

**DIRECTORATE FOR FINANCIAL AND ENTERPRISE AFFAIRS
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More documents related to this discussion can be found at

<http://www.oecd.org/daf/competition/designing-publicly-funded-healthcare-markets.htm>

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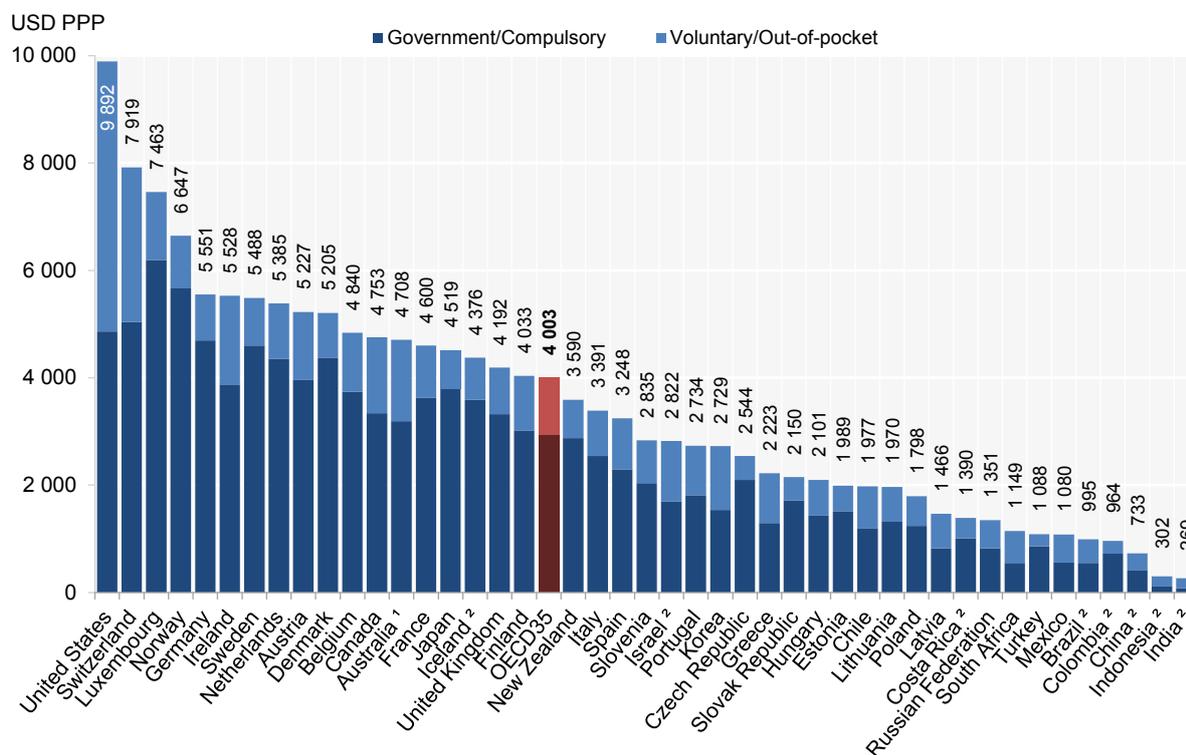
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Norway

1. Introduction

1. The Norwegian healthcare system is a National Health Service ("NHS") with mandatory health insurance mainly financed by general taxation. Figure 1 below shows health expenditures per capita in 2016 for Norway and all other OECD countries.

Figure 1. Health expenditure per capita, 2016¹



Source: OECD Health Statistics 2017, WHO Global Health Expenditure Database

2. As Figure 1 shows, Norway outspends most OECD countries (except USA, Switzerland, and Luxembourg). Norway spent the equivalent of USD 6647 per resident in health expenditures in 2016. This level of spending is 66 per cent more than the OECD average (USD 4003). Furthermore, Figure 1 shows that the government covers more than 85 per cent of total health expenditures in Norway. Co-payments paid by patients in Norway are low due an expenditure cap per patient of NOK 2250 (£ 225) per year.² After the cap is reached, patients receive 100 per cent coverage for any additional health expenditures within the NHS.

¹ OECD, 2017, p. 133.

² Norwegian Directorate of Health <https://helfo.no/frikort-for-helsetjenester> (10.10.2018)

3. The scope for competition within the Norwegian NHS is restricted. The provision of healthcare is subject to extensive regulation. Prices are for most parts fixed, there are low co-payments and the government provide health insurance. However, reforms introduced by the government the last two decades have deregulated restrictions on patient choice and private provision, introducing incentives for provider competition for patients within the NHS. Within specialised healthcare, there has been an increase in the use of competitive tenders to buy private capacity.

4. In this contribution, the Norwegian Competition Authority discusses the potential for competition within the Norwegian NHS today, and share some lessons from the Norwegian experience both with regard to competition within primary healthcare and within specialised healthcare.

5. The contribution is organized as follows. In section 2, the primary healthcare system in Norway is described and discussed: Section 2.1 gives a brief introduction to the institutional set-up. Section 2.2 and 2.3 describe patient choice and the financial funding system, respectively. Finally, section 2.4 discusses the potential for competition within primary healthcare, and presents some main lessons from the Norwegian experience. Correspondingly, section 3 is devoted to the specialised healthcare system in Norway: Section 3.1 and 3.2 present the institutional set-up and introduce the Regional Health Authorities. Section 3.3 gives a description of the private and public suppliers. Section 3.4 and 3.5 describe patient choice and the financial funding system, respectively. Finally, section 3.6 discusses the potential for competition within specialised healthcare and presents the main lessons from the Norwegian experience.

2. Primary Healthcare

2.1. Introduction to the Norwegian primary healthcare system

6. In Norway, primary healthcare is provided almost exclusively by general practitioners ("GPs"). Besides the provision of primary healthcare, GPs have a key role in the healthcare system as gatekeepers for the patients with regard to accessing specialised healthcare. Thus, a patient needs a referral from a GP to obtain specialised healthcare. The GPs responsibilities include: making primary diagnoses, treating general health issues, issuing sickness certificates, prescribing drugs, issuing referrals to physiotherapists, chiropractors and nursing homes, and referring patients to specialised healthcare when necessary (Ringard et. al, 2013, p. 103).

7. The municipalities (the lowest level of government) are responsible for the provision of primary healthcare in Norway. Most GPs are self-employed (84 per cent in Q4 2017) and work under contract with the municipalities.³ The number of vacancies that each municipality can offer is regulated by a central regulatory body, called the Norwegian Directorate of Health, and is based mainly on demographic figures (i.e., need based).

8. The GPs need a licence to set up a practice and a contract with the municipality to treat patients within the NHS.

³ Norwegian Directorate of Health <https://helsedirektoratet.no/Documents/Statistikk%20og%20analyse/Fastlegestatistikk/Fastlegestatistikk%202017/hovedtallsrapport%20fastlegeordningen%2017.pdf> (10.10.2018)

9. There are about 4700 GPs in the NHS.⁴ They serve a population of about 5.2 million.

2.2. Patient choice

10. Patients are in general free to choose their GP. Since the implementation of the Regular GP Scheme (Fastlegereformen in Norwegian) in 2001, each inhabitant of Norway is entitled to be enlisted with a GP. A patient may choose between any GP within the NHS as long as the chosen GP has vacant patient slots. Patients may switch GP (without any reason) at most twice a (calendar) year.

11. In Q4 2017, the share of GPs with vacant slots on their lists was 36 per cent.⁵ This limits the number of GPs that patients can choose from. In 2017, 7.4 per cent of all patients participating in the Regular GP Scheme exercised their right to switch GP.⁶

12. The GPs are not allowed to turn down new patients who want to be enlisted as long as they have vacant slots on their lists. The allocation of new patients is made centrally by the Norwegian Directorate of Health. The GPs can decide their list size within an interval of 500–2500 patients.⁷ The average GP list size is about 1100 patients.⁸

13. Participation in the Regular GP Scheme is voluntary for individuals. However, individuals who do not participate in the Regular GP Scheme, are charged higher co-payments for GP consultations (Ringard et. al, p. 42). Virtually all individuals in Norway (99.3 per cent in Q4 2007) participate in the Regular GP Scheme.⁹

2.3. Financial system

14. The payment system for self-employed GPs is a combination of a fixed amount per patient on the list "capitation fee", payments for consultation and various services offered "fee-for-service" and patients' co-payments. The capitation fee amounts to about 30 per cent of the GP's income and the other two sources of funding, fee-for-service and co-payments, amounts to about 70 per cent (Ringard et. al, 2013, p. 68). This payment system

⁴ Norwegian Directorate of Health <https://helsedirektoratet.no/statistikk-og-analyse/fastlegestatistikk#fastlegestatistikk-2017> (10.10.2018)

⁵ Norwegian Directorate of Health <https://helsedirektoratet.no/Documents/Statistikk%20og%20analyse/Fastlegestatistikk/Fastlegestatistikk%202017/hovedtallsrapport%20fastlegeordningen%202017.pdf> (10.10.2018)

⁶ Norwegian Directorate of Health <https://helsedirektoratet.no/statistikk-og-analyse/fastlegestatistikk#fastlegestatistikk-2017>, Tabellgrunnlag for fastlegestatistikken 2017.xls, Sheet "Tabell 9" (10.10.2018) (English translation: Table of GP statistics).

⁷ [Forskrift om fastlegeordning i kommunene](#), §34 (English translation: Regulations of the Regular GP Scheme in the municipalities, §34).

⁸ Norwegian Directorate of Health <https://helsedirektoratet.no/Documents/Statistikk%20og%20analyse/Fastlegestatistikk/Fastlegestatistikk%202017/hovedtallsrapport%20fastlegeordningen%202017.pdf> (10.10.2018)

⁹ Norwegian Directorate of Health <https://helsedirektoratet.no/Documents/Statistikk%20og%20analyse/Fastlegestatistikk/Fastlegestatistikk%202017/hovedtallsrapport%20fastlegeordningen%2017.pdf> (10.10.2018)

was introduced with the Regular GP Scheme in 2001. Prior to the reform, the GPs were either public employees with fixed salary contracts or self-employed with a contract with the municipalities that entitled them to a fixed budget combined with a fee-for-service. To be eligible for the new payment scheme, the GPs had to be self-employed, and today 84 per cent of the GPs are self-employed with their own practice.¹⁰

15. Prices are regulated (or set by negotiations between the government and the physician association) and cannot be set by the individual GP. The municipalities pay the capitation fee which is a fixed annual payment of about NOK 500 (£ 50) per patient enlisted with the GP.¹¹ The National Insurance Scheme pays the fee-for-service part and the GPs receive a fee per basic consultation and per unit of medical services provided (e.g., prolonged consultation, lab tests, medical procedures) (Ringard et. al, 2013, p. 68). Furthermore, patients pay co-payments. However, as mentioned, the co-payments paid by patients are very low due to an expenditure cap per patient of NOK 2250 (£ 225) per year. After the cap is reached, patients receive 100 per cent coverage for any additional health expenditures within the NHS.

16. The self-employed GPs with their own private practice (84 per cent) can pocket the profits (or have to cover the deficits) from the services they provide to the NHS patients. The residual 16 per cent of the GPs are publicly employed with regular salary contracts.

2.4. Provider competition

17. Regulated prices and low co-payments limit the scope for price competition within primary healthcare in Norway. Thus, competition between primary healthcare providers within the NHS is primarily on non-price variables such as quality.

18. The implementation of the Regular GP Scheme in 2001 increased the scope for competition among GPs. Free patient choice, self-employed GPs and a financial system that is linked to the number of patients a GP has on his or her list gave the GPs an incentive to compete for patients. By providing high quality care, a GP may attract more patients and thereby increase his or her income.

19. However, the Regular GP Scheme will not increase competition unless patients are actively exercising their right to choose and the GPs have vacant slots on their lists, i.e. there is sufficient local competition. The share of patients who exercised their right to switch was 7.4 per cent in 2017 and the share of GPs with vacant slots on their lists was 36 per cent (see section **Error! Reference source not found.**). These numbers indicate that there is potential for competition (thus perhaps not in all local areas).

20. Furthermore, the number of vacancies that each municipality can offer, and hence the number of GPs within each municipality, is regulated. Also, the number of patients a GP may enlist is capped at 2500. These restrictions may potentially limit competition among GPs.

21. The existing empirical literature seems to support that competition has increased after the implementation of the Regular GP Scheme.

¹⁰ For more details, see Brekke and Straume (2017).

¹¹ Norwegian Directorate of Health <https://helfo.no/helseaktor/kommuner-og-fylkeskommuner/kommunen-og-legetjenesten/basistilskudd-for-fastlegeordningen-i-kommunene> (10.10.2018)

22. Brekke and Straume (2017) present a short literature review of the Regular GP Scheme reform in 2001. They conclude that the evidence seems to support that the reform provided competition within primary healthcare.

23. Furthermore, Sandvik (2006) finds that the Regular GP Scheme has reduced waiting times and increased the number of GP consultations. However, he also finds indications that more patients are referred to specialised healthcare and that there is an increase in reimbursable prescriptions and sick leaves. He argues that the most important reason for the increase in referrals is probably increased availability of specialised healthcare.

24. Evidence that GPs respond to financial incentives are found in Brekke et. al (2017a) and Brekke et. al (2018b) . Brekke et. al (2017a) show that a higher consultation fee increases the number of visits, but reduces the treatment intensity per visit. Thus, the GPs see more patients, but spend less time with each. Brekke et. al (2018b) analyse the effects of fee-for-service (self-employment) versus fixed salary on treatment decisions of GPs. They find that payment by fee-for-service leads to an increase in the supply of consultations and a higher provision of medical services per consultation.

25. There are also some studies that indicate that there might be a trade-off between competition and the GPs' gatekeeping role. Iversen and Ma (2011) study referrals to specialised healthcare and find that GPs who operate in more competitive markets (measured as the number of GPs with vacant slots in a municipality) refer more. They also find that GPs who face patient shortage refer more often than GPs with enough patients. They interpret this as GPs satisfying patients' request for referrals to retain patients in their practice. Although their estimates are statistically significant, they are relatively small in economic terms. In line with this study, both Brekke et. al (2017b) and Markussen and Røed (2017) find that competition has a positive impact on GPs' (supply of) certification of sick leaves.

26. Thus, there is evidence that the implementation of patient choice and a financial payment system that is linked to the number of patients a GP has on his or her list have given the GPs the necessary autonomy and incentive to compete for patients within the Norwegian NHS. However, there is also evidence that competition may have increased GPs' referrals to specialised healthcare and certification of sick leave.

3. Specialised healthcare

3.1. Introduction

27. The specialised healthcare service provide diagnostics, treatment and follow-up of patients with acute, serious and chronic diseases and health problems.¹² Patients with acute needs are treated immediately, without any referral. Patients without acute need, will have to be considered by either a GP or other health professionals to get a referral to specialised

¹² Norwegian Government <https://www.regjeringen.no/no/tema/helse-og-omsorg/sykehus/innsikt/nokkeltall-og-fakta---ny/slik--er-spesialisthelsetjenesten-bygd-o/id528748/> (2018.10.18)

healthcare treatment.¹³ Specialised healthcare patients are usually referred to specialised healthcare by a GP.¹⁴ The GPs therefore rationalize the patient flow towards specialised healthcare and act as gatekeepers.

3.2. Regional Health Authorities

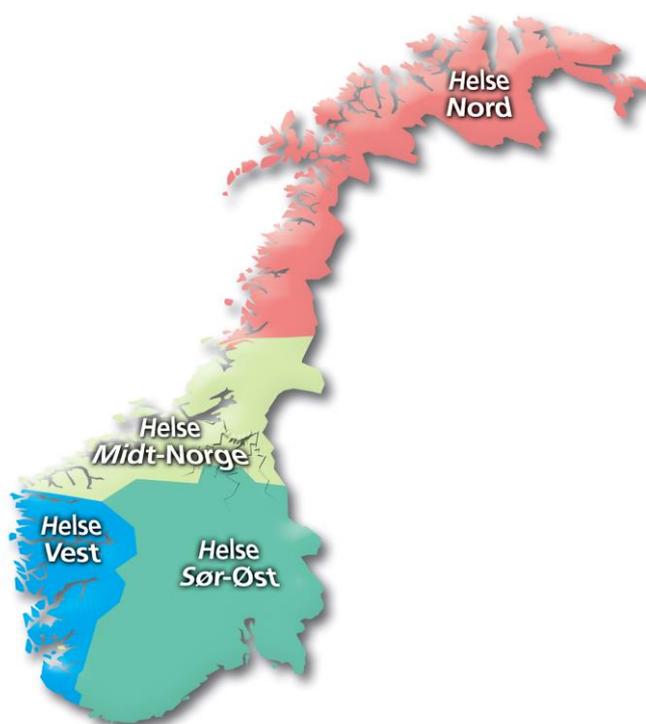
28. The state owned Regional Health Authorities ("RHA") are responsible for the provision of specialised healthcare, including both somatic and mental healthcare, as well as other specialised medical services, laboratory, radiology and ambulatory services, and special care for persons with drug and alcohol addictions. The RHAs perform their assigned duties either by providing the services through self-owned hospitals or by buying the services from private hospitals.¹⁵

29. In Norway there are four RHAs that operate in separate parts of the country: Northern Norway (Helse Nord), Central Norway (Helse Midt-Norge), Western Norway (Helse Vest) and South-East Norway (Helse Sør-Øst). Figure 2 below displays the catchment areas of the four RHAs.

¹³ Norwegian Directory of Health <https://helsedirektoratet.no/retningslinjer/aktuell-informasjon-om-lov-og-forskrift-for-prioriteringsveilederne/seksjon?Tittel=4-nar-henvisning-mottas-2767> (2018.10.18)

¹⁴ Norwegian Government <https://www.regjeringen.no/no/tema/helse-og-omsorg/sykehus/innsikt/nokkeltall-og-fakta---ny/slik--er-spesialisthelsetjenesten-bygd-o/id528748/> (2018.10.18)

¹⁵ The Health Systems and Policy Monitor <https://www.hspm.org/countries/norway08012014/livinghit.aspx?Section=2.3%20Organization&Type=Section> (2018.10.18)

Figure 2. The catchment areas of the four RHAs¹⁶

3.3. Public vs private suppliers

3.3.1. Public hospitals

30. The four RHAs have ownership responsibility for the health enterprises in their respective regions, where they are also responsible for the distribution of healthcare services. The health enterprises (HE) are independent legal entities with governing bodies at regional and local levels.¹⁷ The public hospitals are associated with the different HEs owned by the RHAs. In total there are 29 HEs in Norway.¹⁸ The form of organization provides financial flexibility for the HEs, and profits and deficits can be transferred across fiscal years. Furthermore, the HEs make decision about factors that are relevant for patients' choice of hospital.

31. The operating costs of the HEs were NOK 126.8 billions (£ 12.7 billions) in 2017. In addition, the RHAs had operating costs of NOK 16.9 billions (£ 1.7 billions) in 2017.

¹⁶ Norwegian Government <https://www.regjeringen.no/no/tema/helse-og-omsorg/sykehus/innsikt/nokkeltall-og-fakta---ny/de-regionale-helseforetakene/id528110/> (2018.10.18)

¹⁷ Norwegian Government <https://www.regjeringen.no/en/dep/hod/organisation-and-management-of-the-ministry-of-health-and-care-services/Departments/the-department-of-hospital-ownership/id1413/> (2018.10.18)

¹⁸ Norwegian Government <https://www.regjeringen.no/no/tema/helse-og-omsorg/sykehus/innsikt/nokkeltall-og-fakta---ny/de-regionale-helseforetakene/id528110/> (2018.10.18)

The total costs associated with public hospitals were therefore NOK 143.7 billion (£ 14.4 billions) in 2017.¹⁹

3.3.2. Long-term agreements with non-profit hospitals

32. Further, the RHAs have a binding and committed collaboration with non-profit private hospitals.²⁰ The non-profit private hospitals with long-term agreements are regarded as an integral part of public specialised healthcare,²¹ and these hospitals are financed in the same way as the public hospitals.

In 2017, the costs associated with non-profit private hospitals with long-term agreements with the RHAs were NOK 5.8 billions (£ 0.6 billions).²²

3.3.3. Private supply through tenders

33. The RHAs also buy short-term private capacity. To buy private capacity, the RHAs make use of competitive tenders.²³ Both non-profit and for-profit private operators compete for these contracts.²⁴ Each RHA submits tenders for several specialised healthcare services. Winning a tender or part of a tender means that the supplier is granted the right to offer publicly funded specialised healthcare services in the current health region for a limited period of time. The tender contracts usually have a fixed duration of two years with optional extensions of 1+1 years.²⁵

34. The tender contracts are within the fields of somatic healthcare, mental healthcare and rehabilitation (related to substance abuse). These three fields amount to 83 per cent of the total costs related to specialised healthcare in Norway.²⁶

35. Within somatic healthcare, the tender winning private hospitals accounted for 3.3 per cent of total turnover in 2017. This proportion has been relatively stable in recent years.²⁷

36. Within mental healthcare, the tender winning private hospitals accounted for 3.1 per cent of total turnover in 2017. This proportion has increased gradually over the last

¹⁹ Calculations based on numbers from table 06464: Specialist health services from Statistics Norway <https://www.ssb.no/statbank/table/06464> (2018.10.18)

²⁰ Norwegian Government from <https://www.regjeringen.no/no/tema/helse-og-omsorg/sykehus/innsikt/nokkeltall-og-fakta---ny/de-regionale-helseforetakene/id528110/> (2018.10.18)

²¹ NOU 2016:25, page 41.

²² Calculations based on numbers from table 06464: Specialist health services from Statistics Norway <https://www.ssb.no/statbank/table/06464> (2018.10.18)

²³ Norwegian Directory of Health (2017a), page 10.

²⁴ NOU 2016:25, page 42.

²⁵ The Norwegian Competition Authority (2015).

²⁶ Calculations based on numbers from table 06464: Specialist health services from Statistics Norway <https://www.ssb.no/statbank/table/06464> (2018.10.18)

²⁷ Calculations based on numbers from table 06464: Specialist health services from Statistics Norway <https://www.ssb.no/statbank/table/06464> (2018.10.18)

three years. Within the same time period, the proportion of the non-profit hospitals with long-term agreements has decreased from 9.1 per cent to 6.4 per cent.²⁸ It therefore appears that the tender winning hospitals have gained turnover at the expense of private non-profit hospitals with long-term agreements.

37. Within rehabilitation, the tender winning private hospitals accounted for 27.3 percentage of the total turnover in 2017. As with mental healthcare, the share has increased. In 2014 the proportion was 18 per cent. In comparison, the proportion of the non-profit hospitals decreased from 9.3 per cent in 2014 to 0.7 per cent in 2017.²⁹

38. In 2017, the total costs related to private hospitals with tender contracts were NOK 7 billion (£ 0.7 billions).³⁰ In comparison, the costs were NOK 4.3 billion (£ 0.4 billions) in 2014.³¹ Thus, the costs related to the use of private capacity through competitive tenders has increased with approximately 63 per cent over the last three years. However, the proportion of private capacity through tenders in specialised healthcare is relatively low (3.4 per cent in 2014 and 4.4 per cent in 2017).³²

3.3.4. Private supply through the Approval scheme

39. In 2015, a publicly funded scheme called Approval Scheme ("Godkjenningsordningen" in Norwegian) was introduced. This scheme made it possible for private providers without long-term agreements or tender contracts with the RHAs to provide hospital services to patients. Procurement through the Approval Scheme is supposed to cover only a minor share of overall procurement from private providers.³³ The majority of procurements from private providers is supposed to come from competitive tenders.

40. The Approval Scheme is available for mental healthcare and interdisciplinary specialised drug treatment, somatic healthcare, and rehabilitation and habilitation.³⁴

41. From 2016 to 2017, payments related to the Approval Scheme increased from NOK 58.4 millions (£ 5.8 millions) to NOK 128.7 millions (£ 12.9 millions).³⁵ Thus, the use of private hospitals through the Approval Scheme has increased over the last three years, but

²⁸ Calculations based on numbers from table 06464: Specialist health services from Statistics Norway <https://www.ssb.no/statbank/table/06464> (2018.10.18)

²⁹ Calculations based on numbers from table 06464: Specialist health services from Statistics Norway <https://www.ssb.no/statbank/table/06464> (2018.10.18)

³⁰ Calculations based on numbers from table 06464: Specialist health services from Statistics Norway <https://www.ssb.no/statbank/table/06464> (2018.10.18). The costs related to the Approval Scheme is withdrawn. The cost related to the Approval Scheme is collected from Norwegian Directory of Health (2018b), page 8.

³¹ Calculations based on numbers from table 06464: Specialist health services from Statistics Norway <https://www.ssb.no/statbank/table/06464> (2018.10.18)

³² Calculations based on numbers from table 06464: Specialist health services from Statistics Norway <https://www.ssb.no/statbank/table/06464> (2018.10.18)

³³ Norwegian Directory of Health (2017a), page 4.

³⁴ Forskrift om private virksomheters spesialisthelsetjenester, § 11.

³⁵ Norwegian Directory of Health (2018b), page 8.

still amounts to a very small fraction of both the total costs of specialised healthcare in Norway (0.1 per cent) and the costs associated with private supply (1.8 per cent).

3.4. Patient choice

42. Since 2001, patients are free to choose hospital for elective treatment (and specialist consultations/diagnostic services). With the introduction of the scheme "Free hospital choice", a patient who is referred to specialised healthcare is given the right to freely choose any hospital where the treatment is offered through the NHS-system, regardless of which RHA the patient belongs to. Patients are also refunded their travel costs. Thus, patients may get treatments in other parts of the country without having to cover increased travel costs. However, in Norway distances between hospitals and patients in some regions are considerable, and patients may have non-monetary costs related to travelling. This may limit patients' choice.

43. In 2015, free hospital choice was extended to the scheme "Free treatment choice". With free treatment choice, patients could to a greater extent choose private suppliers. Thus, free treatment choice implied increased use of private suppliers.³⁶ The aims of introducing free treatment choice were to reduce waiting time, increase patient choice and give public hospitals increased incentives to improve efficiency.³⁷

44. In addition to being a gatekeeper for specialist healthcare, the GPs are an important source of information for patients when considering which hospital to choose. The GPs are also responsible for informing the patient about the free patient choice.³⁸ Furthermore, the government has made initiatives to inform patients. In 2012, it was legalized that the Norwegian Health Directorate should develop and publish a range of quality indicators for all hospitals within the NHS. These are published and updated on the website www.helsenorge.no. On the website here is information on a large number of quality indicators, including information about mortality and waiting times.³⁹ In addition, the patients can get information about different hospitals scores for different quality indicators. This ensures that patients have access to relevant information before making their choice of hospital.

45. Increases in patient mobility may indicate that patients are extensively exercising their right to choose hospital. Ringard et al. (2006) reports a small increase in patient mobility after the reform in 2001. In 2000 8.2 per cent used a public hospital outside their local area and in 2003 this number was 9.8 per cent. The use of private for-profit hospitals increased in the same time period from 1.5 to 5.5 per cent.

46. As discussed earlier the patients may have a preference for nearby hospitals. Bjorvatn and Ma (2011) find that patients tends to choose nearby hospitals. Thus, travel time appears to be a cost disadvantage that affects patients' choice. Further, Bjorvatn and Ma (2011) find that a patient is more willing to choose another hospital if the waiting times

³⁶ Norwegian Directory of Health (2017a), page 4.

³⁷ Norwegian Directory of Health (2017a), page 4.

³⁸ Forskrift om fastlegeordning i kommunene, § 24

³⁹ Norwegian Directory of Health <https://helsedirektoratet.no/statistikk-og-analyse/kvalitetsindikatorer/eksisterende-nasjonale-kvalitetsindikatorer#somatisk-helse> (2018.10.18)

are relatively long at the local hospital. This indicates that patients make choices based on their perceptions regarding different hospitals offers, and that waiting time is one of the factors patients consider.

47. Christensen and Hem (2004) find that 50 per cent of the patients who got treatment in another hospital than their local one, made the choice of hospital themselves. A survey of the population's knowledge of the free treatment choice scheme in 2017 showed that 84 per cent of the Norwegian population was aware of the possibility of free patient choice. In a patient experience survey in 2015, 33 per cent of the patients reported that they had actively chosen the hospital where they got treatment.⁴⁰

48. Thus, patient choice may facilitate competition for patients between hospitals. Furthermore, it appears that many patients make an active choice regarding which hospitals to get treatment. The government has, through the publications of quality indicators, ensured that patients have access to relevant information, which may empower the patient to choose.

3.5. Financial system

3.5.1. Funding of the RHAs

49. Specialised healthcare is financed by government grants towards the RHAs. The funding consists of a block grant and activity based funding schemes (based on diagnosis-related groups ("DRGs")).⁴¹ The block grant is determined by, inter alia, the number of residents in the health region, the age composition in the region, different socioeconomic criteria and cost data. There is not a link between activity and income for the block grant.⁴²

50. About half of the total funding comes from the block grant and half comes from activity based DRG funding.⁴³ In addition, there is a quality based financing scheme where a relatively small proportion (approx. 0.4 per cent of total costs of specialised healthcare in Norway⁴⁴) of the RHAs funding is made dependent on the achievement of goals of specified performance targets.⁴⁵

3.5.2. Funding of the hospitals

51. Both public hospitals and non-profit hospitals with long-term agreements with the RHAs are funded through block grants and activity based DRG-funding. Thus, prices for specialised healthcare services offered by these hospitals are regulated and cannot be set by the individual hospitals.

⁴⁰ Norwegian Directory of Health (2017a), page 17-18.

⁴¹ Norwegian Directory of Health (2017b), page 8.

⁴² Norwegian Directory of Health (2015), page 8.

⁴³ Norwegian Directory of Health (2015), page 7.

⁴⁴ According to Norwegian Directory of Health (2018a), page 8, the cost related to quality based funding were NOK 539,3 million (£ 53,9 millions) in 2018.

⁴⁵ Norwegian Directory of Health (2017b), page 8.

52. For competitive tenders, the RHAs have often used first-price sealed-bid auctions. For each treatment which is part of the tender competition, the private hospitals offer a unit price. The RHAs choose the winner(s) based on the price offered and different factors of quality.⁴⁶ The unit prices are therefore set by the private hospitals in the tender.

53. In addition, the state pays for services supplied through the Approval Scheme. Prices through the Approval Scheme are set as unit prices for treatments. The payment system is thus closer to DRG-pricing than to fee-for-service.⁴⁷

3.6. Provider competition

54. Extensive use of regulated prices limits the scope for price competition within specialised healthcare in Norway. Thus, also for specialised healthcare, competition is primarily on non-price variables such as quality. The exception is procurement through competitive tenders where price is an important parameter.

55. Patient choice and activity based DRG-funding facilitate competition on quality among specialised healthcare providers. By providing high quality treatment or shorter waiting times, hospitals may attract more patients and thereby increase their revenues. Thus, both private and public hospitals have an incentive to attract patients in order to increase their revenues.

56. However, the DRG-price, which is the national average cost of a given medical treatment, is capped at 50 per cent (recall that half of the hospitals' funding comes from a block grant and half from activity based DRG-funding, see section 3.5.1). Further, the block grant is paid unconditional on the actual number of patients treated and gives incentives for the hospitals to reduce costs. An increase in the number of patients may therefore lead to a negative profit margin when the hospital treats more patients. This may give the hospitals an incentive to avoid patients rather than attract them, and thus the effect on quality and waiting times is ambiguous (see Brekke and Straume 2017; Brekke et. al 2008, 2011).

57. The quality based financing scheme of the RHAs' funding that is made dependent on the achievement of goals of specified performance targets may also give the hospitals an incentive to improve quality. However, only 0.4 per cent of total costs of specialised healthcare in Norway is linked to the quality based financing scheme.

58. Furthermore, patient choice will not increase competition unless patients are actively exercising their right to choose. Patient choice is well known among the population, and a fair share of hospital patients reports that they have actively chosen the hospital where they got treatment (see section 3.4). The GPs have an important role in the choice the patient make, both as a gatekeeper and as a source of relevant information. Further, information about quality indicators of the hospitals within the NHS-system is available online and several studies indicates that patients exercise their right to choose (see section 3.4). However, the geographical structure of Norway with large distances between hospitals and patients may limit the patients' choice. Even though patients are refunded their travel costs (see section 3.4), patients may have preferences for travelling short

⁴⁶ The Norwegian Competition Authority (2015). *V2015-31 – Aleris Helse AS – Teres Medical Group AS – konkurranse-loven § 16 jf. § 20 – inngrep mot foretakssammenslutning – vilkår*, paragraph 175.

⁴⁷ The Norwegian Health Economics Administration (Helfo) <https://helfo.no/helsektor/fritt-behandlingsvalg/tjenester-og-priser-fritt-behandlingsvalg> (2018.10.18)

distances as increased travel time may also have non-monetary costs for the patients. Thus, large distances and few hospitals may be a concern in parts of the country. In addition, there might be capacity constraints (prolonged waiting times) at the hospitals that limit the patients' choice.

59. The existing empirical literature on the effect of patient choice and activity based DRG-funding on competition in Norway is scant. Although there are some indications of decreases in waiting times and increases in quality and efficiency, these correlations need to be interpreted with caution.

60. Ringard and Hagen (2011) find that waiting times within specialised healthcare dropped markedly after 2001. Furthermore, the authors show that the waiting times were shortest for patients who had chosen non-local hospitals. This indicates that the reduction in waiting times may be driven by increased patient mobility (rather than better capacity utilization). Andersen et al. (2006) find that a higher number of hospitals in a market leads to lower waiting times. Thus, their study, on the other hand, supports a hypothesis that increased hospital competition may have reduced waiting times.

61. Brekke and Straume (2017) reviews the existing literature, and conclude that it is not clear whether patient choice just facilitates a better allocation of patients across hospitals or whether the reduction in waiting times also occurred directly because of increased hospital competition. They also point out that none of the reforms to specialised healthcare were introduced in a way that allows for a quasi-experimental set-up, which makes it hard to obtain causal effects of the reforms.

62. A more recent study by Brekke et. al (2018a) analyses the patient choice reform in Norway and exploit geographical variation in the scope of competition to study the effects. They find that hospitals in more competitive areas have a sharper reduction in acute myocardial infarction mortality, readmissions, and length of stay than hospitals in less competitive areas. Their findings indicate that competition improves health outcomes and hospital cost efficiency.

63. Although there is potential for competition on quality within specialised healthcare in Norway, the empirical evidence is limited and it is uncertain whether the hospitals have been given the necessary autonomy and incentive to compete for patients. One reason for this could be that there is not sufficiently strong incentives for competition. The partial DRG-funding combined with a block grant that is *not* linked to the number of patients could for instance be counterproductive to competition. Other explanations could be the geographical structure of Norway with large distances between hospitals and patient and capacity constraints that limit patients' choice, or perhaps that existing positive effects on competition have thus far not been successfully identified empirically.

64. For fields within specialised healthcare that are open to competitive tenders, there is scope for price competition. Assuming that the hospitals competing for contracts have a preference for winning, they will have an incentive to reduce costs and to reveal their true costs to the purchaser in the bidding process. Thus, competitive tendering is likely to lead to lower prices.

65. To the best of our knowledge, there is only one study on the effect of competitive tendering on prices in Norway. Hagen et. al (2017) analyse the effect of introducing competitive tendering on the prices paid by the RHAs to private for-profit hospitals for day surgery in Norway in the years 2002-2011. They find that competitive tendering decreased the prices to private for-profit hospitals by around 14 per cent. Furthermore, they find that prices in private for-profit hospitals were on average 26 percentage points lower than in

public hospitals. The authors speculate that the price difference between private for-profit hospitals and public hospitals may be explained by the for-profit hospitals' lack of acute services, less severe patient population, reduced teaching responsibilities and ability to streamline production as well as other factors.

66. Reduced prices imply reduced costs for the RHAs and potentially a corresponding increase in supply of services. However, if competitive tendering reduces quality or introduces selection issues (patient selection or physicians' labour supply selection) this may be causes for concern.

67. Holom and Hagen (2017) study quality of care, measured as unplanned acute hospital readmissions, for certain procedures among patients treated in private for-profit hospitals, private non-profit hospitals and public hospitals in Norway. They find that quality differences between hospital types were small. Furthermore, Johannessen and Hagen (2014) study whether physicians' labour supply within private hospitals crowds out physicians' labour supply within public hospitals in Norway. Analysing a subsample of physicians with dual practice, a combination of public and private practice, they find that engagement in dual practice may increase total labour supply. However, within some medical specialities, dual practice leads to reduced labour supply in public hospitals. Holom et al. (2018) study patients' equal access/selection to private for-profit hospitals and non-profit hospitals in Norway. The conclusion the authors draw from studying four procedures is that patients at the lowest education and income levels to a lesser extent get treated at private for-profit hospitals. However, the authors caution that further investigations are needed to probe casual mechanisms and to generalize the findings across more procedures.

68. More studies are needed to draw solid conclusions regarding the effect of competitive tenders on all aspects of competition within specialised healthcare in Norway. However, if prices are reduced without compromising on quality or introducing selection issues, increased use of competitive tendering could potentially lower government spending on specialised healthcare. Alternatively, the government could purchase more health services for the same amount. Despite an increase in the use of competitive tendering in Norway in recent years, competitive tenders make up a very small fraction of total costs of specialised healthcare in Norway.

References

- Andersen, C., Brekke, K.R., Kjerstad, E., Kristiansen, F., Straume, O.R., Sunnevåg, K.J., 2006. Konkurransen i spesialisthelsetjenesten? SNF Rapport 25/2006.
- Bjorvatn, A, Ma, A., 2011. *Patient mobility and public hospital waiting time*, in "Four essays on health care reforms in Norway", PhD Dissertation, University of Bergen, 2011.
- Brekke, K.R., Canta, C., Holmås, T.H., Siciliani L., Straume O.R., 2018a. Hospital Competition in the National Health Service: Evidence from a Patient Choice Reform. Konkurransetilsynet Rapport 7/2018.
- Brekke, K.R., Holmås, T.H., Monstad, K., Straume, O.R., 2018b. How does the type of remuneration affect physician behaviour? Fixed salary versus fee-for-service. SNF Working Paper No 03/18.
- Brekke, K.R., Holmås, T.H., Monstad, K., Straume, O.R., 2017a. Do treatment decisions depend on physicians' financial incentives? *Journal of Public Economics*, 155: 74-92.
- Brekke, K.R., Holmås, T.H., Monstad, K., Straume, O.R., 2017b. Competition and Physician Behaviour: Does the Competitive Environment Affect the Propensity to Issue Sickness Certificates? CESifo Working Paper Series No. 6672.
- Brekke, K.R., Siciliani, L., Straume, O.R., 2008. Competition and waiting times in hospital markets. *Journal of Public Economics*, 92: 1607-1628.
- Brekke, K.R., Siciliani, L., Straume, O.R., 2011. Hospital competition and quality with regulated prices. *Scandinavian Journal of Economics*, 113: 444-469.
- Brekke, K., Straume, O.R., 2017. Competition policy for health care provision in Norway, *Health Policy*, 121: 134-140.
- Christensen, Ø, Hem, K.-G., 2004. *Fritt sykehusvalg i Norge*. SINTEF Rapport A6256, Sintef Helse.
- Forskrift om private virksomheters spesialisthelsetjenester, 2015. Forskrift om private virksomheters adgang til å yte spesialisthelsetjenester mot betaling fra staten (FOR-2015-10-29-1232). Sourced from <https://lovdata.no/dokument/LTI/forskrift/2015-10-29-1232>
- Forskrift om fastlegeordning i kommunene, 2018. Forskrift om fastlegeordning i kommunene (FOR-2018-03-02-316). Sourced from https://lovdata.no/dokument/SF/forskrift/2012-08-29-842/KAPITTEL_4#§22, § 24
- Hagen, T. P., Holom, G. H., Ameyu, K. N., 2017. Outsourcing day surgery to private for-profit hospitals: the price effects of competitive tendering. *Health Economics, Policy and Law*, 13(1): 50-67.
- Holom, G.H., Hagen, T. P., 2017. Quality differences between private for-profit, private non-profit and public hospitals in Norway: a retrospective national register-based study of acute readmission rates following total hip and knee arthroplasties. *BMJ Open*, 7(8).
- Holom, G.H., Alexandersen, N., Goldhaber-Fieber, J.D., Hagen, T.P., 2018. Which patients receive surgery in for-profit and non-profit hospitals in a universal health system? An explorative register-based study in Norway. *BMJ Open*, 8(6).
- Iversen, T., Ma, A., 2011. Market conditions and general practitioners' referrals. *International Journal of Health Care Finance and Economics*, 11: 246-265.
- Johannessen, K.-A., Hagen, T. P., 2014. Physicians' engagement in dual practices and the effects on labor supply in public hospitals: Results from a register -based study. *BMC Health Services Research* 2014, 14: 299.

- Norwegian Competition Authority, 2015. V2015-31 – Aleris Helse AS – Teres Medical Group AS – konkurranseloven § 16 jf. § 20 – inngrep mot foretakssammenslutning – vilkår
- Markussen, S., Røed, K., 2017. The market for paid sick leave. *Journal of Health Economics*, 55: 244-261.
- Norwegian Directorate of Health, 2018a. *Kvalitetsbasert finansiering 2018* (IS-2688). Sourced from www.helsedirektoratet.no
- Norwegian Directorate of Health, 2018b. *Status for Fritt behandlingsvalg* (IS-2740). Sourced from www.helsedirektoratet.no
- Norwegian Directorate of Health, 2017a. *Status for Fritt behandlingsvalg* (IS-2681). Sourced from www.helsedirektoratet.no
- Norwegian Directorate of Health, 2017b. *Finansieringsordningene i spesialisthelsetjenesten – Langsiktige utviklingsbehov* (Saksreferanse: 17/4033-3). Sourced from www.helsedirektoratet.no
- Norwegian Directorate of Health, 2015. *En gjennomgang av finansieringsordningene i spesialisthelsetjenesten*. Sourced from www.helsedirektoratet.no
- NOU 2016:25. *Organisering og styring av spesialisthelsetjenesten*. Sourced from www.regjeringen.no/
- OECD, 2017. *Health at a Glance 2017: OECD Indicators*, OECD Publishing, Paris.
http://dx.doi.org/10.1787/health_glance-2017-en
- Ringard, Å., Hagen, T.P., 2011. Are waiting times for hospital admissions affected by patients' choices and mobility? *BMC Health Services Research* 2011, 11:170.
- Ringard, Å., Hagen, T.P., Rico, A., 2006. *Introducing patient choice of hospital in National Health Systems – A comparison of the UK and Norway*. Working Paper 2006:2, HORN – Health Organization Research Norway.
- Ringard Å., Sagan, A., Sperre Saunes, I., Lindahl, AK., 2013. Norway: Health system review. *Health Systems in Transition*, 15(8): 1–162.
- Sandvik, H., 2006. *Evaluering av fastlegereformen 2001 – 2005. Sammenfatning og analyse av evaluerings delprosjekter (Evaluation of the Regular GP Scheme 2001 – 2005)*. Oslo: Norges forskningsråd, 2006.