

Summary:

Taxi services in rural areas

In 2004, responsibility for the transport of patients in Norway was transferred to the newly formed health corporations. In parallel with this, competitive tendering for the contracts was introduced. This report evaluates the development of rural taxi services in Norway, in the context of this reform. Particular attention has been paid to the cases where the taxi industry has faced competition from other actors such as the tourist coach industry.

The main conclusion of this report is that so far, loss of service has only been a marginal problem, on a national level. At the locations where there has been a loss of taxi license holders, local solutions have been found retaining some level of service. Still this report shows that there are long term trends which point in the way of service reduction if today's regulatory regime is continued and today's market trends continue.

The transport of patients to and from hospitals and other healthcare institutions on contracts from the healthcare corporations account for a dominant part of turnover for the taxi industry in most rural municipalities. Our data indicates that turnover from this transport averages approximately 50 percent of total turnover in rural municipalities. This figure will vary according to the definition of rural areas and sample used. Dependency on transport on contracts from the healthcare corporations as a main source of income is at odds with the requirements for 24-hour service and full time jobs for all license holders. In the cases where the taxi industry has lost contracts for the transport of patients, there have been several license holders exiting the industry or moving to more densely populated areas. A consequence of this is a lower service level for the municipalities in question. On the other hand, looking at rural areas, only in the cases where actors from outside the industry have participated has there been any real competition. The taxi industry is largely monopolistic, with only one dispatch center in each area, for historic reasons. It is therefore a disparity between the Professional Transport Act, requiring 24-hour service and full time employment (section 45) and the Public Procurement Act (section 2 and 3) requiring the health corporations to put their transport contracts for tendering.

This report addresses three main questions

- 1) What is the development of the level of taxi service?
- 2) What are the developments in the transport of patients, with regard to level, efficiency, cost and competition?
- 3) What are the developments in the income and turnover for taxi license holders, and is this different in different market segments?

Discussing methods and data, this report concludes that the publicly available statistics are insufficient to answer the questions set for this report. This report is therefore based upon data from Norges Taxiforbund (Norwegian Taxi Owners union) and selected dispatch centers. This data has been checked with interviews of key personnel in county governments and health corporations.

Today's regulatory regime can be described as a system where regulated entry in the taxi industry is linked with the need to secure a satisfactory level of income as well as ensuring minimum service for the rural population. The entry regulations, as they are practiced today, have been in place for more than 60 years. But in the last decade there have been significant amendments to this regulation. As of 2010 Norway is divided between areas where there is a maximum fare, set by the Norwegian Competition Authority and areas exempt from the maximum fare. The areas exempt from the maximum fare are areas with more than one dispatch center. These areas are in connection to the largest cities in Norway. In these areas fares are set in the market by the dispatch centers. In the rest of Norway the maximum fare applies. It is important to note that the maximum fare is only compulsory for the single trip markets. Negotiated and tendering contracts are exempted.

There are significant differences between the Norwegian counties when it comes to development in the number of taxi licenses. As of spring 2010 there were four municipalities with no active taxi licenses. In these municipalities taxi service has been replaced with other services. In about forty municipalities there are now two taxi licenses or less. The dominant reason given for handing in taxi licenses is old age, with the maximum age for license holders being seventy years. Still, there are a significant number of licenses being handed in due to low turnover. In the cases where the taxi industry has lost tendered contracts, this is given as a reason for handing over the taxi licenses. Loss of contracts for the transport of patients dominates within this category. From interviewing representatives of the county governments we learned that this has been the case in three counties. This report provides an in depth analyses of two of these counties and concludes that the loss of tender for the transport of patients has reduced the number of taxis in both. In both cases there has been a loss of tender in favor of tourist coach license holders, directly related to taxi licenses being handed in.

Data available for this report *does not support* the conclusion that the loss of taxi licenses has resulted in a *loss of service*. In most areas we observe that there continue to be taxis, in the few municipalities where this is not the case, the county government has accepted alternative solutions, providing a replacement service. On the other hand, we observed several cases of *reduced level of service* as a consequence of the taxi industry losing tenders to tourist coach operators. This is particularly visible in the municipalities where the transport of patients is a dominant source of revenue. This report concludes that in most cases the taxi industry has not had competition from tourist coach operators on tendered contracts, but where they have met competition from tourist coaches, and the tourist coach operator has won the contract this has resulted in a reduced taxi service.

Still, the case need not be that the transfer of responsibility of the transport of patients to the health corporations is the cause of the observed development.

There is great variation between counties and regions regarding the use of tendering and competition and contracting details.

Discussing the trends and efficiency within the transport of patients, this report find that the studies done for the health authorities, so far, has had a focus on cost control rather than efficiency. A main point in these reports is that there seems to be a reduced rate of cost increase since 2006. This report supports this conclusion, for some counties, but the report also finds that costs increased in the period after 2006. This study has been limited to the transport of patients, and has therefore not taken into account increased efficiency in the in hospital treatment that might have taken place. In a societal perspective, increased use of transport might be beneficial. A major problem in this report is the lack of good quality statistics for the transport of patients. Our data from one county indicates that significant savings, due to increased efficiency took place before the transfer of responsibility to the health corporations, not after. We also find that cost control has been increasing before, during and after the transfer of responsibility.

Data presented in this report suggests that there has been a major increase in turnover for the taxi industry during the last decade, at least in some of the counties studied. We note that this includes, but is not limited to, urban areas. The data suggests that most market segments has increased in urban areas, but in rural areas the transport of patients have been the main factor explaining growth in turnover between 1997 and 2004. Data also suggests that there has been little increase in turnover from the transport of patients after 2004. There are significant differences in the breakdown of income for the taxi industry in urban and rural areas, with the transport of patients counting for about 25 percent in the urban areas studied and an average of about 50 percent in the rural areas studied. The data also suggest that the turnover per taxi permit is significantly lower in rural than in urban areas.

The taxi industry's dependency on the transport of patients, in particular in rural areas, results in vulnerability. Loss of tendered contracts to tourist coaches results in significant losses in turnover and in many cases the taxi licenses are being handed in. The data available for this report lead us to suggest that this results in a reduced service level, also for other taxi services in the municipality in question.

The main conclusion in this report is therefore that, although there is not enough data to support a conclusion that transferring the responsibility for the transport of patients to the health corporations has resulted in a loss of taxi services, still there are reasons to believe that this will change.