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## Health Reform Monitor

# The 2015 hospital treatment choice reform in Norway: Continuity or change?



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## ABSTRACT

In several European countries, including Norway, policies to increase patient choice of hospital provider have remained high on the political agenda. The main reason behind the interest in hospital choice reforms in Norway has been the belief that increasing choice can remedy the persistent problem of long waiting times for elective hospital care. Prior to the 2013 General Election, the Conservative Party campaigned in favour of a new choice reform: “the treatment choice reform”. This article describes the background and process leading up to introduction of the reform in the autumn of 2015. It also provides a description of the content and discusses possible implications of the reform for patients, providers and government bodies. In sum, the reform contains elements of both continuity and change. The main novelty of the reform lies in the increased role of private for-profit healthcare providers.

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## 1. Institutional setting and reform background

As in most European countries, statutory coverage in Norway is obligatory and opting out is not permitted. There is no choice of the statutory benefits package but patients are allowed to choose their healthcare provider. Healthcare provision is organized at two main levels, municipalities and state. The municipalities are responsible for primary care and enjoy a great deal of freedom in organizing health services. Patients are in general free to choose their general practitioner (GP). GPs act as gatekeepers responsible for referring patients to specialist care, i.e., a privately practicing specialist or a hospital. The referral process normally comprises the following stages: (1) the GP examines the patient and, if specialist care is needed, writes a letter of referral; (2) the referral is assessed by a public hospital; (3)

the hospital determines if care is needed and if the decision is affirmative the hospital grants the patient the right to treatment within a specified period of time (waiting time guarantee); (4) if the guaranteed waiting time is exceeded by the hospital, the patient is allowed to select an alternative provider (either another public hospital or a private hospital under contract with the Regional Health Authority (RHA)) [1]. The responsibility for specialist care lies with the state—the owner of the four RHAs, which in turn own hospital trusts. The Ministry of Health influences the activity of the RHAs (e.g., what their budget allocation should be spent on) through its annual “letters of instruction”. These letters are supplemented by annual circular letters from the Directorate of Health focusing on issues such as quality of care, e-health, etc. The Directorate is an agency subordinate to the Ministry and is involved in implementation of healthcare policies.

Waiting times for elective hospital care have been seen as a major shortcoming of the healthcare system since mid-1980s and have been the motivation behind a number of

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waiting-time guarantees and choice reforms [1,2]. Since 2001, somatic patients have had the right to choose any public hospital in the country (but the level of hospital, secondary or tertiary, could not be chosen) [3]. Subsequently, patient choice was expanded to include private hospitals contracted by the RHAs (patients who received care at private hospitals not contracted by the RHAs had to pay for it out of their pocket). However, this expansion did not necessarily mean a major change for the patients in terms of increasing their choice as almost all hospitals in Norway (approximately 99%) are publicly owned and funded through public budgets [4]. Not-for-profit private hospitals, often organized as foundations owned by ideological organizations such as the church, are publicly funded and seen as part of the public healthcare services. Private for-profit (PFP) providers play a small role in the provision of specialist care, as less than 1% of hospital beds are in private for-profit hospitals [1]. The largest proportion of private provision of somatic hospital care is found for elective day surgery (about 10%) [5]. Other patient and user groups, such as psychiatric patients and patients in need of treatment for alcohol and substance use have also been granted the right to choose a hospital/institution (in 2004 and 2005, respectively). In recent years, the RHAs have also started offering patients the option to receive rehabilitation care in a different region.

Although patient choice can contribute to reducing hospital-waiting times for individual patients [6,7], an overall effect on waiting times in Norway has yet to be demonstrated. The waiting times problem has persisted and not left the policy debate. According to a 2010 OECD survey, 21% of Norwegian respondents had to wait four months or more for elective surgery (third highest score after Canada (25%) and Sweden (22%)) [8,9]. Between 2011 and 2014, the average waiting times were the highest for somatic treatment (70 and 80 days), with patient waiting for orthopaedic and medically essential plastic surgery facing the longest waiting times. For alcohol and drug treatment a reduction in waiting times was observed, from about 75 days in 2011 to about 60 days in 2014. For psychiatric care, the average waiting times remained stable at about 55 days [10].

The article aims to describe the background and process leading up to introduction of the new treatment choice reform in late 2015. It provides a description of its content and discusses possible implications of the reform for the patients, providers and other stakeholders.

## 2. Policy goals and policy process

### 2.1. Policy development

In mid-June 2014, the government launched what they named the “reform of free treatment choice in specialist care” [11]. The issue appeared on the political agenda prior to the General Election in September 2013, with the Conservative Party campaigning in favour of extending patients’ choice of hospital. The Conservative Party won the 2013 elections and went on to form a governmental coalition with the Progress Party. The two parties are supported by the centrist Christian Democratic Party and the

Liberal Party in Parliament. With respect to healthcare, the coalition parties agreed that “The Government will (...) carry out a major reform of the health service. Patients’ rights will be strengthened and individuals will be given the right to choose their healthcare provider. This will ensure that patients will not have to wait in queues when private and non-profit healthcare providers have available capacity” [12]. Thus, the primary focus of the reform was on strengthening patients’ rights by increasing their choice of healthcare provider, with shorter waiting times for elective care being the more immediate goal. Private providers without a tender agreement with the RHAs were to be included in this extended choice, increasing the pool of providers that patients can choose from.

Immediately after the General Elections in September 2013 the Ministry of Health and Care Services began drafting a proposal for the announced reform. The Prime Minister officially presented the draft proposal in June 2014, emphasizing once again that the reform was intended to extend the existing choice scheme and reduce waiting times for elective hospital care. The proposed reform would entail amending several existing policy tools, including payment mechanisms and ICT-systems. The proposal also called for new regulations in the following areas: a system of granting approvals for private hospitals to be included in the treatment choice scheme would be established (but it was not detailed in the proposal) and a new system for quality assurance would be set up, giving the RHAs the responsibility for assuring quality among private hospitals included in the scheme [11].

### 2.2. The public consultation process and key stakeholder positions

After the proposal was presented, the Ministry opened the customary public consultation process to provide an opportunity for affected stakeholders to state their opinions. The consultation process lasted three months and elicited about 100 responses [13]. Fig. 1 summarizes the position of key stakeholders.

Several of the largest patient organizations (e.g., the Federation of Organizations of Disabled People, the Cancer Society and the Patient Organization for Circulatory Diseases) expressed concerns about the proposal. The key reasons were: complexity of the reform and its administrative costs and the opportunity for private hospitals to prioritize to patients with more “easy-to-treat” conditions. Another issue was the implications for workforce planning in the public part of the system, given that more private providers would compete for the same experts. Patient representatives from the public hospital boards were also worried that private hospitals would prioritize “easy-to-treat” patients and suggested, in a common statement, that no private hospitals should be granted the right to assess GP referrals and to grant individual patients the right to specialist care. The Union for senior citizens expressed a general concern about the ongoing centralization of specialist care, and feared that the choice available to older could be restricted patients due to longer travel distances to hospitals. However, their position and the position of other patient groups were more nuanced and some aspects of the

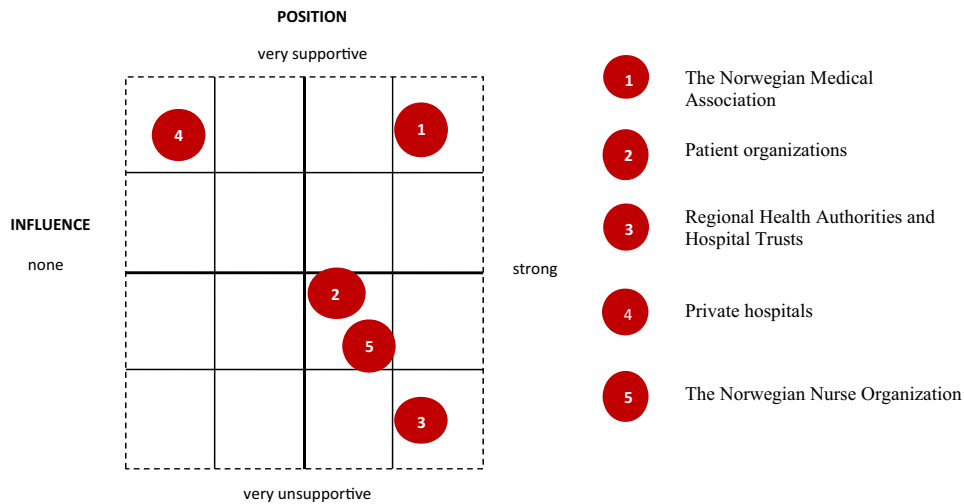


Fig. 1. Stakeholders position towards the proposed choice reform. Source: Authors' evaluations.

reform were assessed positively: patient representatives from the public hospital boards welcomed the fact that the reform would remove the division between patients who could afford to access private care and those who could not. The Union for senior citizens also supported the opening of the market to more private providers, as they believed it to improve overall access to care. Organizations within the fields of mental health and substance use were in general more supportive of the proposal, but emphasized the need for the simultaneous development of decision making support systems.

The South-Eastern RHA (the biggest RHA in terms of population and number of hospitals) was sceptical about the introduction of a new quality regime linked to the approval of private hospitals and the changes in the financing mechanisms. The RHA foresaw two different quality regimes and several financing mechanisms. The position of other RHAs was in line with that of the South-Eastern RHA. The local hospital trusts supported their respective RHAs, adding that a rapid increase of private hospitals could lead to staff shortage in the public sector.

The Norwegian Nurses Organisation (NNO) was sceptical about the increased role of private for-profit providers. The NNO was unconvinced that the impact of the reform on public hospitals and municipalities had been sufficiently analysed. More specifically, they were concerned whether it would be possible to assure provision of well-coordinated care when patient pathways would be partly transferred to private providers. They also feared staff shortage in public hospitals.

Unsurprisingly, the proposal was supported by PFP-hospitals, as it would potentially give them access to more public funding as well as a more important role in the provision of specialist care. They were in favour of having a central quality assurance system applicable to all hospitals, which would ensure that the same quality standards apply to all providers. At the same time, they expressed concerns about whether the proposed scheme would be sufficiently funded to encourage the establishment of more private hospitals. Contrary to the NNO, the Norwegian Medical

Association was in favour of allowing more PFP providers as a measure to improve access to specialist care.

### 2.3. The political debate and the adoption of the reform

Despite the concerns expressed in the consultation process, in January 2015 the government decided to put forward the largely unchanged proposal to the Parliament [13,14]. The Parliament debated it between January and late March. The voting on the legislative components of the reform, i.e., the amendments of the Patients' Rights Act and the Specialist Health Services Act, took place in mid-April. As expected, the opposition voted against the proposal and the coalition parties, who have the majority of seats in the Parliament, voted in favour. The amendments were approved by the Parliament at the end of May and their implementation was scheduled from 1 November 2015 [15].

## 3. Reform content and its implications

The patient treatment choice reform represents both a continuation and change with respect to previous choice reforms (see Table 1).

From the patients' perspective, the main change is that the choice of hospital provider is greater than before, as it now also includes non-contracted private providers. The fact that selected private hospitals are able to consider GP referrals and grant the right to specialist care may mean faster access to care for patients. The reform is not expected to impact upon patients' rights obtained through the recently implemented EU Directive on cross-border healthcare [14].

Previous restrictions on the annual number of patients to be treated by public hospitals have been lifted, which may improve access. Although not a part of the free treatment choice reform, this change is expected to improve the position of public hospitals when the choice reform is implemented [14]. Patient choice, however, did not apply to private rehabilitation institutions. After the passing of

**Table 1**  
The 2015 treatment choice reform: what has changed?

Stakeholders	Situation pre-2015 reform	Changes introduced by 2015 reform
Patients <sup>a</sup>	Have a right to choose the hospital to which their GP referral for specialist care will be sent to and considered—choice among <b>public hospitals only</b> Patients who were granted the right to specialist care have a choice of hospital provider among <b>public hospitals and private hospitals under contract with the RHAs</b> (somatic care, mental healthcare and addiction treatment are included) Rehabilitation care is <b>not explicitly mentioned</b> in the scheme	Choice extended to <b>certain private hospitals with a tender agreement</b> with the RHAs (details are being elaborated) Choice of hospital provider extended to <b>all private hospitals, including those with no contract with the RHAs</b>  Private rehabilitation institutions explicitly <i>not</i> included, but the government has now put forward a <b>new proposal that includes rehabilitation care in the scheme</b>
Public hospitals <sup>b</sup>	Included; have the right to assess GP referrals and to grant patients right to specialist care	Same as before; <b>but no fixed number of patients that can be treated<sup>c</sup></b>
Private providers under contract with the public system	Included but <b>do not have the right to consider GP referrals and grant patients the right to specialist care</b> (only public hospitals have this right now)	Same as before; <b>Selected private providers with a tender agreement with the RHAs may be given permission to consider GP referrals and grant patients the right to specialist care.</b>
Private providers not under contract with the public system	<b>Not included</b> in the hospital choice	<b>Included</b> in the treatment choice
RHAs <sup>d</sup>	Arrange tenders and contract with private providers; monitor provision of contracted care	Same as before; <b>Select private providers with a tender agreement that can consider GP-referrals and grant patients the right to specialist care</b> Expected to purchase more services from private hospitals through public tenders <sup>c</sup>
Directorate of Health	Collects, processes and presents updated and relevant information to support patients who want to exercise their right to choose (e.g., through websites, a dedicated telephone line)	Same as before; <b>Plus grants authorization to private hospitals not under contract</b> with the public system and supervises them; <b>determines the types of services and prices that can be provided by private non-contracted hospitals and pays them</b>

<sup>a</sup> Regulated by the Patient Rights Act.

<sup>b</sup> Regulated by the Specialist Health Services Act and future secondary legislation.

<sup>c</sup> Not part of the choice reform (previously implemented reforms).

<sup>d</sup> Regulated by the Health Authorities and Health Trusts Act.

the legislation, the government has put forward a new proposal that, when enacted, will include private rehabilitation in the choice scheme.

The right given to certain private providers with a tender agreement with the RHAs to assess GP referrals and to grant patients the right to specialist care imply changes for the RHAs. The RHAs will have to establish procedures for granting (and withdrawing) permissions to consider GP referrals by private hospitals and for monitoring private providers that have been granted this right. The RHAs are also expected to buy more services from private providers via public tenders. This in turn may constitute administrative challenge to the planning, budgeting and monitoring processes of the RHAs.

For PFP hospitals contracted by the RHAs, the main change is that in the future they may be given the same right as public hospital to grant patients the right to specialist care. This change would, when implemented, give these providers the same control over patient flows as the public hospitals have today when it comes to receiving and assessing GP referrals. Moreover, they may also be given the authority to grant the patient the right to specialist care and to set individual waiting times for the patients.

For the non-contracted PFP hospitals the key change is their inclusion in the treatment choice scheme. In order to be included, these providers must obtain a licence from the Directorate of Health. Among the prerequisites are the existence of internal quality assurance, communication (with municipalities) and electronic patient information systems. The government has, to cover the expected increase in activity, granted an addition 150 million NOK in 2015 and 400 million NOK in 2016.

Non-contracted PFP hospitals may only provide health-care services that are included on a pre-defined list (together with their respective prices) set by the Directorate of Health. This list is based on the information about bottlenecks in the public system (i.e., long waiting times). Presently, the list only contains inpatient services in the area of mental health and substance abuse treatment and a limited number of services within somatic care. Private hospitals are reimbursed on a fee-for-service (FFS) basis by the Health Economics Administration (HELFO) [16] (see [1] for more information about the role of HELFO). The Directorate will also have to ensure that private non-contracted providers satisfy the same standards for quality of care and patient safety as public and private contracted providers. As before, the Directorate is responsible for collecting,

processing and presenting updated and relevant information (e.g., on waiting times) to support patients who want to exercise their right to choose.

#### 4. Discussion

For many years, lengthy waiting times have been a serious problem in the Norwegian healthcare system and persisted in spite of the implementation of a number of reforms aimed at reducing them. The new treatment choice reform was proposed in June 2014 [11]. The legislative framework was adopted by the Parliament in the spring of 2015 and is now being implemented [15]. While previous reforms focused primarily on the patients' right to choose provider, less attention has been paid to developing the supply side of the system. The 2015 reform has, although the reform rhetoric has focused on patient choice, mainly sought to develop the supply side of the system. First by including private non-contracted providers into the choice scheme and secondly to pave the way for a more enhanced role for private providers under contract with the RHAs.

The draft proposed to first extend the choice of treatment to two vulnerable patients groups: mental health patients and patients with substance abuse problems. Private provision is well established in these two areas which may facilitate the establishment and inclusion of new providers in the scheme. The government has also made it clear that the RHAs will in the future be expected to buy more services from private contracted providers, which may prove to be further incentive for new providers to enter the market.

Important aspects of the reform are still being implemented. The key question is to what extent the RHAs will transfer the responsibility of receiving and assessing GP referrals to private providers. The question is crucial for the public system (the RHAs) in terms of both controlling patients' flows into specialist care, and for having control over their own budgets. Similarly, the Directorate needs to implement the structure and processes for approving private non-contracted providers and to monitor their activity.

The 2015 reform can be described as combining existing demand side with new supply side policies, as it includes both enhancing patient choice and increasing supply of both public and private hospital services. Policies combining demand and supply measures have usually been found to have a stronger effect on reducing waiting-times compared to initiatives focusing primarily on either demand or supply side measures [17]. Thus, other countries (e.g., within the OECD) struggling with lengthy waiting times may follow the developments in Norway with interest [18].

#### 5. Conclusion

In terms of the impact on health system goals, like access, it is too early to speculate what the outcomes of the reform may be. The success of the reform in driving down waiting times will depend to a large extent on whether patients will actively exercise their increased opportunity to choose. While prior to the 2001 reform Norwegians

were in general supportive of introducing choice of hospital provider [19], only a few patients actually exercised their right when seeking hospital care [7,20]. The government has, however, promised to monitor the reform. An evaluation, which will be administrated by the Norwegian Research Council, is expected to start in 2016 [14].

#### Conflict of interest

The authors declare that there are no conflicts of interest.

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