Convergence or Divergence? Reforming Primary Care in Norway and Britain

OLAUG S. LIAN

University of Tromsø

THE HEALTH CARE SYSTEMS IN MOST INDUSTRIALIZED countries are being challenged. The challenges are similar because they are shaped by global trends such as decreasing economic growth, escalating costs, aging populations, advances in medical knowledge and technology, heightened expectations, and an increasing dependence on medicine to solve human problems. Together, these partly interrelated factors have brought the current demand for care to a point that it exceeds available resources. In response to these challenges, most countries have begun to change the way their health services are funded and organized.

These developments have prompted an exploration of the degree of convergence in the health policies in Western welfare states. To what extent are health care systems becoming more alike? Is there a new paradigm by which health systems are being redefined and reformed? Is there a move away from divergence toward convergence? Many scholars answer yes to these questions. According to Wessen (1999b, 11–12), “common goals and problems, a shared heritage, and the influence of powerful ideological concerns have combined with the thrust of modern medical science to foster convergence among contemporary health care systems.” One basic theme of this new management style, referred to as New Public Management, is the removal of organizational differences between the public and private sectors, thereby reducing inefficiency in the public sector (Hood 1991, 1994). To achieve this goal, traditional command-and-control-dominated health care systems are being

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350 Main Street, Malden, MA 02148, USA, and PO Box 1354,
9600 Garsington Road, Oxford OX4 2DQ, UK.

reshaped in the image of the market. Cooperation is being replaced by competition, and formal rules and guidelines are being replaced by financial incentives.

The convergence thesis has a strong competitor in the cultural diversity thesis, which predicts that each country has unique historical and cultural traditions that are likely to override global changes and create patterns of divergence. Powell (1999) claims that current patterns of change show a diversity that is derived from the sociopolitical structure of the reform programs.

This article discusses the convergence thesis in tandem with a comparative study of recent changes in primary care in Norway and Britain. The main dimension of the comparison is cross-national, but the historical dimension also is important because convergence is related to development over time. What are these changes? Are the two countries moving in the same direction? In what way and on what level have convergence and divergence occurred, and why do the variations occur? To answer these questions, I analyzed some similarities and differences in the changes in the two countries' general practitioner (GP) services between 1990 and 2002. I chose general practitioners because of their central position in many health care systems. In addition, besides the services they provide, they control access to the hospital. More important, many countries are currently trying to bolster the GPs' gatekeeping function as a way to control health care costs (Mechanic and Rochefort 1996). The many initiatives in this sector make GPs a good case for the theoretical issues raised here. I focus on three dimensions of policy formulation—goals, content, and process—and examine each in relation to the social context of the political initiatives (i.e., an institutional approach). The discussion centers on issues of concern to all countries in the West: devising appropriate organizational structures and remuneration systems for physicians in order to give all citizens equal access to high-quality services, increasing patients' responsiveness and creating more value for money, and strengthening the role of primary care. My purpose is to understand and explain rather than to evaluate or advise.

Theoretical Considerations

The convergence thesis implies a global trend in the formation of health policies. Regardless of political party and ideology, countries respond

to global changes by means of global methods. As a result, institutions throughout the world are increasingly coming to resemble one another (Hood 1998). Convergence, however, is not a synonym for similarity, and it is not a static condition. Rather, it is a dynamic process related to patterns of development over time: "Convergence means moving from different positions toward some common point" (Inkeles 1981, 13). The opposite process, divergence, means moving further apart. Hence, time is important.

The convergence thesis states that pressures are producing convergence in the objectives and activities of national health systems across the globe (Mechanic 1975; Mechanic and Rochefort 1996). The thesis is related to a sociological theory that predicts that since all industrialized nations must respond to a common set of technological and organizational constraints, their national institutions, despite their cultural or ideological differences, will become increasingly alike over time (Form 1979). This does not imply, however, that medical systems will cease to be distinctive or that such development is inevitable (Inkeles 1981), although some view it as "softly deterministic" (Field 1999, 42). The convergence thesis is particularly supported by multinational organizations such as the Organization for Economic Cooperation and Development (OECD), the World Health Organization (WHO), and the World Bank. A comparison of 17 OECD countries concludes: "The most remarkable feature of the health care system reforms across the 17 countries is the degree of emerging convergence" (OECD 1994, 45). This convergence is toward market competition and a public contract model, that is, a system in which services are financed publicly and provided by independent providers linked to third-party payers by contract (OECD 1992), thereby encouraging market competition. The convergence thesis also is supported by independent researchers (Chernichovsky 1995; Figueras, Sakellarides, and Saltman 1998; Flood 2000; Freeman 2000; Ham 1997; Saltman and von Otter 1995). For instance, drawing on lessons from Germany, Canada, Sweden, and the United Kingdom, Wessen (1999a, 388) noted, "Common effects of demographic changes and technological advances seem in large part to overwhelm unique historical and structural patterns."

The convergence thesis is challenged, however, by an increasing number of comparative analysts for being simplistic and inaccurate (Pollitt 2000). According to Pollitt and Summa (1997, 7), "a uniform 'one-track' picture is not at all accurate." Jacobs (1998) sees the convergence

in terminology—the language of the market—as creating only an *illusion* of convergence in policy. Tuohy (1999) argues that health policies vary dramatically in ways that can be understood only by analyzing the particular logic of each system and nation. Hood (1998, 219) questions the thesis while pointing to the fact that “they match the needs of particular players, like OECD and the World Bank, for a legitimating role in what they do.” Finally, Navarro (2001) has criticized a report by the World Health Organization revealing enormous differences in health policies in Europe but failing to analyze them.

Context and Historical Background

Although a cross-national comparison is difficult because it can easily be obscured by cultural and organizational differences, Norway and Britain are enough alike to be comparable. Most important, the basic structures of the two health systems are similar. As opposed to the insurance-based model used on most of the European continent, both countries have a nationally tax-funded health system in which many facilities are owned and run by the public sector. The main objective of this model is to provide a comprehensive range of services in a system of universal access, free of charge at the point of delivery. GPs in the two countries also have the same functions: they work only outside the hospital, and they control access to specialized care.

In regard to more general aspects, the two countries have different administrative traditions, political and electoral systems, and general cultural norms and values. While almost all aspects of the New Public Management are compatible with the British Anglo-Saxon state tradition (i.e., a minimal state tradition), several are incompatible with the Scandinavian state tradition. The strong tradition of solidarity and the strong bias toward state action in the Scandinavian countries run counter to deregulation, privatization, performance-related payment, competition, and other market-oriented management styles (Peters 2000). Culturally, inequalities are generally more accepted in Britain than in Norway. Norwegians see Britain as a very class-divided society, with the health sector as one of few exceptions.

When Norway and Britain began to reform their primary care sector in the early 1990s, they started at different points. Between 1912 and

1984, Norwegian GPs were tied to a state-run system of administration. Then in 1984, municipal councils (435 in all) were made responsible for financing and providing primary care. The councils were free to decide whether to hire GPs as public employees or to contract with them as private physicians, in accordance with negotiations between the council and the GP. The GPs hired as public employees received a fixed salary, and the GPs contracted as private physicians received a combination of basic allowances and fee-for-service. Between 1987 and 1992, about 35 to 38 percent of the GPs were salaried employees, and 51 to 53 percent had contracts (the rest did not have contracts or were trainees) (Norwegian Statistics 2002). Since 1992, an increasing proportion of GPs have been working on contract, especially in urban areas. By 2001, only 15 percent of the GPs were salaried employees, and 74 percent were private contractors. This change may have been prompted by the government's announcement to change the way GPs were funded and organized in order to more closely resemble a contract model. From 1991 to 2001, the number of man-labor years that GPs worked rose by 26 percent (Norwegian Statistics 2002). And until 2001, there was no list system of regular GPs; people could visit any GP they wanted.

Since the National Health System was created in 1948, GPs in Britain have been independent professionals working under contract (referred to as the Red Book) in a publicly managed health system. The contract gives them responsibility for a specific list of patients, 24 hours a day, every day of the year. Apart from this, however, the service has changed significantly since its inception. In the *postwar stage* between 1948 and 1965, GPs were paid mainly on a capitation basis (as they had been since the introduction of national insurance in 1913) (Bosanquet and Salisbury 1998). In the *family doctor charter stage* between 1966 and 1990, a basic practice allowance was introduced as a supplement to the capitation, giving the GPs a basic salary, regardless of their workload. They also received support for improving their office, a favorable business tax, and reimbursement for 70 percent of their nurses' and clerical staff's wages. Overall, the payment to GPs was substantially increased.

Historically, the British health care system has been more centralized than the Norwegian system. In Britain, most services are run by state agencies (table 1). This centralism is often illustrated by Aneurin Bevan, the "creator" of the British NHS, as follows: "When a bedpan is dropped

TABLE 1
Norway and Britain: GDP per Capita, Public Expenditure on Health,
Physician Density, and Average List Size

	Norway	Britain
Gross domestic product (GDP) per capita, US\$, 2000	36,028	23,954
Public expenditure on health, percentage of GDP, 2000	6.7	5.9
Public expenditure on health by level (central/local), percentage, 1992	44/56	100/0
Practicing physicians per 1,000 population, 2000	2.9	1.8
GPs per 1,000 population, 2000	0.8	0.6
Number of GPs (full-time equivalent persons), 2000	3,809	37,285
GPs' average list size, 2001	1,153	1,841

Sources: Department of Health 2002b; OECD 2001, 2002b; Rikstrygdeverket 2003.

on a hospital floor, its noise should resound in the Palace of Westminster" (Klein 1998, 117). In Norway, the responsibility for running health services is divided among the central government (state hospitals), regional trusts (regional and local hospitals), and municipal councils (primary care and nursing homes). This decentralized system, which dates back to the 1980s, was founded on democratic values, bringing the politics of health care closer to those who are directly affected by it. Local governments draw on local taxes and a mix of block grants and specific allocations from the national government to cover their expenditures. In addition to funding, the central government also provides legislation and supervision to ensure that the services offered by the local governments comply with the national goals. Another important difference is that Norway has a higher density of practicing physicians and GPs, and slightly higher public expenditures for health (measured as a percentage of GDP), than Britain does (table 1).

Policy Goals

Norway and Britain face the same challenges as do most of the Western world: continuously rising expectations and demands for health services from quality-conscious patients, escalating costs, and geographical variations in the availability and quality of care. To address these challenges, the two countries are pursuing similar goals in the reorganization of primary care:

1. *Quality and access*: Both countries are trying to increase the accessibility to and quality of care and responsiveness to patients, improve the geographical distribution of physicians, and reduce the inequalities of care. In Norway the problem is attracting GPs to rural areas, and in Britain it is attracting GPs to deprived inner-city areas, but the basic issue is the same: providing equal access.
2. *Costs*: Other common goals are slowing the growth of public spending and obtaining better value for money, especially by increasing the efficiency of services and devising an appropriate incentive structure for payments to physicians (Robinson 2001). Both countries are working toward more uniform systems of reimbursements (Norway) and commissioning (Britain).
3. *The role of primary care*: A third policy goal is to improve the working relations between primary and secondary care and (for Britain) to strengthen the role of primary care within the health care system. GPs are encouraged to do more work themselves and are discouraged from referring so many patients to hospital. This strategy is based on (a) reducing overall costs (because primary care involves fewer high-tech, capital-intensive interventions, it is assumed to be less expensive than secondary care) and (b) improving the quality of care (general practitioners are generally more holistically oriented and more oriented toward prevention, etc.) (White 2001).

Overall, the two countries' policy goals mainly converge. The only divergence is related mainly to differences in the importance attached to each policy goal, especially strengthening the role of primary care.

Policy Content

Organizational Structures

In June 2001, Norway introduced the most important reform in its primary care after 1984, the so-called Fastlege scheme (Fastlege means "personal doctor"). A Labour government initiated the system in 1990, and subsequent Labour governments worked it out in more detail and implemented it. The reform had two main elements: it introduced major

changes in the way GPs were organized and how they were paid (Sosial-og helsedepartementet 1999). Basically, the Fastlege system gives citizens an opportunity to have a personal GP. The GPs are responsible for planning and coordinating individualized preventive work, as well as examinations and treatment of the patients on their lists. They also are responsible for keeping their patients' medical records up-to-date (including case histories and medications). Although these responsibilities are continuous, after normal working hours—that is, on weekends, evenings, and nights—patients may contact emergency clinics organized by the municipalities. Although patients may choose their GP, those GPs who so wish may have the administration select 30 percent of their list to reflect the demographics of the population. Personal GPs practicing full time may be required to have up to 1,500 persons on their list (300 per day of practice), but all GPs have the right to argue for a shorter list. Having a personal GP is supposed to enhance the accessibility and quality of services by creating a more stable doctor-patient relationship, to prevent “doctor shopping” in the cities (and thereby reduce costs), and to improve working relations between primary and secondary care.

The Fastlege reform also has a new model for employing GPs, based on contracted physicians in private practice. Whereas many GPs previously practiced in publicly owned facilities, most now must own or rent their own offices. In accordance with the new organizational model, many Norwegian GPs have been transformed from public employees into self-employed contractors. The terms and conditions of individual contracts are negotiated locally, but the main aspects are regulated by national standards (remuneration, size and composition of patient lists, and duties to patients, among other things). This change represents a move away from the Semashko model of the former socialist countries of Central and Eastern Europe, in which publicly employed physicians were an important element, to the pre-Beveridge model of Britain. The change is also in line with the New Public Management philosophy, as it implies a partial privatization of enterprises that previously were publicly owned and run.

Unlike the changes in Norway, the changes in Britain were made in several waves with short interruptions. The first wave came in 1991, when the Thatcher government introduced the internal market. In order to generate competition within the NHS, providers of health care (hospital trusts) were separated from purchasers (health authorities and GP fundholders). Hospital trusts were to compete with one another for

customers. Fundholding GPs thus became providers of general medical services as well as purchasers of hospital care. Health authorities purchased hospital care for patients of GPs not holding funds. (Le Grand 1999). Competition was introduced as an incentive for providers to improve the quality of services, value for money, and consumer satisfaction (Enthoven 1999).

The second wave came in 1997, when the Conservative government introduced the 1997 NHS (Primary Care) Act (based on Department of Health 1996a, 1996b, 1996c). Until 1997, the terms and conditions of physicians' contracts were negotiated nationally. The new act introduced flexibility into the organization of primary care, the reimbursement of GPs, and the division of work among professions. One purpose of the act was to enable health authorities, providers, and health professionals to deliver services "in a way which is better attuned to local needs and circumstances" (Department of Health 1996a, 1). The government also started a pilot project to explore different models for the provision of primary care, which produced many interesting experiments. The project was introduced in April 1997 as Primary Care Act Pilots, later renamed the PMS (Personal Medical Services) pilot scheme. Under the PMS scheme, national contracts are set aside, and contracts instead are negotiated locally and tailored to suit local conditions. The contractual freedoms include relaxing the demarcation between doctors' and nurses' roles, loosening the rules governing the number of clinical practitioners in any area, creating flexible remuneration systems, and introducing several new organizational models for the delivery of primary care.

When the Labour Party came back into office in 1997, it announced its intention to abolish the internal market and replace some of the previous competition with a more collaborative approach (Department of Health 1997). It wanted "a new culture of public sector enterprise in the NHS to rival the culture of private sector enterprise" (Department of Health 2001). The government argued that the competition created by the internal market had led to instability, a waste of resources on administrative costs, unfairness created by distorted priorities, an erosion of staff morale, and too little attention paid to the quality of care (Department of Health 1997). The government's political statements were partly supported by evaluations of the reforms. For instance, there are persuasive reasons to believe that fundholders used their contracting power to obtain priority for their own patients, thus creating "a two-tier system in access to care; one for the patients of fundholders and one for

non-fundholders" (Goodwin 1998, 67). Still, the measurable changes were not as great as their supporters predicted—or their critics feared: "Perhaps the most striking conclusion to arise from this survey of the evidence is how little overall measurable change there seems to have been" (Le Grand, Mays, and Mulligan 1998, 129). This is explained by the fact that the Conservative government largely failed to create the internal market it set forth to do (Enthoven 1999; Le Grand, Mays, and Mulligan 1998; West 1998).

Despite rhetoric to the contrary, key elements of the internal market were retained (Le Grand 1999). In response to the assumed "two-tier system" created by the fundholding, the Labour government introduced "primary care trusts" (PCTs) and "primary care groups" (PCGs), a transitional form of PCTs. The PCTs are groups of GPs (around 50), nurses, and other health or social care professionals who work together with patient organizations and health authorities to manage the services for their local community (Department of Health 1997). The trusts are independent, legally established NHS bodies with cash-limited budgets calculated according to their population's share of available resources. Their budget is meant to cover hospital and community health services, including drugs (the trusts can keep any savings they make). The PCTs are to take the lead in planning, providing, and developing local health services. The trusts may be viewed as the purchasing side of an internal market (Le Grand 1999), but they differ from the fundholders in that they are groups, not individuals (Dixon and Mays 1997). One purpose of the reform is to increase the power of primary care over other levels and to reduce the pressure on—and costs of—secondary care, by developing new GP services and moving services to a lower and less expensive level. By 2004, all PCTs are to be responsible for both providing primary care and commissioning hospital services and thereby controlling about 75 percent of the NHS's budget (Klein 2001a). Through these changes, the chief responsibility for purchasing health care will move from 3,600 fundholders, 100 health authorities, and 90 total purchasing pilots to 500 PCTs. Responsibility will thus be moved from a central to a local level, to those best placed to make decisions based on clinical need (Department of Health 2001). According to British Health Secretary Alan Milburn, the initiative is part of a plan to move the center of gravity within the health services from Whitehall to the NHS's front line (Department of Health 2001). Local freedom is accompanied by a greater emphasis on performance requirements and monitoring. Because the

system is compulsory, it will gather the previous variety of arrangements for GP commissioning into a single model (Smith and Barnes 2000).

When the contents of the two countries' health policies are compared, they do not seem to have converged much during the last decade. Through the Fastlege reform, GPs in Norway were transformed from public employees into self-employed contractors in private practice with responsibility for a specific group of patients, just as they have been in Britain for decades (table 1). Almost at the same time, a growing proportion of British GPs have become public employees. Local managerial freedom is increasingly important in Britain, as it has been in Norway for decades. This represents a move toward greater convergence (although in Britain this freedom is accompanied by a stronger emphasis on external monitoring of performances than in Norway). The commissioning role and the integration of health and social services in the British system of primary care trusts have no equivalents in Norway. The rhetoric of the two countries' political documents also differs. Although the British have moved away from the market rhetoric of the Thatcher era and replaced competition with collaboration as their new catchword, the Norwegians seem to be heading toward a greater use of market terms. Hence, there is divergence in the changes in physicians' employment status, the role and content of primary care, its place in the system as a whole, and systems for external audit. There is convergence in the system of personal GPs and the more decentralized decision making.

How can this divergence be explained? Several factors are important here. First, Norway has a higher density of both GPs and other physicians than Britain does. The average Norwegian GP has almost 700 fewer patients on his or her list than the average British GP does (table 1). In addition, the two countries' economic situations differ: Norway is one of the richest countries in the world as measured by GDP per capita (table 1). (As the world's second-biggest net oil exporter, Norway has benefited from rising oil prices.) Also, Norway has a higher tax level and a larger public sector than Britain does. Public spending in Norway as a percentage of GDP is the highest of all the OECD countries, while in Britain it is average in the OECD (in 2001 about 55 and 38 percent, respectively) (OECD 2002a). Hence, problems with delivery and access, and the economic pressure to make fundamental changes, have probably been greater in Britain than in Norway. One of the main diverging aspects—defining primary care trusts as commissioners of specialized care in Britain—is mainly an attempt to stabilize expenditures. There

is more economic pressure in Britain to make such reforms than there is in Norway.

Another factor pertains to political institutions and electoral systems. The two-party Westminster system in Britain makes it easier to implement changes because it favors large parties, and the governing party automatically has a majority of the MPs. Norway has a multiparty system with weaker governments, and organized interests are an integral part of the policy process. When a new government is elected in Norway, it often continues to implement reforms enacted by previous governments, even when other political parties have initiated them. This is partly because of the Norwegian parliament's power and composition: several medium-size parties, no clear majority, and few dramatic changes from one election to another. In Britain, when a new government is formed, it immediately launches its own reform ideas, distinct from those of the previous government. The rhetoric of the Labour government in 1997 about abolishing the internal market and replacing competition with cooperation is a good example. As many commentators have argued, the politics are not as revolutionary as often presented: competition never fully took hold, and key elements of the internal market were retained (Le Grand 1999).

Administrative systems are important as well. The organization of trusts in Britain is a way of delegating authority downward in a previously centralized system. Decentralizing central government functions was impossible in Norway because these functions were already decentralized. Finally, the two countries differ demographically. Norway is one of the most sparsely populated countries in Europe, with only 15 inhabitants per square kilometer. A quarter of the population lives in rural areas. This demographic pattern makes Primary Care Trusts less suitable for Norway than they are for highly urbanized Britain.

Systems of Remuneration

In Norway, the Fastlege system implies a new model for reimbursing GPs, whose fixed salaries have been replaced by a mix of capitation and fee-for-service. The remuneration has three elements: (1) per capita payment from the municipality for every registered patient; (2) fee-for-service reimbursement from the state for each consultation, with different rates for different procedures; and (3) a copayment from patients for each consultation. There are no limits regarding how much reimbursement GPs may claim. On average, per capita payments make

up about 30 percent of a GP's income, and fee-for-service (part 2 and 3) account for about 70 percent. This is an increase in activity-based financing from about 60 to 65 percent. Out of these payments, GPs must cover the expenses of their offices, nursing and ancillary staff, and equipment, in addition to their own salary and income tax. Municipalities may still employ GPs on a salaried basis if they so wish, but most GPs are in private practice. The main objectives are to provide better financial control and a more rational utilization of medical resources, to make it easier to manage and evaluate GPs' services, and to avoid the previous variation in remuneration models (Department of Health and Social Affairs 2000a). The fee-for-service payment is intended to encourage the GPs to do more work themselves.

Norway's reimbursement system has been criticized for being designed to solve city problems (such as doctor shopping) and unsuitable for the country's demographics. When the recruitment and retention of GPs became a problem during the 1990s, the rural areas suffered the most. The problems were in a reverse ratio to both the size of the community and the degree of centralization. On average, 28 percent of all permanent posts in the northernmost part of the country (around 70° N) were vacant in 1997, and some municipalities had as many as 20 short-term deputies during the year (Andersen, Herder, and Forsdahl 1999). Critics feared that the reform would cause GPs in rural areas to move to more profitable practices in the cities and thus reduce the number of GPs already in the districts. Hence, the reform would decrease rather than increase equality of access across the country. To avoid this, the government introduced a leveling grant for municipalities with a population of fewer than 5,000 (247 of the 435 municipalities) and an average list size of fewer than 1,200. That is, GPs with fewer than 1,200 patients practicing in these municipalities are paid capitation fees *as if* they had 1,200 patients (Department of Health and Social Affairs 2000b).

Britain made several changes in financing during the 1990s. In the 1990 contract, financial incentives had a more important role. Some fees were eliminated, and others were made conditional on meeting stated targets (e.g., 90 percent of childhood immunizations administered and 80 percent of cervical cytology performed). The proportion of income derived from capitation payments rose to about 60 percent, and thus reduced the basic practice allowance (Webster 1998). Enhanced capitation payments were introduced for patients over 65 years and for those living in deprived or underserved areas.

The PMS scheme introduced even more changes. Instead of submitting claims for various fees and allowances, GPs receive a regular monthly payment for providing an agreed-on set of services (Walsh et al. 2000). The best-known feature of the scheme is that it allows GPs to be employed on a salaried basis rather than as self-employed contractors working “outside” the NHS. The main purpose was to recruit doctors for underserved areas and thereby to begin addressing the inequitable distribution of GPs across Britain, where the more affluent, healthier suburban areas tend to attract more and better-qualified clinicians than do the deprived inner-city areas (Benzeval and Judge 1996; Gravelle and Sutton 1998; Medical Practices Committee 1999). The PMS scheme lay dormant for some time after the election in 1997 but finally came to life with the launch of several “waves” of pilots, the fourth of which commenced in October 2002. By that time, nearly one-third of the GPs were working under alternative contracts (Department of Health 2002a), and the number is expected to rise during the fifth wave in 2003.

When we compare recent changes in remuneration systems in the two countries, we find no convergence toward some common point. Whereas most Norwegian GPs derive more than two-thirds of their income from fee-for-service payments, British GPs usually use either a combination of capitation and target payments or regular payments (GPs on PMS contracts). The proportion of capitation payments has risen in Britain but has decreased in Norway. British GPs receive some form of weighted capitation, but Norwegian GPs do not, although some receive a leveling grant.

Some of the minor differences in remuneration systems are easy to explain. For instance, there is limited space for higher capitation payments in socially deprived areas in Norway because there are few such areas, except perhaps in the capital city. That is because Norway, unlike Britain, has almost no poverty and a very egalitarian distribution of wages. Between 1979 and 1995, Norway had the lowest wage differential and the lowest poverty rate of all the OECD countries, whereas Britain had the highest poverty rate and the fourth-highest wage differential (Moene and Wallerstein 2000). But even though Norway has no need for higher payments in socially deprived areas, there certainly are enough sparsely populated areas that could do with a bit of weighted capitation. The Norwegian government probably did not weight the capitation payment because it is a minor part of its remuneration system.

It is more difficult to explain why Norway chose 70 percent fee-for-service payments, and Britain has virtually none. One argument is that with a high proportion of fee-for-service, female doctors (who usually have fewer patients on their lists) would not be paid less than their male colleagues. More likely, the high proportion of fee-for-service remuneration reflects the politically powerful medical profession's role in designing the reform of Norway's health policies. Physicians may see fee-for-service payments as serving their own economic interests, an enhancement of professional freedom and independence, or as the best way to cope with recruitment problems and the declining status of GPs. The differences may also be related to the fact that unlike Britain, Norway charges patients copayments for GPs' services, which contributes to the high proportion of fee-for-service payments. Finally, it is widely recognized that fee-for-service payments are an incentive to overtreat patients, thereby increasing the cost of services. Such an increase might be easier for Norway to absorb because of its more favorable economic situation.

Another important difference between the two countries relates to strategies (financial incentives) for attracting doctors to areas where there are shortages. Norway has introduced leveling grants for rural areas and reduced the proportion of salaried physicians. This is counter to the overall international trend "for more doctors to be paid on a salaried basis" (Fitzpatrick 1999, 274). It is too early to tell how successful this strategy will be, but one year after its implementation, 120 lists and nearly 80,000 (of 4.5 million) inhabitants had no regular GP (Rikstrygdeverket 2003). Britain has introduced a higher capitation payment for patients in underserved areas and increased the flexibility in employment arrangements, such as the option of a fixed salary. Still, the situation in deprived inner-city areas does not appear to have improved. In fact, the whole system seems to be on the brink of a breakdown: A survey of more than one hundred GPs from across Britain showed that "GPs morale is at an all time low" (British Medical Association 2001a), and a poll of 36,000 GPs showed that more than eight of ten would consider resigning if major changes were not made (British Medical Association 2001b). The results were described as a demonstration of "the depth of disenchantment, despair and disillusion felt by GPs throughout the UK" (British Medical Association 2001b).

Because of its strong egalitarian culture, it is difficult to understand why Norway has refused to try harder to attract GPs to underserved

areas, as the highly class-divided Britain has done. One reason may be that health services have a more prominent position in the British welfare state than they do in the Norwegian state. Health services in Norway generally have to compete for funds with a wider range of public services than they do in Britain. Norway has one of the most comprehensive welfare states in the world, covering numerous services from culture and sports to health and education. Most schools and hospitals are public, and the country does offer generous social security arrangements for people who are sick, disabled, old, unemployed, or single parents. Schools, nursing homes, and pensions are viewed as having the same importance as health care, whereas in Britain, health care is regarded as a cornerstone of the welfare state. The British people are proud of their NHS; it is probably the country's greatest symbol of equity and solidarity. Indeed, Prime Minister Tony Blair (2000) called the creation of the NHS "the greatest civilising act of emancipation this country has ever known."

The position of the NHS in Britain may be one reason why the country seems to do more to attract GPs to underserved areas than Norway does. This explanation is not supported by OECD statistics, however: Norway spends more of its GDP on public health services than Britain does (table 1). Another explanation may be that Norway's decentralized system enables politicians to delegate the responsibility for recruiting and retaining GPs to the municipalities. Politicians may also have tactical reasons. Because Norway's rural areas have fewer voters than Britain's urban areas do, Norwegian politicians can avoid tackling the problems of rural areas without losing too many voters in the next election. But if British politicians overlooked the problems in deprived urban areas, they would face major vote losses. Finally, the two countries' divergent strategies may be related to the different kind and extent of their problems. Distribution is probably not as great a problem in Norway as it is in Britain because Norway has more physicians. In addition, persuading GPs to work in inner-city areas in Britain is necessary to prevent hospitals' emergency departments from collapsing.

Policy Process

Norway's Labour government proposed the Fastlege system in 1990. In 1997, after pilot projects in four municipalities were evaluated, the parliament decided to make the system permanent. The reform's final

design was worked out jointly by central, regional, and local authorities and the Norwegian Medical Association. In October 1998, a public hearing of the preliminary proposal was presented to 185 different organizations, which resulted in more than 300 statements, and led to some changes in the final proposal.

In 2000, after the National Parliament passed the changes in the 1984 Local Authority Health Care Act, significant parts of the reform still had not been settled. A liaison committee consisting of representatives from the Ministry of Health, the Norwegian Association of Local and Regional Authorities, the Municipality of Oslo, and the Norwegian Medical Association was given collective responsibility for resolving some parts of the reform. Among these were salary rates, size of per capita payments, leveling grants and other remunerations, and the frameworks for individual contracts (Department of Health and Social Affairs 2000a). When the final round of meetings started, it soon became apparent that the negotiations would be difficult. In September 2000, the Medical Association withdrew from the discussions, stating that it could not agree on the proposal. Three weeks later, all participants (some of whom had been working behind the scenes) agreed on the details of the system, even though they had not met officially.

In Britain, the policy process was quite different. In the 1950s, the medical profession had a hand in every level of decision making in the NHS. Nonetheless, even though the structure on paper was highly corporate, the British Medical Association (BMA) in practice found it difficult to deliver the goods (Klein 2001b). Although it had veto rights over specific policies, it could not achieve what it had hoped to. Although the BMA succeeded in determining which issues would be on the agenda and how they would be framed, it was not able to secure resources for its own members (Klein 2001b). Between 1950 and 1959, the average salary of a general practitioner fell by about 20 percent. In response, in 1965 the BMA published a series of demands in the Charter for the Family Doctor Service and threatened mass resignations by GPs if these demands were not met. After negotiations between the BMA and the Health Ministry, the charter was adopted in 1966. But even then, only some of their demands were met, and others were ignored (Klein 2001b).

In the 1980s, Britain's medical profession became a powerless, passive spectator of developments. The culmination was in 1989 when the Conservative government published a white paper entitled *Working for*

Patients, which “brought about the biggest explosion of political anger and professional fury in the history of the NHS” (Klein 2001b, 111). When the reforms were forced through in 1991, despite severe opposition from the medical profession, the BMA’s power was clearly weakened. The succeeding governments have been a bit more responsive. For instance, in 1995–96 the minister of health undertook a six-month-long “listening exercise” gathering suggestions from NHS staff on how to improve services. Several white papers reflected these views (Department of Health 1996a, 1996c), but the BMA is still relatively powerless.

Norway’s and Britain’s policy processes have been very different. Norway’s decision-making process has been consensus oriented. Most decisions have been made through negotiations by interest groups, with the medical association as one of the key actors. In Britain, physicians have had less influence, especially in regard to the Thatcher reforms, which were implemented despite massive opposition from the medical profession (Pollitt and Summa 1997).

Norway’s politically powerful medical profession has managed what its British counterpart has not: to influence decisions about how their wages are calculated. This must be seen in relation to the differences between the two countries’ political systems. Unlike that of Britain, and contrary to international trends, Norway’s medical profession has been able to influence health policy through its institutional integration into the state machinery (Erichsen 1995). Moreover, the health sector is not a special case; rather, the Norwegian policy style is consensual. Many different interest groups participate in making policy as part of the country’s corporative political system, an important feature of the Scandinavian state tradition, which has a strong “democratic and participatory ethos” (Peters 2000). Differences in electoral systems, which make Norwegian governments weaker than those in Britain, may also be important. For the last few decades, all Norwegian governments have been coalition or one-party governments with only minority representation and hence dependent on support from other parties to get its proposals through parliament. Such differences affect the policy process. A government’s ability to drive through legislative changes, overriding opposition from doctors and others, generally is greater in countries like Britain (Klein 1997). But this does not necessarily mean that the government is more able to influence the activities and practices of health professionals. Political institutions are not value-free technical tools but reflect ideological differences. Accordingly, Norway’s

consensus-oriented political style reflects the importance of democratic values in its society.

Dynamics

Health policies are the result of a complex blend of economic, structural, political, and cultural factors. By discussing the variations in the development of GP services in Norway and Britain in relation to the two countries' economic, structural, political, and cultural differences, I have tried to explain the differences in their health policies. In some cases there is divergence, which seems to be derived from the social context of the reforms. In other cases, historical and cultural traditions seem to have been overwhelmed by global changes. The overall trend, however, is divergence: there does not seem to be a movement toward a common point. National characteristics seem to channel policy development along particular paths. This does not mean that they are moving further apart; rather, the two countries seem to be going in different directions from different starting points. These conclusions are supported by a comparative analysis by Wendy Renade, who found substantial convergence between several countries in perceived problems and the language used to express them, but divergence in policy formulation and implementation (Renade 1998). These conclusions also agree with those from the Four Country Conference on Primary Health Care, which revealed significant differences between reform programs in the countries involved (Four Country Conference 1997).

The divergences and convergences are as follows: Norway and Britain face similar challenges, which they are addressing with many of the same objectives: to increase equality of access, quality of care, and value for money; to improve working relations between primary and secondary care; and (for Britain) to strengthen the role of primary care. But the two countries have chosen different means for making these changes. At some levels, their actions converge. For instance, both countries now have a system of independent contractors with responsibility for a particular population. They also seem to be converging toward a system in which central command and control (defining policy goals, monitoring outcome, etc.) are combined with local freedom to choose the most suitable means (the "tight-loose" principle), and policymaking is separated from implementation (the "steer, not row" principle, in

which politicians are more concerned with strategy and less with implementation). Otherwise, there are few steps toward greater convergence: Norway relies on fee-for-service payments, and Britain relies on weighted capitation and target payments, or regular payments. The proportion of salaried GPs is decreasing in Norway but is increasing in Britain. British initiatives to strengthen the role of primary care within the health system and to integrate other community services into GP services have no equivalents in Norway. While Norway is supplementing existing arrangements, Britain is replacing them with new ones. There seems to be a general movement toward divergence in remuneration and recruitment systems, convergence in objectives, and both divergence and convergence in organizational aspects. I explained the main divergences as follows:

1. Britain has introduced primary care trusts with cash-limited budgets and control over three-quarters of the NHS's budget, whereas Norway has given to patients the right to a regular GP and to the GPs a blank check. These differences may be the result of several factors: (a) Norway has fewer problems regarding delivery and access, partly because of a greater number of GPs per inhabitant and a better economic situation; (b) Norway's political institutions make it less important for a government to demonstrate how it differs from the previous one; (c) Norway already had a decentralized system, the management of GP services was delegated to the municipalities in 1984; and (d) because Norway is sparsely populated, primary care trusts are less suitable than they are for the big cities in Britain.
2. Differences in the two countries' systems of remuneration are explained by differences in physicians' political power and in political institutions and electoral systems: (a) The medical profession is much more powerful in Norway than it is in Britain; and (b) because of resistance from powerful trade unions and strong political opposition, Norwegian governments are less able to implement policy changes than British governments are.
3. The two countries' different strategies for reducing the uneven distribution of GPs are explained by four factors: (a) The long tradition of a decentralized health care system in Norway makes it easier for politicians to delegate the responsibility for recruitment

to the municipalities; (b) the NHS has a more important position in the British welfare state, whereas the Norwegian NHS is only one of several equally important public policy domains; (c) while the interests of the rural population in Norway can be sacrificed without losing too many votes, the interests of people in deprived urban areas in Britain cannot be neglected without losing a huge bloc of votes.

Most of these factors are institutional or structural and hence support the theories of Immergut (1992) and Tuohy (1999), who sees policy change as the product of a complex interaction between institutional and structural factors, largely outside medicine: "Episodes of policy change in the health care arena were brought about by the opening of 'windows of opportunity' as a result of events in the broader political arena" (Tuohy 1999, 107). This does not mean that individuals do not matter; they do, partly because the institutions themselves are created by people. But they are created under circumstances inherited from the past, which therefore influence their decisions.

Epilogue

Whether we see similarities or differences depends on where we look, and where we look depends on what kind of questions we ask. If our aim is to find global trends, we will set out to find similarities, and that is what we will find. In recent years, this is what most comparative analysts have done. But such generalizations are likely to prevent us from seeing the nuances and complex patterns of social change. In our search for global trends, it is easy to lose sight of national differences and to misjudge the possibility of a cross-national transfer of experiences (Marmor and Boyum 1999). To avoid this, we need more analyses based on qualitative data from more specific empirical fields, in which differences between countries are not brushed aside as insignificant or overshadowed by a strong focus on similarities. This study has shown that differences between countries are important. In many ways, differences are the most interesting starting point for a comparative analysis. In a world dominated by global developments, why do nations still choose their own paths? To answer this question, we can look for differences in countries'

reform programs and relate them to their social context. The result will not only reveal the nuances and complexity of social patterns but should also give us a better understanding of the dynamics of change in the countries involved and in policy formation in general.

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Address correspondence to: Olaug S. Lian, PhD, Department of Community Medicine, Faculty of Medicine, University of Tromsø, N-9037 Tromsø, Norway (e-mail: Olaug.Lian@ism.uit.no).