7.2	6.4	99.9
2002	35.3	24.7	16.6	0.8	3.2	13.3	6.2	100.1
2005	35.5	27.6	15.9	0.2	3.1	11.8	5.9	100.0
2010	32.0	30.6	14.4	0.5	4.2	11.7	6.6	100.0

Note: There are breaks in the series for 1991 and 2002 reflecting accounting standards (nursing homes classified as health from 1991) and the hospital reform in 2002.

Source: National accounts, Statistics Norway

Social expenditures may be defined as education, health and social protection. These are services where the central government imposes national standards to secure that services are of a reasonable standard and to limit the variation across local governments. In Norway the spending needs equalisation system for local governments includes so called welfare services, a term that roughly corresponds to social expenditures. Social expenditures is the main local government responsibility in terms consumption, and its importance has increased over time (see Figure 5). The share of social expenditures in local government consumption increased from 73 percent in 1970 to 82 percent in 2000. After the central government became responsible for hospitals, the share of social expenditures has been 78 percent on average.

Figure 5: Social expenditures (education, health and social protection) as a share of local government consumption.



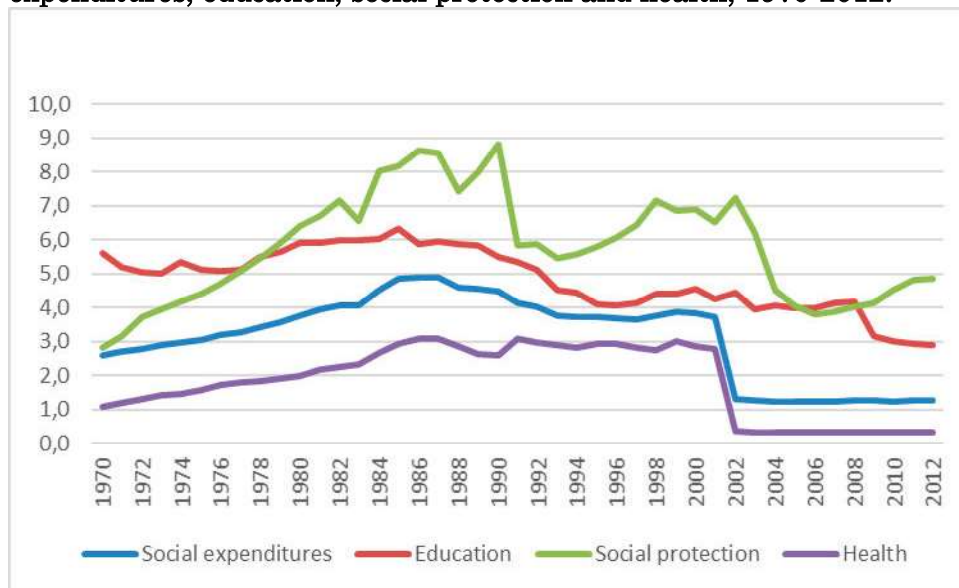
Source: National accounts, Statistics Norway

Among social expenditures, the expansion has been largest for social protection. Its share of local government consumption more than doubled from 1970 to 1990. In 1991 there is a break in the series, reflecting that institutions for the elderly became classified as health instead of social protection. Then the share of social protection increased during the 1990s, jumped in 2002 because of the hospital reform and increased again during the 2000s. The growth reflects expansion of (home-based) care for the elderly, and in recent years, a sharp increase of younger users (below 67 years of age) in home-based care and the child care reform. The aims of the child care reform were to increase the number of child care places to achieve full coverage and to impose a maximum limit on user charges. Full coverage was achieved in 2010.

On the other hand, education has been on the decline despite a number of reforms like expansion of before and after care, right to upper secondary education (1994) and school start for 6-year-old students (1997). However, in absolute terms, education has not been declining. On average the real annual growth has been around 2 percent. The relative decline of education reflects even higher growth in social protection and

health (until 2001). This fits well with the low expenditure elasticities for education, as estimated by Borge and Rattsø (1994) and Aaberge and Langørgen (2003), among others.

Figure 6: The ratio of local to central government consumption for social expenditures, education, social protection and health, 1970-2012.



Source: National accounts, Statistics Norway

The ratio between local and central government consumptions is an indicator of the degree of decentralisation of service provision. Figure 6 shows the development of the local-central ratio for social expenditures as well as the individual components education, social protection and health. It appears that the local-central ratios increased steadily during the 1970s and the first half of the 1980s. For social expenditures, the local-central ratio peaked at nearly 5 in the mid-1980s, i.e. local government consumption for social expenditures were nearly 5 times as large as central government consumption. Since the mid-1980s there has been a gradual decline in the local-central ratios, and after the hospital reform, the local-central ratio for social expenditures has been stable at 1.3. By this measure there has been a sharp decline in the degree of decentralisation over the last three decades.

The reduction in the degree of decentralisation is mainly driven by the hospital reform in 2002, but the same trend is observed for education and social protection. In social protection a major shift occurred in 2004 when the central government took over responsibility for child welfare institutions and foster homes from the counties. For education the trend is not driven by shifts in responsibilities between government tiers, but rather by a huge expansion of higher education (universities and regional colleges), which is a central government responsibility.

1.4. Financing and regulation of welfare services: Some recent experiences

With the responsibility for welfare services, Norwegian local governments have an important role in society, and the performance of the local public sector is subject to intense public debate. International knowledge tests (PISA and TIMSS) have demonstrated that student achievement in primary and lower secondary education is below the OECD-average despite high resource use per student compared to other countries. In upper secondary education (high schools) the dropout rate is around 1/3 on average and with huge variation across counties. Care for the elderly has expanded in recent years, but with an increased number of elderly, the coverage rates have not increased much. And individual cases of insufficient care receive substantial media attention. In many small municipalities, specialised services like educational-psychological service and child welfare suffer from a too tiny specialist environment to develop high-quality services. Maintenance backlog and buildings (schools and nursing homes) in decay is also a concern (Borge and Hopland 2016). These concerns tend to raise demands for earmarking, regulation, central government takeover of services and also increased grants from an (until now) oil rich central government. In the following I provide some recent examples of earmarking, regulation and central governments takeover of services.

Earmarking

The general purpose grant scheme has been under constant pressure since it was introduced in 1986, see Figure 7 and the discussions by Carlsen (1995) and Borge (2010). The degree of earmarking increased steadily from 1987 to the hospital reform in 2001, despite an ambition to further reduce it after 1986. The drop in 2002 reflects that hospitals, to a larger extent than other services, were financed by earmarked grants. After 2002, the degree of earmarking increased again, mainly

due to the child care reform that was financed by earmarked grants. After child care was included in the general purpose grant system in 2011, the degree of earmarking has returned to the lowest level in 30 years. A likely interpretation of this development is that the central government often meets the demand for more earmarking, but also that it is able to phase out most of them.

Figure 7: The development of earmarking, 1986-2013



The child care reform is a prime example of how earmarked grants are applied. They are used temporarily to expand a service, and after the service is built up they are phased out. However, it is important to notice that in the case of child care, earmarking was replaced by an individual right to child care for children above 1 years of age.

Individual rights may be more difficult to impose for other services like child welfare and care for the elderly, where earmarked grants are also in place. Child welfare has been expanded in recent years financed by an earmarked grant amounting NOK 0.5 billion (USD 62 million) in 2015. It will be hard to design an individual right to child welfare in the same fashion as for child care as decisions to some extent must be based on judgement. A phase out of the child welfare grant will probably be more difficult than the phase out of the child care grant.

Care for the elderly is largely financed by taxes and general purpose grants, but two types of earmarked grants have to some extent become a permanent feature. The first type is an earmarked grant that compensates municipalities for “resource-demanding” users. More specifically, the grant is of the matching type and equals 80 percent of the local costs above a specific threshold for individual users. The justification for this grant scheme is that many Norwegian local governments are too small for the “law of large numbers” to apply. There is huge variation across municipalities, in both the number of resource-demanding users (per capita) and the change in the number of resource-demanding users over time, in particular for municipalities with less than 10,000 inhabitants. This variation is a source of a financial risk, and the grant works to reduce the risk borne by the municipalities. The risk is shifted over to the national government, which is in a better position to bear the risk because of a larger insurance pool. The risk sharing aspect is also emphasised by Bergvall et al (2006) in their discussion of the theory and practice of intergovernmental transfers. However, there is a concern that the grant weakens the municipalities’ incentives to keep costs down for users above the threshold. The grant for resource-demanding users has had a sharp increase in recent years, and in 2015 it amounted to 8 percent of total spending on elderly care.

The other type is a grant for nursing homes consisting of two parts. The first part is an investment grant of the matching type to cover parts of the projected building costs. The remaining costs are supposed to be financed by borrowing, and the second part is an annual grant to cover interest and instalments. The total amount is NOK 2.6 billion (USD 325 million) in 2015. These earmarked grants date back to the late 1990s as part of the Action Plan for the Elderly. Although the action plan ended in 2003, the earmarked grants have remained.¹⁴ The effects of this action plan is analysed by Borge and Haraldsvik (2016). They find that the action plan worked as intended to increase expenditures and the share of single rooms in nursing homes, but it had unintended consequences in terms of lower spending on education, reduced child care coverage and increased budget deficit.

¹⁴ The compensation for interest and instalments would last longer than the action plan, but that was not the case for the investment grant that makes up nearly 2/3 of the total amount.

The current conservative government has announced that the state should take more responsibility for quality and investments in the care for the elderly sector. Starting in May 2016 an experiment with central financing of elderly care will be rolled out in 20 municipalities. The municipalities can choose between two models (A and B). In model A, services for individual users are assigned based on criteria set by the central government. Municipal employees assign services and the costs are covered by the state. There will be some budgetary risk for the state because of uncertainty with respect to the number of users and the services provided for each user. Cost control (per unit of service) is achieved by a centrally determined price model. The model assumes that municipalities and private providers are willing to provide the service for the fixed price. Model A can be understood as a Prospective Payments System (PPS). Model B is more similar to the present system. The difference is that the municipal budget for elderly care is effectively determined by the central government through a sectoral block grant and there is no budgetary risk for the central government.¹⁵

In model A, the municipalities are almost totally put on the sideline for elderly care. They have little or no responsibility for financing and no discretion in assignment of services. They mainly supply services along with private providers. In model B, the municipalities have discretion in assignment, but little responsibility for financing. Both models are in conflict with the principle that the government tier responsible for a service should also be responsible for financing. Model A is probably not a long term solution and is best understood as a first step towards a central government takeover of elderly care.

Regulation

The new Local Government Act of 1992 gave municipalities and counties more freedom with respect to the organisation of the political system and service production. As pointed out by Lilleschulstad (2016), the new act was a framework act and later the laws for the specific services were changed to be in line with the new Local Government Act. It is fair to say that the legal regulations of the specific services leave municipalities and counties with substantial flexibility in how to run the services. An example of reduced formal regulation is the elimination of the

¹⁵ A similar model was originally proposed for the child care reform, but in the end a more traditional model of financing was chosen.

maximum class size rule in 2003, which was replaced by a requirement of a proper pedagogical group size.

However, sectoral interests do not have faith that all local governments are able to decide on a proper number of teachers per student or more generally a proper number of employees per user. They argue that the central government should impose stricter minimum standards and regulate the number of teachers per student and the number of employees per user in nursing homes. The previous government proposed to impose a maximum group size in primary and lower secondary education. Borge, Falch and Strøm (2012) showed that affected municipalities (higher group size than the proposed maximum) on average had better student performance than municipalities that would not be affected (lower group size than the proposed maximum). They argued that a maximum group size would force municipalities with well-functioning schools (in terms of student achievement) to increase spending on education and reduce spending for other services. This would most likely reduce allocative efficiency. In the end the proposal was downscaled and ended up as a minor earmarked grant for lower group size, targeted towards municipalities with poor student performance and few teachers per student.

Central government takeover

As discussed in Sections 2 and 3, the division of labour between the government tiers has shifted from the county governments to central government in recent years by the state takeovers of hospitals and child welfare institutions. A small step in the opposite direction was increased county responsibilities for roads and regional development in 2010. The responsibilities of the municipalities are largely unaffected, but there are also some tendencies of increased central government involvement in municipal services.

The clearest example is the establishment of the Norwegian Labour and Welfare Administration (NAV). The so called NAV reform was carried out from 2006 to 2011. The reform was mainly a merger between two central government agencies, the social security administration and the directorate of labour, but local NAV-offices also include municipal activities related to social assistance. The idea is to have “one door” for the users, but behind this door is a complicated organisation with both central governments and municipal employees. In many cases, the munic-

palties have contributed to even more complication by including social services like child welfare and substance abuse treatment in the NAV offices. One of the main aims by the NAV reform was to reduce unemployment by coordinating the forces of the former director of labour (responsible for individuals that are registered as unemployed) and the municipal social assistance department (responsible for recipients of social assistance with a looser attachment to the labour market). The NAV reform is evaluated by Fevang, Markussen, and Røed (2014) who utilised that the timing of reform implementation varied across the country. Their main finding is that the establishment of NAV-offices increased the unemployment spell for both registered unemployed and recipients of social assistance. But since the negative effects seem to be reduced over time, it cannot be concluded that the old model was better than the new one.

Over time, the municipal welfare services are getting more complicated and require more specialised skills. This is clearly the case for specialised services like child welfare, educational-psychological service and substance abuse treatment, but also for larger services like education, care for the elderly and primary health care. Education used to be mostly about the building and location of schools, but nowadays there is more emphasis on student learning – a much more complicated task. In the care for the elderly sector, welfare technology must be developed and applied to meet the wave of the elderly. There is an increasing concern that most municipalities are far too small to handle these challenges, and in 2014, the current central government appointed an expert group to propose criteria for a new size structure for the municipalities. The expert group concluded that municipalities should have at least 15.000-20.000 inhabitants in order provide good services, given their present responsibilities. Municipalities of that size could also take on a more coherent responsibility for specialised welfare services. The central government has initiated a voluntary reform process, but without any explicit minimum size. Based on the experiences from Finland (e.g. Moisio 2016), it is unlikely that a voluntary process will result in a coherent municipal structure in all parts of the country.

1.5. Has decentralisation come to an end?

During the last three decades of the 20th century local government consumption in Norway increased steadily as a share of GDP. The hospital reform in 2002 reduced the importance of the local public sector as a

provider of welfare services. However, the degree of decentralisation (measured as the ratio of local to central government consumption) has been on decline since the mid-1980s, and central government has become more involved in provision of public services. Recent trends in earmarking, regulation and service organisation point towards even more centralisation. This triggers the question of whether decentralisation has come to an end.

In my view the ongoing process of municipal amalgamations is crucial in this respect. A successful amalgamation reform will make the municipalities capable of carrying the current services and take on new tasks. As a consequence, the trend of increased centralisation may be reversed. The argument is that the central government will be more willing to delegate service responsibility to larger municipalities that are capable of providing high quality services. Moreover, the need for earmarking and regulation will be reduced as larger municipalities can handle financial risks and will have more competence to provide specialised services and to improve service quality for larger services such as education and elderly care.

With an unsuccessful amalgamation reform (which seems to be the case), many municipalities will be too small to carry the current responsibilities. As a consequence, the central government may be reluctant to give the municipalities new tasks and their responsibility for specialised welfare services may be reduced. Central regulation and earmarking is likely to remain, and may even increase as detailed regulation is necessary to compensate for the lack of competence in the smaller municipalities. Reduced responsibilities for the municipalities would not necessarily lead to an increased degree of centralisation, measured as the ratio of local to central government consumption. That depends on whether the responsibilities are shifted to the counties or the national government.

However, even with an unsuccessful amalgamation reform, it is unlikely that the responsibilities of the municipalities will be much reduced in the short term. Currently the central government has little appetite to take over more local services since the NAV reform has been messy and the hospital reform expensive (Tjerbo and Hagen 2009). In the nearest future we will probably see a continuation of recent trends, i.e. somewhat increased centralisation and more earmarking and regulation.

References

- Aaberge, R., and A. Langørgen (2003): *Fiscal and spending behavior of local governments: Identification of price effects when prices are not observed*, Public Choice 117, 125-161.
- Bergvall, D., C. Charbit, D.-J. Kraan and O. Merk (2006): *Intergovernmental transfers and decentralised public spending*, OECD Journal on Budgeting 5(4), 111-158.
- Borge, L.-E. (2010): *Growth and design of earmarked grants: The Norwegian experience*, in J. Kim, J. Lotz and N.J. Mau (eds) General Grants versus Earmarked Grants: Theory and Practice, The Korea Institute of Public Finance and the Danish Ministry of Interior and Health, 191-205.
- Borge, L.-E. and M. Haraldsvik (2016): *Unintended consequences of a grant reform: How the action plan for the elderly affected the budget deficit and services for the young*, Manuscript, Norwegian University of Science and Technology.
- Borge, L.-E. and A.O. Hopland (2016): *Schools and public buildings in decay: The role of political fragmentation*, Economics of Governance, forthcoming.
- Borge, L.-E., and J. Rattsø (1994): *Demographic shift, relative costs and the allocation of local public consumption in Norway*, Regional Science and Urban Economics 25, 705-726.
- Borge, L.-E., T. Falch and B. Strøm (2012): *Nasjonal regulering av lærertetthet? (National regulation of the teacher-pupil ratio?)*, Samfunnsøkonomen 126(2), 4-11.
- Carlsen, F. (1995): *Why is central regulation of local Spending decisions so pervasive? Evidence from a case study*, Public Budgeting and Finance 15, 43-57.
- Fevang, E., S. Markussen and K. Røed (2014): *NAV-reformen: Støvet legger seg etter turbulent omstilling (The NAV-reform: The dust falls to earth after a turbulent transition*, Søkelys på arbeidsmarkedet 31, 83-99.
- Lilleschulstad, G. (2016): *Local government in Norway – principles, guidelines and responsibilities*, Paper prepared for the 5th Copenhagen Workshop.
- Moisio, A. (2016): *Less regulation, or more? Recent trends in Finnish local government steering*, Paper prepared for the 5th Copenhagen Workshop.
- Tjerbo, T. and T.P. Hagen (2009): *Deficits, soft budget constraints and bailouts: Budgeting after the Norwegian hospital reform*, Scandinavian Political Studies 32, 337-358.