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Accessibility, Transparency and Public Choice

A study of the free choice policy within the Norwegian specialized health care system

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Abstract

This thesis presents a study of the free choice policy within the Norwegian specialized health care system, structured around the values of accessibility, transparency, and public choice, derived from classic theories of democracy as well as major international reform movements.

Using a theory of trust in a transformative perspective, the study examines how the values of accessibility, transparency, and public choice, have been translated into the Norwegian reform context, and the different levels of the specialized health care system in Norway. Furthermore, the study examines how the recent changes within the Norwegian health care system have affected and thus enabled patients to make use of their right to choose hospital.

The thesis discusses the origin, the content, and the outcome of recent Norwegian health care reforms, by depicting a timeline through international influence from paradigmatic changes within the field of medicine, international health care reform movements, and implementation within the Norwegian context at the political level, the ministerial level, and the hospital level.

From an instrumental point of view, it seems clear that institutions promoting accessibility, transparency and public choice, are installed within the reformed Norwegian specialized health care sector. Nevertheless, it seems similarly clear that institutional and cultural elements are reducing the optimal outcome that otherwise could have been expected. From a perspective of trust, the current implementations of these institutions do not fully enable patients to make use of their right of choice. This thesis indicates that the way in which these institutions are installed do not promote trust, but rather loyalty in terms of faith and confidence, which in the long run might produce a sentiment of political poverty.
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Introduction

Since 1999, the Norwegian specialized health care sector has been faced with a new reality imposed by several reform initiatives, which inspired by international trends, have aimed at reshaping the power structure of the health care system in an effort to enhance the effectiveness, and thereby health care outcomes for patients and citizens in general. This thesis is a study of the free choice policy within the Norwegian specialized health care system.

Background

The document which founded the base for these recent reforms, aptly labelled “The Patient First” (NOU 1997:2), constituted a shift in Norwegian health care policy. A shift from institutionalized clientism to a focus on customer relations. This shift is in line with both Evidence-based medicine and Patient centred medicine, two distinct paradigms which have entered the international arena in the past three decades (Hope 1996:1), and also inline with the New Public Management movement (Lian 2003: 31-32; Lagreid, et al. 2003: 7), which has gained increased influence within the Norwegian public sector in recent years (Christensen & Lagreid 2003c: 8).

One of the main aspirations of these recent reforms has been to enhance the level of trust patients, and citizens in general, have in the health care system, by introducing patients’ rights. The initial paragraph of the Patient Rights Act states that:

“The objective of this Act is to contribute to ensuring the population equal access to health care of good quality by granting patients rights in their relations with the health service.

The provisions of this Act shall contribute to the promotion of a relationship based on trust between the patient and the health service while having respect for the individual patient’s life, integrity and human worth” (Act of July 2nd 1999 no. 63 § 1-1).

Nevertheless, these recent reforms also includes elements that to a certain extent are in contradiction to the predominant element of the new patients’ rights, that is to say the patients’ right to choose hospital1 (Østergren 2003:1-2). The tension between the different reform elements is an interesting phenomenon and dilemma, as these reforms represent a three-fold redistribution of power within the health care system. That is to say, empowerment of patients through the introduction of patient rights, empowerment of hospitals trough increased autonomy and economical responsibility, and finally, empowerment of the central government through centralized and increased political control as regards to economic aspects of the health care system, and the evolvement of
the health care system and the health care policy in general (Lægreid, et al. 2003: 7; Mathiesen 2002: 9-13). The tension between the different reform elements is intentional (Ot.prp.nr.66 2000-2001:129), and can be viewed as a power-balancing mechanism between the three main stakeholders within the new power structure of the Norwegian health care system; the patient, the hospital, and the central government.

“The health policies ambition, of equal access to vital health care services, necessitates strong governmental control of the public health care sector. Although the challenge is to find a balance, which also takes into consideration, the enterprises’ need for autonomy, as well as enhanced user participation through the patients’ free choice of hospital and other patients’ rights” (Ot.prp.nr.66 2000-2001 § 2.1.3) 2.

Prior studies of patients’ choice

Although the Norwegian health care reforms described in this thesis have not been in force for more than a few years, scholars have already published critical reviews focusing on the implementation of different reform elements in relation to patients’ choices. That is to say that they have challenged the reality of the patients’ right of choice in relation to the degree of freedom, the accessibility of relevant information, even the very existence of relevant information. Similar concerns have also been pointed out by scholars in relation to health care reforms introducing patients’ choice in Denmark and Sweden.

Scandinavian public health care systems have historically been described as highly uniformed, as the different national health care systems have been based on regional democratic authority maintained through county governance (Vrangbæk & Østergren 2004). Moreover, the Nordic Council of Ministers has coordinated national reform activities in relation to the different health care systems within the region (Kristensen 2003: 3). Although there are major differences between the different health care systems in the Nordic region (ibid.), studies reviewing health care reform implementations within these countries are worthy of note within the context of this thesis.

Carlsen & Norheim’s interesting studies (2003a; 2003b) of the Norwegian Regular General Practitioner Scheme, investigated among other things, the gatekeeping function of the RGP in relation to the patients’ choice. Based on a series of group interviews with RGP’s and other medical professionals, they state in their concluding remarks that, although the gatekeeping function of the GP’s has been weakened due to the introduction of the RGP scheme (Carlsen & Norheim 2003a: 21), it is an interesting paradox that the ambitions of increasing the patients’ autonomy might be incompatible with the gatekeeping function bestowed upon the general practitioners (Carlsen & Norheim 2003b: 19). In Sweden, studies have shown that few general practitioners, which are the key mediators between hospitals and patients in relation to patients’ choice within the Swedish system, on a regular basis helps their patients in their choice between different health care providers. Moreover, the GP’s have shown little knowledge about local regulations, as well as a relaxed attitude towards the inconsistency between health care policies and their own practice as regards to the patients’ right of choice. The
physicians attitude and their failing knowledge are believed to be key elements explaining why many Swedish patients still are unaware of their right of choice (Spångberg 2003).

Another interesting study is Elin Aasmundrud Mathiesen’s theoretical analysis of competition within the Norwegian hospital sector (2002). In her analysis, Mathiesen points out that although there are substantial data available as regards to differences in wait time at different hospitals, data concerning waiting lists and wait time are not the source of information preferred by patients in the process of choice. Lacking relevant information, patients seem to prefer knowledge about the competence of the medical staff at different hospitals, advice from GP’s or friends, and the distance between their homes and the respective hospitals, as their prime sources of information. Furthermore, Mathiesen warns that competition, however imperfect, and patients’ choice, combined with lack of relevant information describing the quality of different hospitals, might lead to a situation where the quality of health care services in general diminishes due to an overemphasized focus on wait time (Mathiesen 2002: 77). Mathiesen’s warning may very well have been in place, as statistics have shown that whilst the number of patients treated in the first four months of 2004 has risen by 7 per cent (NPR 2004a), the number of patients seeking recompense due to medical errors and malpractice has risen by 33 per cent (NPE 2004), compared to the corresponding period of 2003.

Competition within the Danish health care system has also been described as imperfect, mainly due to lacking financial incentives and the reluctant attitudes displayed by the counties (Vrangbæk & Bech 2004: 35). Swedish authorities have shown a similar reluctance as regards to competition within the health care system, as competition and patients’ choice tends to increase the level of public disbursements in relation to health care (Kaarboe & Østergren 2001).

The Foundation for Health Services Research (Heltef), which is responsible for the registration and analysis of data related to Norwegian patient satisfaction surveys, expresses a similar concern. In their opinion the information system used by the National Information Service for the Patients’ Right of Choice, is deliberately designed to make it hard for patients and others to compare Norwegian hospitals in relation to the quality of the services they provide. As the CEO at Heltef, Pål Guldbrandsen, puts it:

“If you ask patients if they are satisfied with the hospital care, most patients’ answer that they are.

[…]

Moreover, when you then code these answers according to a scale ranging from 0 to 100, all hospitals will unjustly seem to be doing very well” (NRK 2004b).

Although, Heltef ingressively had recommended a methodology based on assigning grades ranging from 1 to 5 for each hospital, the authorities waived such a system as it might be demotivating for hospitals scoring low (Ibid.). Nevertheless, problems in relation to patient satisfaction surveys are well known in Norway. In 1992, Thor Øivind Jensen et al. published their experiences after 10 years of patient satisfaction surveys in
Norway. They had found that Norwegian patients, however badly treated, usually answered that they were satisfied. They found that there were several reasons for this, such as dependency, gullibility due to lack of experiences, as well as lack of information in general (Jensen, et al. 1992: 12-14).

Although there are several studies focusing on patients’ right of choice in Scandinavia, these studies have all focused on a small subset of factors influencing implementations of health care reforms in relation to patients’ choice, such as activity-based financing, general practitioners, or policy. This study will make use of a broader set of data from various levels of the Norwegian specialized health care sector, as well as data from the international field of public health care reform movements.

The scope of the thesis

This study is a part of the transparency program within “Autonomy, Transparency and Management; Reform dynamics in health care: a comparative project”, founded by the Norwegian Research Council, at Stein Rokkan Centre for Social Studies. The focal point of attention of the transparency programs is: “how the movements for patients’ rights and political control over health care services play together and contradict each other” (Bleiklie, et al. 2002: 8). In line with this, the focus of this thesis is put upon the free choice policy within the Norwegian specialized health care system with a special focus on the reality of the patients’ right to choose hospital, as this is the predominant element intended to empower patients by subjecting the Norwegian hospital sector to the power of the peoples’ free and critical choice.

How are reform ideals and initiatives translated into practice? Are the slogan “The Patient First”, and the focus on building trust, just rhetorical slogans and symbols (Christensen & Lægreid 2003a: 4-5), used when politicians and health care executives sweet-talk the public? Some might ask if trust is such a valuable aspect and analytical perspective in relation to patients’ choice and public health care reforms, and they may rightfully be doing so. Analytical problems as regards to the concept of trust will be discussed later on in chapter 3 in relation to the elaboration of the theoretical concept applied in this thesis. However, according to the OECD, trust is a condition for reform (OECD 2000a: 25). Moreover, the efforts of building trust is in part dependent on the possibilities of choice (OECD 2000a: 30) ‘Trust is important for the effect of public health care reforms, important for the caring professions’ ability to perform, as well as important for the level and quality of health care outcomes. (Gilbert 1998: 1015; Goold 2002: 79; Hupcey, et al. 2001: 283; Mechanic 1998: 299; Rhodes 2001: 502). As Hall et al. points out:

“Preserving, enhancing, and justifying trust are the fundamental goals of much of medical ethics and are prominent objectives in health care law and public policy” (Hall, et al. 2001: 613).
Research questions

Within the context of this study the practical implementation of central elements of The Patients’ Rights Act are of predominant interest. Nevertheless, other reform initiatives are also of a significant nature. The two research questions in this thesis are interrelated as far as the analysis in relation to the second question is dependent upon the analysis in relation to the first. These research questions are:

**Q1.** How have the values of accessibility, transparency, and public choice been translated into the Norwegian reform context, and the different levels of the specialized health care system in Norway?

**Q2.** Do the recent changes within the Norwegian health care system enable patients to make use of their right to choose hospital?

In the search for feasible answers to the two research questions, this study will make use of a theory of trust in a transformative perspective. The theory of trust and the transformative perspective will be elaborated in the third chapter of this thesis.

Empirical reality

The empirical reality of the specialized health care sector in Norwegian, which is the case in question in this study, is characterized by complexity. The use of the terms health care and health service within the legislation in relation to patients’ rights, encompasses a wide range of different health care services:

“For the purpose of this Act, the following terms shall mean:

[...]

c: health care: acts which have a preventive, diagnostic, therapeutic and health preserving effects carried out by health personnel for the purposes of rehabilitation care and nursing

d: the health service: the primary health service, the specialist health service and the dental health service” (Act of July 2nd 1999 no. 63 § 1-3).

These definitions are within the limitations of this study far too complex, both in a reasonable and economical sense. Therefore, this study will focus on elective health care within the specialized health care service; that is to say, treatment eligible for patient choice and provided by somatic hospitals. In the following the expressions health care, health service, health sector and public health, either in singular or plural sense, refer to the specialized health service setting.

Nevertheless, some of the empirical complexity is still present. The Norwegian health care system can be viewed as divided into three different levels, each having different responsibilities in relation to the implementation of these reforms. Moreover, all levels have the power to induce changes to the system more or less independent of activities at
other levels. The levels are; the political level, which encompasses the Norwegian parliament and the Norwegian Council of State, the ministerial level, which encompasses the Ministry of Health as well as other ministerial health agencies with nationwide responsibilities in relation to control and support functions within the specialized health care sector, and finally, the hospital level, which encompasses the Norwegian hospital sector, including regional and local health enterprises.

Due to the high number of institutional actors within the Norwegian specialized health care sector, this study will depict a cross-section of the system. In addition to institutional actors at the political and ministerial level, the empirical focus will be put upon three health care providers within one of the five health regions in Norway. These hospitals represents historically the three most common types of hospitals within the Norwegian hospital structure; a university hospital, which also is one of the largest local health enterprises in Norway, a private diaconal hospital with a long history of service in the public health care sector, and finally, a formerly independent community hospital, which now is organized as a department within a local health enterprise.

The structure of the thesis

The next chapter of this thesis focuses on questions of methodology as regards to the choices that have been made, and problems that have emerged during the research process. In chapter 3, the theoretical framework applied in this study will be elucidated, whilst chapter 4 through chapter 8, presents the case studies. The case studies are presented in an analytic manner in which the different elements are analysed and discussed as they are introduced.

Chapter 4 discusses two major theoretical paradigms within the field of medicine, while chapter 5 discusses major international health care reform movements, which in a significant way have influenced the Norwegian health care reform process. In chapter 6, four central reform initiatives, instigated by the Norwegian parliament and the Norwegian Council of State, will be described. Chapter 7, and chapter 8, describes how these reforms have been implemented, respectively by the Ministry of Health in chapter 7, and by different actors within the Norwegian hospital sector in chapter 8.

By summing up the empirical findings presented in chapter 4 to 8, the two chapters following thereafter aims at answering the two research questions in this thesis. In chapter 9, the first research question will be discussed, while the second research question will be the subject of chapter 10.

The finale chapter of this thesis presents concluding remarks and reflections of the limitations of the study, before the main conclusions are presented.
Some reflections of methodology

This chapter describes the methodology applied in this thesis. The following represents a retrospective view of the process through which this thesis has been produced, the choices that have been made, and the problems that have emerged during the research process.

A case study

The study described in this thesis is a case study in so far as the study concerns the free choice policy within the Norwegian specialized health care sector as a present-day phenomenon that cannot easily be delineated from the context of the Norwegian specialized health care sector itself (cf. Yin 1981: 59). The case study label does not prescribe a particular type of data or evidence, nor a particular type of methodology applied in such a study. Case studies can be based on either qualitative or quantitative data, or a combination of these, collected by the means of different data collections methods (Yin 1981: 58-59). Moreover, these data can be analysed by means of either qualitative or quantitative methods, or a mixture of these (Sale, et al. 2002: 44). That is to say, qualitative data can be quantified and analysed by means of advanced statistical methods, whilst quantitative data very well might be analysed in a narrative sense (Sale, et al. 2002: 49-50). Furthermore, the case study label does not prescribe a particular research strategy in terms of neither reductionism nor holism (Verschuren 2001: 389-390). Even more, a case study is not bounded by a particular logic or way of reasoning, as far as it can be based on a deductive or an inductive approach, as well as a combination of these; normally labelled retroduction (Östergren & Müllern 1996: 10-11).

The choice of methodology

Nevertheless, although it might seem like the case study researcher freely can choose between the offerings from this smorgasbord of methodology, it is not so. Although the choice might be either or both, the perhaps most fundamental choice that most researchers will have to make is the choice between a qualitative and a quantitative approach. Nonetheless, this choice might not be as difficult as it seem at first glance, as there is a fundamental difference between these two approaches. Whereas the quantitative approach is based upon the belief that there in an empirical sense can be only one true objective reality that is independent of the researchers actions, perception and values, and that any empirical phenomenon can be divided into the different sub elements of which it is constituted, the qualitative approach sees reality as a social construct which only comes into existence through human cognition. In other words,
although there might be an true objective reality, the perception of the reality is influenced by the observers own framework of reference, in so far as “perception is based on a multitude of parallel and hierarchically organized [cognitive] processes” (Medin & Ross 1992: 109). This means that what the observer actually sees in an objective sense might be consistent with an infinitive number of different interpretations. Nevertheless, in most cases this ambiguity escapes the observer’s attention, as his observation is paired with his image of the world and the assumptions he has drawn from it, which in sum leads to a more unambiguous interpretation (Medin & Ross 1992: 109-110). A fine example here would be Charles Perrow’s discussion of the “normal” nuclear accident, where some might perceive the cause of an accident as a closed valve that should not have been closed (Perrow 1999: 19), whilst the system analyst, in this case Perrow himself, perceives the cause to be a complex system failure (Perrow 1999: 60-61).

Therefore, whereas the optimum within quantitative research is a value-free framework in which casual analysis can revile the true objective reality, qualitative research can be described as a process in which reality and researcher influence each other (Sale, et al. 2002: 44-46). As regards to the researchers role, the distinction drawn here is not unlike Immanuel Kant’s distinction between pure and practical reason in so far as pure reason concerns the objective in terms of perfection, and the practical is subjective and based on the civil constitution, an individual’s education, as well as hers/his moral and physical feelings (Kant 1898: 105-130).

Consequently, the researcher’s choice of methodology is not so much a personal choice, although unquestionably influenced by the researcher’s standing as regards to the qualitative-quantitative debate. The choice of methodology will instead have to be based on the phenomenon in question in the particular study. In relation to the study described in this thesis, the point of departure was theories of trust. Although trust as any other phenomenon from an academic point of view can be defined and specified in numerous ways, most researchers recognize that trust is a subjective and contextually constituted phenomenon that does not independently existent in the pure virginal reality normally labelled nature. Nevertheless, although the subjective and contextual nature of trust doubtlessly will represent a challenge for any researcher, the nature of trust does not eliminate the option of a quantitative approach.

However, trust is not the only phenomenon in question in this thesis. The case in question, the Norwegian free choice policy in relation to specialized health care, is in itself a phenomenon, although a phenomenon that unquestionably is constituted upon other phenomenons such as trust and international reform movements. Moreover, a central assumption made in this study is that the values of accessibility, transparency, and public choice, are central elements in relation to the Norwegian free choice policy, as the implementation of these values will determine the possibilities Norwegian patients have for making free, critical, and informed choices. In other words, the assumption made is that there is no singular causation determining this possibility for choice. Consequently, as conjunctural causations, as opposite to a singular causation, is not within the feasibility of the reductionistic quantitative method, a qualitative approach was chosen for this study. Although a qualitative approach very well might be reductionistic in nature, the
qualitative approach is the only option allowing for a more holistic approach in search of conjunctional causations (Ragin 1989; Sale, et al. 2002; Verschuren 2001).

The initial idea

This thesis focuses on the free choice policy within the Norwegian specialized health care sector. The first research question stated in chapter 1 focuses on the transformative process in which the values of accessibility, transparency, and public choice have been translated into the Norwegian reform context, whilst the second research question investigate how the changes induced by this transformative process have created possibilities for a free and critical choice for Norwegian patients. However, these research questions were not parts of the pre-planned research strategy, nor has the pre-planned strategy survived the test of reality without modifications. The research questions and the strategy have rather been developed in a retroductive manner throughout the process. The study presented in this thesis is the end product of this process.

As mentioned above, the point of departure for this thesis was theories of trust. Fascinated by trust as a phenomenon, although confused by the diversity in which this phenomenon is described and conceptualized in academic literature, I set forth in a deductive manner to investigate the importance of trust for the relationship between citizens and the State within the context of the health care sector. Based upon the assumption that people transfer some of its power to the State when voluntarily entering in to the civil society (cf. Hobbes 1651: 131-132; Locke 1674: 206), and that this transfer of power is based upon an expectation of some favourable future outcome, I believe that trust is the cement upon which the civil society is created; the vehicle providing the legitimacy of the State. In its recommendations for the “Government of the Future”, the OECD formulated the relationship between trust and legitimacy as follows: “When government succeeds in anticipating citizens’ needs, it earns currency in the form of trust. The price of failure is a loss of legitimacy” (OECD 2000a: 24).

From an empirical perspective, the point of departure was the newly instated patients’ rights act, which constituted among other rights the patients’ right to choose hospital. The initial paragraph of this act states that the provision of the act is intended to promote relationships based on trust between patients and the health care service 12. Moreover, in combination with other reform initiatives; the new financial system introducing a partially activity based system of funding, and the hospital reform introducing private corporate hospitals in to the realms of publicly funded health care provision, the patients’ right to chose hospital created a new situation in which competition between different health care providers might occur. Based upon this I assumed that different types of hospitals, due to differences in their ideology and history, would apply different strategies in their attempts to attract patients equipped with the right of choice.
Deduction, induction, or retroduction

When faced with reality I soon realised that my pre-established concept of trust, my assumptions as regards to the specialized health care sector, as well as my initial research questions, combined, did not make much sense. I therefore more than once have been forced to rethink my research strategy in a retroductive manner; applying both deduction and induction until my theoretical concepts, research questions, and selection of data enabled me to describe and analyse the Norwegian free choice policy, and the possibilities for choice, in an intelligible way.

Whereas deduction can be described as an inferential process, in which conclusions about the concrete and particular are drawn from some abstract principles already known or assumed; e.g. the assumptions described above, induction can be described as a process of inference in which some general law or principle is formulated based upon empirical observation. Retroduction represent another way of reasoning opposite neither to deduction nor induction, as it to some degree combines these into one encapsulating process of inference (Östergren & Müllern 1996: 15-16). However, this description does not fully describe the potentiality of retroductive reasoning. According to Claire Selltiz and her colleagues, retroduction is a way of inference in which the researcher tries to find “plausible reasons why some event could have occurred in an attempt to construct an explanation of why the event did occur” (Selltiz, et al. 1976: 32).

Although criticized in relation to natural science, retroduction can be a useful concept for qualitative studies within the field of social science (Östergren & Müllern 1996: 19), as it to some degree resembles what Immanuel Kant has described as practical reasoning (Kant 1898: 105-130). An example of experience that might influence the process of retroductive reasoning can be my own personal experiences as a patient at two of the hospitals in this study, as far as these experiences have influenced my understanding of the world. In social science, the researchers own framework of reference is not necessarily the only complexity causing problems. E.g., when using data collected through interviews or from secondary written sources describing the phenomenon in question, the researcher is faced with what Östergren & Müllern describes as “a two-fold interpretative dilemma” (Östergren & Müllern 1996: 21-22). Firstly, the researcher will have to understand the author’s or the interview subjects’ framework of reference. Secondly, the researcher will consequently have to perform an interpretation of the “others interpretations” (ibid.).

Retroduction as described here is a flexible way of reasoning, both in a positive and negative sense. In a positive sense the flexibility allows for a broad search for plausible reasons in the complexity caused by the characteristic feature of a case study; the problem of delineation between phenomenon and context (Yin 1981: 59), as well as the two-fold interpretative dilemma. Retroductive reasoning allows for the use of the
multiple of theoretical perspectives often required in the quest for a meaningful understanding of the phenomenon in question. However, this flexibility can also be facilitated in an after the fact attempt of rationalization to justify a research project gone wrong (Östergren & Müllern 1996: 22-23).

The scope of the thesis

As mentioned above, early on in the process of the study it became apparent that the initial scope of the study had to be modified, as the empirical reality proved to be somewhat different from assumed. This was not at least true for the theoretical perspective applied in this study, as it has been redrafted more than once during the process.

However, the first problems that occurred concerned Norwegian hospitals. Initially six hospitals were chosen as units of investigation in the study. These hospitals represented two units from each of the three types of hospitals; public, NGO, and corporate hospitals, which at that time seemed to encapsulate the full hospital typology. The idea was that by comparing these hospitals, one of each type within two different health regions, the study would highlight problems shared by the hospitals as well as differences in applied strategies. Nevertheless, the private corporate hospitals that were asked to participate in the study all declined our request. Furthermore, the financial resources available for the study did not allow for the costs of collecting data from two health regions. Moreover, with the exception of two single incidents (cf. Hafstad 2003), none of the Norwegian hospitals seemed to have an active marketing strategy for attracting more patients. To make things even worse, the initial hospital typology proved to be inaccurate. Consequently, the combination of these factors necessitated a new strategy.

The answer to this problem proved to be to broaden the scope of the study so to encompass the Norwegian free choice policy, and the patients’ possibilities for making free and critical choices, from adoption of ideas to translation through legislation and implementations. From a more profound reading of available written sources, and transcriptions of interviews conducted by one of my advisors; Katarina Östergren, I became aware of the importance international reform movements have had for the Norwegian health care reform. Moreover, it seemed clear that legislative activities as well as initiatives made by the Ministry of Health were at least as important for the patients’ choice as activities at the hospital level. Through what can be described as a backward tracing process, the different levels of the Norwegian specialized health care sector were studied, using Lægreid et al.’s (2003) profound article as point of departure. Thereafter, based on information from written sources and informants, the importance that New Public Management, Evidence Based Medicine, and Patient Centred Medicine have had for the development of international reform movements as well as the Norwegian health care reform, was investigated.

Based on the information obtained through this process of investigation, a new assumption could be made; that the values of accessibility, transparency, and public
choice, are central elements in relation to the Norwegian free choice policy, as the implementation of these values might determine the possibilities Norwegian patients have for making free and critical choices. Consequently, this process enabled me to develop new research question encapsulating the knowledge derived from the exploration process and the assumption mentioned here.

Methodology in practise

The exploration process described above, also affected the perception of the empirical reality, as this process enabled the development of a refined hospital typology, as well as a model of the Norwegian specialized health care sector, a model around which the research process could be structured.

A model of the Norwegian specialized health care sector

The Norwegian health care system can be viewed as divided into three different levels (see Figure 1), each having different responsibilities in relation to the implementation of these reforms. Moreover, all levels have the power to induce changes to the system more or less independent of activities at other levels. The levels are; (1) the political level, which encompasses the Norwegian parliament and the Norwegian Council of State, (2) the ministerial level, which encompasses the Ministry of Health as well as other governmental health agencies with nationwide responsibilities in relation to control and support functions within the specialized health care sector, and finally, (3) the hospital level, which encompasses the Norwegian hospital sector, including regional and local health enterprises, as well as private hospitals.

Figure 1 – A model of the Norwegian specialized health care sector

The Norwegian hospital structure and typology

The hospitals within the publicly funded health care sector today represent a wide variety that roughly can be divided into four categories. These are (h1) publicly owned hospitals, (h2) private hospitals owned by NGO’s that prior to the hospital reform were an integral part of the county-based public health care system, (h3) private hospitals directly approved and funded by the parliament, and (h4) private corporate hospitals based purely
on business principles with capital accumulation as their prime target (Iversen 2002: 13). Although this typology encompasses all Norwegian hospitals, it does not take into account the organizational changes that have taken place within the publicly owned part of the hospital sector. As mentioned in chapter four, the Norwegian hospital reform reorganized public hospitals into health enterprises. In this process, some hospitals became masters in terms of corporate headquarters, whereas others lost their former independence. From a perspective of adoption and change, it would be fair to assume that these hospitals not necessarily have adapted to the changes in the same way. It can therefore be useful to specify these hospitals by their status, as respectively (h1-a) health enterprises, and (h1-b) formerly autonomous hospitals. If we apply this typology to Norwegian somatic hospitals, we find that there in total are 94 somatic hospitals in Norway providing health care services eligible for the patients’ choice (see Table 1). A complete list of these hospitals can be found in 0 of this thesis.

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<th>Table 1 – A typology of Norwegian hospitals</th>
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<td>Publicly owned</td>
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Leaving the matter of public hospitals aside for now, there is still the matter of the incorporation of private hospitals into the realms of the publicly governed health care system. Although h2 and h3 hospitals for a long time have been an integral part of the Norwegian health care system, h2 hospitals’ participation was not always formalized through contractual arrangements. Nevertheless, as the governmental whitepaper on the hospital reform stated that formalization and thereby continuance of prior relations between private hospitals (h2) and the county-based health care system were a condition for the state’s takeover of county owned public hospitals in 2002 (Ot.prp.nr.66 2000-2001 § 2.10.3), these relations have now been formalized through contractual arrangements between these hospitals and the regional health authority within their respective regions (HD 2004b: 62-63).

**A cross-section of the Norwegian specialized health care sector**

Due to the high number of institutional actors within the Norwegian specialized health care sector, this study will depict a cross-section of the system. In addition to institutional actors at the political and ministerial level, the empirical focus will be put upon three health care providers within one of the five health regions in Norway.

**The selection of hospitals**

The selection of hospitals does not fully cover the above-defined typology, as far as private h3 and h4 hospitals are not included in this part of the study. Several private corporate hospitals were invited to take part in the study; nevertheless, they all respectfully declined our requests. Although the hospitals examined in this thesis are used merely as examples of how the Norwegian health care reform has affected Norwegian
hospitals, the lack of data from private h3 and h4 hospitals is drawback for the study, as data from such hospitals would have enriched the study.

The three hospitals chosen for closer examination, represents historically the three most common types of hospitals within the Norwegian hospital structure. The hospitals have all been selected based on individual features. These hospitals are:

**Hospital A** a publicly owned (h1-a) university hospital, which is one of the largest local health enterprises in Norway. The hospital was chosen because it offers the broadest range of specialized health care services in Norway.

**Hospital B** a privately owned (h2) diaconal hospital with a long history of service in the public health care sector. The hospital was chosen due to the leading role it plays among diaconal hospitals in Norway, and the initiative it has taken to establish a multilateral forum for diaconal hospitals in Scandinavia.

**Hospital C** a formerly independent publicly owned (h1-b) community hospital; which now is organized as a department within a local health enterprise. The hospital was chosen due to the problems it has experienced in the past in relation to cases of medical errors, and its efforts to regain trust of the local community.

**Classified identities**

Nationwide public sector reforms, such as the Norwegian health care reforms described in this thesis, do not impose changes at a national or institutional level only (Korunka, et al. 2003: 52-56). Such reforms might also impose serious changes on the economical, social, or working life of those employed within the sector. Uncertainty might be the term that most appropriately encompasses these implications for the workforce. The reform process will without doubt produce situations of conflict either on a personal or an institutional level (Bolton 2004: 318; Chandler, et al. 2002: 1060-1063; Rosenberg & Donald 1995), resulting in e.g. discontent expressed by those selected for personal interviews in this study. Such personal interviews might also reveal information that in some circumstances might be held against the informants by their peers and their superiors, or since my informants for the most part are executives within their institutions; by politicians, members of the public press, and by their subordinates. Even if the health care sector involves a large number of employees15 and several hundreds of institutions, these informants will be easily identifiable if the right information is provided. As a researcher I have an ethical obligation to protect the informants in this study against any implications that might influence their way of life in a personal or professional sense (NESH 2001: 12-14). This aspect must be weighed up against the methodological demand for verifiable information (Hellevik 1999: 16; NESH 2001: 13). The purpose of this study has not been to investigate the possibilities for choice and the probabilities for trust in the specific context of the very institutions or individuals that
have been subjects of investigation in the interviews used in this study. Quite the opposite, the purpose of this study has been to examine the possibilities for choice and the probabilities for trust within the health care system in general, by depicting a cross-section of the system. Based on this, I will argue that the informants need for protection have to be taken seriously, even though the methodological demand of verifiable information is not fulfilled when omitting information that might lead to identification of the informants in this study. This might be a major drawback for the reliability of this study.

**Different types of data**

The study described in this thesis is based on a broad set of different types of data from a variety of sources such as documents, statistics, and verbal sources. Whereas data from verbal sources in most cases are primary data, although not pure data if we take the “two-fold interpretative dilemma” into account, data from documents and statistics can be described as either primary or secondary; primary data being original data that have been collected specially with the study in mind, while secondary data are data that have been collected, analysed, and re-presented for another purpose, hence the researchers framework of reference discussed above.

As far as documents and statistics as data sources concerns, the typology needs to be further elaborated. Both documents and statistics come in various types that can be classified by cross-tabulating the following identifiers: primary, secondary, printed, and online internet (online) source. This cross-tabulation produces a typology of four categories, which can be used to classify these data sources (see Table 2).

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<tr>
<td>Online</td>
<td>2</td>
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Printed sources are normally regarded as more stable than those published online, as online sources can be edited or completely removed at any given moment. However, this does not mean that every printed source is valid at any given moment, it rather points out that online sources in relation to the methodological demand for verifiable information (Hellevik 1999: 16; NESH 2001: 13), can represent a problem when it comes to replication of the study in question. Within the context of this thesis, a telling example of this problem would be the web site of the National Information Service for the Patients’ Right of Choice (FSN 2004c), which has changed more than once during the research process. A common solution to this problem is to include the date of collection of online sources in the bibliography. Nevertheless, this solution does not fully solve this problem.
Documents

Documents are the predominant data source used in this study. These documents are of various types and have been collected in various ways. Moreover, each of the empirical chapters in this thesis, chapter 4 to 8, can be characterized by the type of documents used.

The documents used in chapter 4, describing the origin, content, and problems concerning evidence base medicine and patient centred medicine, are with a few exceptions documents of type 3; printed secondary sources. These are mainly articles from different scientific journals, collected using the Medline Database and what best can be described as a “snowball logic”; following the articles’ bibliographies.

Chapter 5, describing international reform movements, is based on data from documents of type 1 and 3. The primary sources used here are multilateral treaties such as the Alma-Ata declaration, “Health For All” (e.g. WHO 1978) and the Ljubljana Charter (e.g. WHO 1996e), while the secondary sources are papers (e.g. Docteur & Oxley 2003; Hurst & Jee-Hughes 2000) and reports (e.g. Liu 2003; WHO 2000d) analysing the effect and implementations of the treaties.

In contrast, the documents used in the description of the legislative side of the Norwegian health care reform in chapter 6, represents all four types of documents, although mainly type 1 in terms of official documents such as whitepapers (e.g. St.meld.nr.50 1993-94), national enquiries (e.g. NOU 1997:2), law proposals (e.g. Ot.prp.nr.66 2000-2001), and passed laws (e.g. Lov av 2. Juli 1999 nr. 63). Examples of other types of documents are: type 2 decrees of the Council of State (e.g. SR 2004), type 3 academic papers (e.g. Lægreid, et al. 2003), and type 4 journalistic articles (e.g. Kubens 2004). In chapter 7, describing the roles of the Ministry of Health, all four types of documents are also used, although more evenly distributed per category.

Whereas documents are the predominant source of data in chapter 4 to 6, documents as sources of data do not play a predominant role in chapter 7, and even less so in chapter 8. Nevertheless, written sources of all four types have been used in the description of the Norwegian hospital sector in chapter 8. Still, most of the documents used in this chapter are classified inline with the discussion above.

Statistics

Quantitative data in form of statistics play an important role in this study, especially in chapter 7 and 8. The predominant type of data used comes from secondary online sources (type 4) such as Statistics Norway, The Norwegian Patient Registry, and The National Information Service for the Patients’ Right of Choice. In addition primary online data (type 2) have been used in chapter 2 (see Table 1), 4 (see Table 6), 8 (see Table 15), and in Appendix II (see Table 21). Of these, Table 6 is special as it is compiled of data of both type 2 and 3.

The quantitative data used in this thesis are analysed using univariate and bivariate analysis. Whereas univariate analysis involves the examination across cases of one variable at a time; which within the context of this study refers to using the distribution or the
central tendency of the values (Hellevik 1999: 209 \& 229f), bivariate analysis involves a cross-tabulation of two variables; which in our context refers to using the absolute or relative distribution of the values (Hellevik 1999: 210 \& 236).

An example of a simple univariate analysis using distribution as measure can be found in Table 21 (see Appendix II) where Norwegian somatic hospitals are listed per type inline with the above-defined typology. Similar examples of bivariate analysis using absolute distribution (see Table 24), or relative distribution (see Table 23), can be found in Appendix IV.

**Verbal sources**

Although interviews are the most common type of verbal sources of data, other verbal sources such as press conferences, television programmes, and speeches can contain valuable data. This study has used data from both a press conference and several interviews.

The press conference in question was held by the former Minister of Health Dagfinn Høybråten, in relation to the inauguration of the renewed National Information Service for the Patient’s Right of Choice on May 8th 2003 at 0930. The press conference was transcribed based on a videotaped version published online by the Ministry of Health (cf. HD 2003c). The transcribed press conference is mainly used as a source in the description of ministry’s role in chapter 7.

In total, eleven semi-structured interviews have been used in this study, of which five have been used in an exploratory manner, whilst the remaining six have been used in both an explanatory and an exploratory way, and quoted in the thesis. The first five have all been conducted by my advisor dr. philos Katarina Østergren, though transcribed by me. Of the remaining six, two have been conducted in cooperation with my advisor, whilst four, of which one was a follow-up, have been conducted solely by me. All interviews were conducted in the period March – October 2003. The interviews have been conducted as informal face-to-face interviews at the respondents’ offices, each lasting for approximately 60 to 90 minutes. All respondents held at the time of the interview executive or other administrative positions within one of the three hospitals described in chapter 8.

The interviews have mainly been used in relation to the description of the Norwegian hospital sector in chapter 8. The purpose of these interviews was to gain insight into the experiences of the organizations and people involved in the transformation process at the hospital level, with a special focus on how the values of accessibility, transparency, and public choice have influenced these hospitals’ strategies towards a redefined outer world of competition. Has their environment become populated with patients on the quest for prime services, and competing hospitals on the quest for profitable patients, or is there other factors governing their new reality? The face-to-face interview format was chosen as this format allows for more comprehensive answers than otherwise would have been possible e.g. through surveys. Moreover, this format allowed answers to be followed up in real-time.
As discussed above, the identity of the respondents are classified. Where information obtained from respondents is used, this will be indicated with a reference similar to the following: “(Informant A1)”, where the letters A to C identifies the hospital, and the number separates the informants within one hospital. The codes do not indicate the respondents’ rank.

Reliability and validity

Now that we have an idea of the scope of the thesis, data sources used, and the theoretical framework applied, it is time to consider the reliability and validity of the study. As the question of validity relates to the relevance of the data (Hellevik 1999: 102, 183), and reliability concerns the accuracy of the data and the way in which they are treated (Hellevik 1999: 183), let us start with the question of validity.

Although validity relates to the relevance of the data, in view of the research questions and the scope of a study (Hellevik 1999: 102, 183), there is no uniform view in academic literature of how the question of validity is to be answered (Kvale 1995).

According to Fred N. Kerlinger, “The commonest definition of validity is epitomized by the question: are we measuring what we think we are measuring?” (Kerlinger 1973:457 in Kvale 1995). As this definition seems to imply that only quantifiable data can secure the validity of a study (Kvale 1995), this definition might be somewhat problematic in relation to a qualitative study. Taking this problem into account, Lawrence A. Pervin suggests that validity should rather be defined as “the extent to which our observations indeed reflect the phenomena or variables of interest to us” (Pervin 1984:48 in Kvale 1995).

However, as the definition stated above encapsulates these definitions, the broader definition will be applied; validity relates to the relevance of the data, in view of the research questions and the scope of the study.

The questions then become: are paradigmatic changes within the field of medicine, and international reform movements, relevant in relation to the Norwegian free choice policy? Are the actions taken by the Norwegian parliament, the Council of State, the Ministry of Health, and Norwegian hospitals, relevant in relation to how the values of accessibility, transparency, and public choice are translated into the Norwegian health care context? Are these values and the theory of trust applied, relevant in relation to the patients’ right to make free, critical, and informed choices?

One might argue that a study of the free choice policy within the Norwegian specialized health care sector should focus its’ investigative efforts solely at Norwegian data, such as laws and regulations, and pragmatic measures applied by different actors such as the Ministry of Health, governmental health agencies, and health care providers. However, as health care policies, like other public policies, deal with problems that are not necessarily nation specific, it has become customary for nation states to participate in international forums in an effort to learn from shared experiences, and develop new strategies; so-called international reform movements (cf. Christensen & Lægreid 2003a: 6; Frenk, et al. 2003: 1669). This is also the case when it comes to the Norwegian health
care policy, as Norway has been a member of both WHO\textsuperscript{17} and the OECD\textsuperscript{18} for many years.

Such international reform movements are, however, not merely products of multilateral political deliberations. Alongside international collaborative policy efforts, there have been made significant efforts within the field of medicine to develop measures for improving the quality of provided health care services, e.g. evidence-based medicine. Moreover, these scientific efforts and the international reform movement have mutually influenced each other, in so far as such scientific measures have been endorsed by both international and national reform movements, as well as been vital sources of inspiration driving the development of international reform movements and national health care strategies (NOU 1997:18 § 1.1; 1998:21 § 12.2; Ot.prp.nr.66 2000-2001 § 2.7.2; WHO 1999d: 31; 2000d: xiii-xvi). Base on this, I will argue that both changes within the field of medicine, and international reform efforts, are relevant in relation to the Norwegian health care reform context.

Leaving the question of international influence on the Norwegian context aside, which objects of investigation are relevant in relation to the question of how the values of accessibility, transparency, and public choice have been translated into the Norwegian reform context, and the different levels of the specialized health care system in Norway? The question of how these values are translated, is a question about both process and output, as far as the Norwegian health care system can be viewed as hierarchically organized into different levels where the process at one level produces an output that influence the process at subordinate levels (cf. Scott 1998: 50-51), from the parliament as legislator, to patients as subjects of policy outputs. Following this line of thought, I will argue that activities at all levels of the Norwegian health care system are relevant in relation to the case in question, the Norwegian free choice policy.

Leaving the question of objects of investigation aside, are the values of accessibility, transparency, and public choice, and the concept of trust, relevant in relation to the patients’ right of choice? The answer to this question is to be found in the initial paragraph of the Patient Rights Act (Act of July 2nd 1999 no. 63), which states that:

> “The objective of this Act is to contribute to ensuring the population equal access to health care of good quality by granting patients rights in their relations with the health service” (cf. § 1-1).

The goal stated here is a goal of accessibility in terms of equal access to health care of good quality. Furthermore, this statement proclaims that the goal of accessibility is to be achieved through patients’ rights, of which the most prominent are: accessibility: the right to health care (cf. §§ 2-1 – 2-3), transparency: the right to information (cf. Act of July 2nd 1999 no. 63 § 3-2; Lov av 2. Juli 1999 nr.61 § 3-11), and public choice: the right of choice (cf. Act of July 2nd 1999 no. 63 § 2-4).

Furthermore, the initial paragraph of the Patient Rights Act states that:

> "The provisions of this Act shall contribute to the promotion of a relationship based on trust between the patient and the health service while having respect for the individual patient’s life, integrity and human worth” (cf. § 1-1).
As one of the central objectives of the free choice policy is to promote relationships based on trust, the concept of trust becomes interesting in relation to the free choice policy. Moreover, as will be discussed in the next chapter of this thesis, trust is dependent on the possibility of making free, critical, and informed choices. Based on this, I will argue that the values of accessibility, transparency, and public choice, and the concept of trust, are relevant in relation to a study of the free choice policy within the Norwegian specialized health care sector.

Now that the question of validity has been discussed, we can look at the question of reliability. As mentioned above, reliability the accuracy of the data and the way in which they are treated (Hellevik 1999: 183). The questions of reliability then become: are the documents, the statistics, and the interviews used in this study reliable sources of information? Are these sources used in a way that secures reliable data?

The documents used as sources of data in relation to changes within the field of medicine, international reform movements, and the Norwegian health care reform, are mainly documents published by primary sources, such as medical scientists discussing the problems of medical science, reform recommendations issued by multilateral organizations, and legal documents issued by Norwegian authorities. In addition, secondary sources analysing these objects of investigation have been used to broaden the scope, such as systematic reviews of scientific publications, reports commissioned by multilateral organizations, and reports published by Norwegian authorities. As far as statistical data concerns, are all sources collected, verified, and published by governmental agencies. The verbal sources used in this thesis, are the former Minister of Health, Dagfinn Hoybråten, and executives and other administrative personnel within the three hospitals examined in this study.

To avoid confusion concerning the content of these sources and interpretations of the content, references are used extensively throughout the thesis. Nevertheless, due to the two-fold interpretive dilemma discussed above, the reliability of the re-presentation of social facts obtained from these sources might be flawed when sources are not directly quoted in the text. Consequently, such measures might not fully secure the reliability of the data. A solution to this problem might be to view reliability, and validity, in qualitative research as dependent upon the openness in which the research process is conducted and presented (cf. Chenail 1995), in other words the trustworthiness of e.g. this thesis (cf. Offe 1999: 56).

The studies presented in this thesis do not by far meet the requirements of generalizability. However, the findings of these studies might be transferable as far as transferability can be defined as “the extent to which its findings can be applied in other contexts or with other respondents” (Erlandson, et al. 1993: 31). The questions of reliability and validity will be discussed further in chapter 11.
Theoretical elaborations

In this chapter, the theoretical concept applied in this study will be elaborated; a theory of trust in a transformative perspective. However, since trust as an analytic concept is somewhat disputed, the first part of this chapter presents a thorough discussion of the term of trust in an attempt to conceptualize an analytic model applicable in relation to the scope of this study. The theory of trust discussed here highlights the liberalistic and pluralistic focus of modern reform ideals; the voice and choice of people as a reform tool. Thereafter, in the second part of this chapter, a transformative perspective will be elaborated. This perspective highlights problems of transformation, facing the health care sector in its transition from institutionalized clientism to plural choice, by focusing on instrumental, institutional, and cultural elements influencing the process.

A theory of trust

"In general, trust is a central component of social solidarity and the cement used to produce cohesion within the social networks that compose the structure of society" (Simmel & Wolff 1964: 318)

As these words by Simmel indicate, an attempt to put forward a definition of the term trust will have to take into account contributions from multiple academic disciplines. In this thesis the main contributions come from the fields of economics, political science, psychology, and sociology.

According to Sandro Castaldo (2002), who has examined the literature on trust published in the past three decades, there are 72 different definitions of trust in offering (Castaldo 2002: 1-6). Although, trust has become a widely used term in academic literature, it is nevertheless a poorly understood concept, which often is misused. The reason for this might be that the term of trust when used in academic literature, and when used in common every-day language, not always refers to the same mechanisms.

When the term is used as an analytic term, trust, like any emphasized term, has to be defined accurately so to enable precise distinctions between the term and its different counterparts. In every-day language however, there might not be any significant demand for accuracy. Moreover, if significant, accuracy might be enhanced by extensive knowledge of the communicator's linguistic pattern of behaviour, or a more holistic or longitudinal perception of the context in which the term is used. If we look up the term of trust in the Oxford English Dictionary Online (OED), the inconsistent and variable use of the term becomes apparent, as trust here is associated with a broad range of different terms, such as ability, confidence, duty, dependency, expectations, faith, fidelity, hope, intentions, loyalty, obligation, reliability, responsibility, as well as safety. Moreover, OED associates the term with interpersonal relations, as well as attitudes towards things.
in general (OED 2004c). Nevertheless, the term of trust might be referring to different contextual interpretations when applied in academic studies (Levi 1998a: 77-78), although a definition of the term of trust is not always given in academic literature and studies, and it might be unclear to which interpretations the authors are referring.

The lingual confusion described here might be one of the main problems causing questions concerning the analytic value of the concept of trust. For instance, if one are to undertake a survey, based on questionnaires, e.g. of a population’s level of trust in different governmental agencies. If you then have a question similar to: “do you have trust in the agency”, it would be difficult if not right out impossible to draw any significant conclusions from the data obtained, as you might not know how the subjects have interpreted the question. That is to say if it in your study is significant to distinguish between the different interpretations of the term, e.g. the theoretical concept applied in the study is based on theories of trust.

The study described in this thesis does not make use of surveys in the data collection process. Nevertheless, it makes use of an expressed intention of increasing and maintaining trust, which parallel to the above mentioned question encompasses a perception or perhaps more accurate an understanding of the term, an understanding upon which the communicator(s) have based their expressed intention. Therefore, it is necessary to work out a typology of different plausible interpretations that might be encompassed in the expressed intention. In the following, the term of trust will be elaborated in an analytic context. That is to say, the term will be defined in a way that allows for distinction between different plausible interpretations and for systematic reasoning.

What is trust?

There are generally two broad conceptions of trust applied in academic literature, trust in a particularized sense, and trust in a general sense, although neither of these conceptions is used consistently throughout the literature. Nevertheless, most scholars have a common perception of the core elements constituting trust whichever they are using the term in a particularized, or a general sense.

Just like love and hate, trust and distrust are terms human beings as social actors make use of when describing their relations to other social actors in society. They can have trust in an actor and have distrust in another actor in the society. Trust is an expectation of an action or a non-action, which A anticipates from B, in favour of A (Gambetta 1988: 217; Hardin 1999: 26-29; Levi 1998a: 78; Möllering 2001: 404; Offe 1999: 47). In other words, trust is a positive expectation of some future outcome, as opposite to distrust that based on this definition is a negative expectation of the same (Hardin 1997: 1). This distinguishes trust from satisfaction, which commonly is confused with the term of trust. If we imagine a continuum where the present forms the centre point, we can see that trust concerns expectations of the future, while satisfaction concerns an assessment of the past. From the patient’s point of view, trust might then be the expectations that the hospital will provide for him the best available care and
treatment, and not let other factors such as economy, or market strategy, influence decisions concerning the hospitalization. Whilst the patient's satisfaction on the other hand will be a post-hospitalization assessment of how well these expectations were fulfilled by the hospital and its staff.

Trust does not only apply to relations between single individuals as social actors (particularized trust), the term is also applicable to relations between a single individual, or a collective of individuals, and an organization as an actor in society (generalized trust). (Giddens 1991: 136, 185; Levi 1998a: 80; Møllering 2002; Offe 1999: 44-45; Rothstein 2000: 479-484). In this sense, the term organization refers to a formalized collective of individuals. Nevertheles, trust is a subjective and relational state based on an individual’s assessment (Gambetta 1988: 217; Levi 1998a: 78; Luhmann 1988: 97). Taking this into consideration, trust towards an organization, e.g. a hospital, then depends upon the organization’s ability to influence the behaviour of its employees so it subsequently is in accordance with expectations (Giddens 1991: 136, 185; Grimèn 1996: 4-5; Levi 1998a: 80; Offe 1999: 69-70).

**Trust and confidence**

Some might argue that trust is not a necessity for coping with everyday life since formally constituted institutions are present in the post modern society (Offe 2001: 65-66; Rothstein 1999). Nonetheless, it is common knowledge that no rule, law, business-contract, or similar, are immune against misinterpretation, reinterpretation, negligence, or any other way of disruptive conduct (Hirschman 1970: 1; Kornai 2003: 5-8; Offe 1999: 54, 65-67). In addition, due to what Simon has described as bounded rationality (Simon 1957), those employing these institutions, regardless of their honest intention, will not be able to overcome the complexity of the system and the vast amount of information needed to employ its rules (Young 1998: 6).

Furthermore, some scholars (e.g. Lomnitz 1977; Lorenzen 1997; Rose-Ackerman 2001; Seligman 1997; Smith 2001) will argue that the term of trust is not applicable to relations between individuals and an organization, and in addition not applicable to relations between organizations. Their argument is that those types of relations will need to be described within the term of confidence (Seligman 1997: 18-19; Smith 2001: 290-294), or systems/routines of trust (Lorenzen 1997: 15-16).

On the other hand Niklas Luhmann (Luhmann 1988) and Claus Offe (1999) argue that there is a substantial difference between trust and confidence. Luhmann’s distinction between trust and confidence is based upon the difference between danger and risk. Danger being the fact that something bad or unexpected might happen. That is to say, you will not be able to avoid this occurrence by changing your action. Risk, on the other hand, is a direct result of your choice of action (Luhmann 1988: 97-99). As Luhmann puts it:

"Trust is only required if a bad outcome would make you regret your action" (Luhmann 1988: 98).
In line with Luhmann, Offe argues that trust relates to action, and confidence relates to institutions as factual arrangements of formal and informal rules and sanctions (Offe 1999: 44-45). That is to say that institutions limits the individual agent’s choice of actions, e.g. by constituting rules and regulations for storing, transporting, and using explosives, and thereby reducing the danger of you being hit by flying debris on your way to work. Or by constituting laws demanding evacuation plans, and early-warning systems, for municipalities, or counties, situated in earthquake prone areas.

For the purpose of this study, I will argue that relations between individuals and organizations simultaneously can be described by the term of confidence and the term of trust, and that there is a substantial difference in the essence of these two terms. In my view, the term confidence relates to the structure or order in society or parts of it, e.g. the structure within an organization. Trust, on the other hand, relates to action performed by a single individual, or a collective of individuals, within the society. The reason for my argument is that such a distinction enables a distinction between the patient's trust towards those employed within health care services and the health care service itself, and the patient’s confidence in the health care service and the health care system in general. This does not mean that I, alongside my distinction between behavior and structure, have joined Adam Seligman (1997; 2000) on his journey to the heavenly divined, and separated the self from the structure in which it is embedded, that is to say the society. It merely points out the existence of Simon’s bounded rationality (Simon 1957), as well as the logic of appropriateness as defined by March & Olsen (1989: 21-26). Hence, “Who am I? What kind of situation is this? What does someone like me do in a situation like this?”

To make my argument on the difference between trust and confidence more accessible, I will present an example: Let us assume that I develop a serious and positional fatal condition e.g. lung cancer. In this case, I can be confident, based on the health care legislation within the Norwegian constitution (cf. Act of July 2nd 1999 no. 63 § 2-1), that I will receive medical treatment if I am aware of the condition, and able to track down my local GP. However, if I am not aware of my condition and only suspect that something is not as it should be, can I then trust the GP to diagnose my condition correctly? Moreover, if the GP arrives at the correct diagnosis, regardless of my beforehand personal awareness, can I then trust the medical specialists, other decision makers or a collective of them, within the specialized health care service, to provide for me the most efficient treatment? In Norway, research has revealed that only 16-17% of patients’ diagnosed with lung cancer gets surgery. Of these, pending on sex and stage of development, approximately 39 – 72 % are cured. The remaining 83-84 % of patients diagnosed with lung cancer receives alternative treatment in accordance with the health care legislation; nevertheless, only patients receiving surgery are cured (Rostad, et al. 2002: 2259). In their study of 869 lung cancer patients diagnosed as inoperable in the period 1995-1998, Rostad et al. (2002) found that 270 of these patients nevertheless were operable, and additionally 127 were found to be possibly operable. Moreover, the reasons for these incorrect diagnoses were found to be either inconsistent use of classification standards19, or incorrect diagnosed stage of development, which both resulted in patients...
being incorrectly diagnosed as inoperable (Rostad, et al. 2002: 2260). Rostad et al. laconically sum up their study by stating:

“We believe that more patients with localized disease in the present series should have been operated on” (Rostad, et al. 2002: 2258).

As this example illustrates, confidence in institutions is a poor substitute for trust. Although Norwegian patients can be confident that they will receive medical care when needed, trust and confidence are not the same. Trust relates to the conduct of those employed within an organization and confidence relates to rules and regulations, formally constituted, or not, embedded in the organization.

Nevertheless, institutions as sets of rules and sanctions play an important part when it comes to trust. Based on the rather inconsistent use of the two terms in academic litterateur (Hardin 1999: 24; Offe 1999: 44), some interesting questions arise. Are trust and confidence interdependent? Is the existence of confidence a necessity for the existence of trust? In pursuit of the answer to these questions, it can be helpful to make use of the famous image outlined by John Locke20 of a world totally without confidence (Locke 1674: 195-206). Without the existence of a certain amount of confidence in society, human beings will find themselves in a state of anarchy. Due to the vast amount of danger, risk, and uncertainty present in this state, they will find themselves in a constant battle for the survival of the fittest, in a world of enmity. This image leads to the conclusion that a certain amount of rules, laws, and corresponding sanctions, are a necessity for the existence of a social society in which the levels of danger and uncertainty are lowered to a level that allows interaction between human beings in a non-hostile manner. As trust is a non-hostile way of interaction, we can assume that a certain amount of confidence is a necessity for the existence of trust among actors in a society (Levi 1998b: 7-8; Offe 1999: 71; Peters 1999: 88; Rothstein 2000: 480; Rothstein & Stolle 2002: 15-17).

Trust, choice and risk

If one are to trust some one there has to be some sort of choice available to the truster. As Luhmann puts it:

“If you do not consider alternatives (every morning you leave the house without a weapon!), you are in a situation of confidence. If you choose one action in preference to others in spite of the possibility of being disappointed by the action of others, you define the situation as one of trust” (Luhmann 1988: 97).

In other words, trust involves an assessment of the trustee’s trustworthiness performed by the truster, either consciously or unconsciously, in a context of risk (Gambetta 1988: 217; Gran 2002: 420; Hardin 2002b: 7; Levi 1998a: 78; Offe 1999: 47). The truster asks himself two questions: “Why should I trust someone at all?” “Next, he asks: “Why should I trust in B?” To answer these questions the truster is depended on knowledge. Nevertheless, to trust some one is not a matter of choice. As Russell Hardin puts it:
“If, on your own knowledge, it is rational for you to trust me, then you do trust me. Similarly, if it is rational for you to distrust me, then you do distrust me. Here it is the knowledge that is rational, not a choice whether to trust. There is no act of choosing to trust – my knowledge or beliefs about you constitute my degree of trust or distrust of you” (Hardin 1997: 1).

From a pragmatic view, we can find the answer to the first question mentioned above. When deploying trust the truster enhances his capabilities by economizing his cognitive resources, e.g. by reducing the need for monitoring and sanctioning. This means that the truster may invest less cognitive resources in relations based on trust, and consequently is able to invest more resources in other relations (Gran 2002: 420; Levi 1998a: 78-79; Offe 1999: 46; Skinner & Spira 2001: 1-2).

In the analysis, the element of risk has a triple role. First, the risk that evolves from A’s perception of the overall situation, which necessitates the truster to trust someone at all (Luhmann 1988: 100-101). An example of this could be the truster’s perception of the risk of dying as a result of a diagnosed cardiovascular disease.

Secondly, there are the “risks of failure to perform by the trusted” (Levi quoted in Offe 1999: 46), for example the risk of experiencing medical errors or malpractice. Yearly approximately 10 per cent of Norwegian patients experiences some sort of medical error. Moreover, medical errors account for approximately 2000 fatalities among Norwegian patients each year (NTB 2004a).

Finally, there is the risk that the truster misinterprets the trustee’s rationale for action. In other words, A can trust B mistakenly (Levi 1998a: 78). The patient might trust the hospital to provide the best treatment, but instead get an alternative treatment (cf. Rostad, et al. 2002), e.g. due to budget cuts or research on alternative interventions.

As these elements of risk imply, trust does not remove the element of uncertainty. Quite the opposite; trust can be imagined as a mental process enabling us to form expectations that helps us to overcome the uncertainty present in the situation (Möllering 2001: 412). Trust becomes “a hypothesis certain enough to serve as a basis for practical conduct” (Simmel quoted in Möllering 2001: 412). In other words trust becomes a useful “tool” to overcome the complexity of modern society by increasing the “tolerance of uncertainty” (Luhmann 1979: 50).

**Trust and Knowledge**

The increased tolerance of uncertainty, originating from trust, is based on knowledge, and beliefs or faith (Giddens 1991: 19; Hardin 2002b: 10; Levi 1998a: 79; Offe 1999: 55). Nevertheless, this knowledge, including beliefs and faith, is of a subjective nature, that is to say that trust is dependent on the truster’s own perception of his own knowledge (Hardin 2002b: 13; Luhmann 1988: 97). Moreover, perception involves both interpretation and suspension, as interpretation relates to our knowledge and beliefs, whilst suspension “brackets out uncertainty and ignorance” and thereby makes interpretative knowledge seemingly certain (Möllering 2001: 414).
This broad conception of knowledge can originate from several sources (Levi 1998a: 79). First, the truster’s knowledge can straightforward be based on personal experience with the trustee, observations of the trustee’s conduct in interaction with others (Levi 1998a: 79), or second hand information from other actors that have experiences in relation to the trustee; e.g., through mass media (Luhmann 1988: 101). That is to say that the knowledge is based on the truster’s prior engagement, information, and monitoring of the trustee (Luhmann 1988: 97; Offe 1999: 53).

Secondly, knowledge can be based on A’s personal identity, cultural belonging (Offe 1999: 55, 63), or as Turner describes it, based on his “role taking” (Seligman 1997: 17). That is to say that the knowledge is based on markers, symbols or signals that is known and can be perceived by the truster, but not easily manipulated by the potential trustee (Offe 1999: 63-64).

Thirdly, the knowledge can be based on the values an institution is perceived to promote. This means that the trust A has in B, is based on A’s perception of the organization’s ability to constrain B’s conduct (Levi 1998a: 79). That is to say, the organizations, as a value infused institution, commits and enforce “a specific set of values” upon those employed within its organization. A set of values compiled of the core values of truth and justice, that is to say truth-telling, promise-keeping, fairness, and solidarity (Offe 1999: 73-75).

Nevertheless, as already mentioned institutions are poor substitutes for trust, as there are no guarantees that these core values will be honoured. A solution to this problem of doubt might be what Claus Offé has labelled populism. That is to say that the knowledge that the trust will be based on, is the perceived charisma of the leader (Levi 1998a: 86). In other words the personal style, the communication skills, the reputation, as well as other personality features ascribed to the leader (Offe 1999: 77). Hence, an organization is noting more than a formalized collective of individuals.

**Conceptualizing trust**

So far, we have argued that trust is an expectation of some future outcome, based on the truster’s knowledge, and beliefs or faith, as regards to the trustee. Furthermore, trust is dependent on choice as there cannot be any trust if the truster does not consider any alternative actions. Consequently trust involves risk, as risk as opposite to danger, steams from the truster’s choice of action. To trust some one is to say that you, based on your interpretation and suspension of knowledge, regard that one as trustworthy, although we have to bear in mind that trust is not a product of a process of rational calculation.

There have been several attempts to conceptualize trust based on these core elements. In her work on “Inter-firm Relations”, Mari Sako (1992) argues that trust can be broken down in three different sub-categories of trust. Contractual trust, being the expectation that someone will keep their promises. Competence trust, being the expectation that someone is able to perform as expected. And finally, goodwill trust, referring to an expectation of open commitment (ibid.). Without reference to the work by Mari Sako, Margaret Levi in her paper on distrust, put forward the same three factors,
or rather the lack of them, as the constituting elements of distrust (Levi 1998b: 8-9). Other scholars have put forward similar constituting elements of trust and trustworthiness. That is to say moral, competence and willingness to comply (Barber 1983: 15), ethical or moral “values held by the trustee” (Bacharach & Gambetta 1997: 6), information accessibility (Good 1988; Levi 1998a: 79), competence, fairness and honesty (Horne & Levi 2002: 2-3; Levi 1998a: 8), competence or at least the ability to portray as competent and encapsulated interest (Hardin 2002b: 3-9; Levi & Stoker 2000: 476), fairness, honesty and impartiality (Rothstein 2002: 18; Rothstein & Stolle 2002: 13-18), accountability (Kornai 2003: 6), ethics, predictability and fairness (Caldwell, et al. 2003: 2).

The truster’s assessment of these core elements or perhaps more aptly core values of trust, held by the trustee, is nothing more than an assessment of the trustworthiness of the trustee. However, due to the incapability encompassed by Simon’s famous notion of bounded rationality, the truster’s assessment is prone to fraud, as trust and trustworthiness can be enhanced by the trustee’s ability to portray as trustworthy. Although, such strategies presupposes both an information controlling capability and a capability to control the interpretation of this information, which both overcomes the possibilities within the post-modern information society (Good 1988: 38-39; Levi 1998a: 93; Skinner & Spira 2001). In recent years quite a few corporations, e.g. Arthur F. Anderson, Enron and WorldCom, have attempted such strategies and failed (Caldwell, et al. 2003: 2; Hardin 2002a: 6-7; Skinner & Spira 2001: 5). As Offe puts it:

“Being trusted is an important kind of ‘social capital’ that can be ‘spent’ in a variety of ways. It can also be wasted“ (Offe 1999: 51).

Whether or not enhancement of trust and trustworthiness are considered as matters of window dressing, we need to pay attention to its core elements. That is to say, what makes the trustee seem trustworthy? Claus Offe’s answer to this question is rather simple:

“A trustworthy person is someone who exposes himself (and thereby enhances his autonomy) to continuous and scrupulous examination by others” (Offe 1999: 56).

Furthermore, since the truster cannot possibly have personal knowledge of all individuals within an organisation, the truster is dependent upon substitute information about the core institutional values that the organization as an institution stands for. According to Offe, these values are not just any values, but values that can be derived by cross-tabulating respectively active and passive strategies of truth and justice (Offe 1999: 73-76). This cross-tabulation produces the values of truth-telling, promise-keeping, fairness, and solidarity (see Table 3).

| Table 3 – Trust-generating values represented by institutions (from Offe 1999: 73) |
|----------------|----------------|----------------|
|                | Truth          | Justice        |
| Passive        | Truth-telling  | Fairness       |
| Active         | Promise-keeping| Solidarity     |
In his paper “Honesty, Competence and Trust: A Behavioural Approach” (Zsolnai 2002), Laszlo Zsolnai, inspired by the works of the psychologist Gian-Vittorio Caprara and his colleagues (Caprara 2001), and Mari Sako (1992), presents another interesting approach to the constituting elements of trust. He conlates the above-mentioned institutional values of trust held by an organization, into two main factors, that is to say competence and honesty (see Table 4).

**Table 4 – Competence and Honesty as the main constituting elements of trust (from Zsolnai 2002: 4).**

<table>
<thead>
<tr>
<th>Competence</th>
<th>Honesty</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>trust</td>
<td></td>
<td>negative trust</td>
</tr>
<tr>
<td>Low</td>
<td>distrust</td>
<td></td>
<td>lack of trust</td>
</tr>
</tbody>
</table>

In his empirical pilot study, asking 100 students how they perceive 8 different control organizations in the Hungarian economy on the two variables, using a score between 1 and 5, 1 representing the lowest and 5 representing the highest, Zsolnai found support for his theory (see Table 5). According to his findings, an agent will invest in a relation if he perceives the other agent as having a high level of competence and a high degree of honesty (Zsolnai 2002: 7). The findings of Zsolnai are in line with the argument presented by (March & Olsen 1975), that if people trust others, they seek interaction with them.

**Table 5 – Strategies in Relationships (from Zsolnai 2002:7)**

<table>
<thead>
<tr>
<th>Competence</th>
<th>Honesty</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>invest</td>
<td></td>
<td>Avoid</td>
</tr>
<tr>
<td>Low</td>
<td>Minimize</td>
<td></td>
<td>exploit</td>
</tr>
</tbody>
</table>

Yet another useful model is presented by Thorvald Gran in his paper “Trust and power in land politics in South Africa” (Gran 2002). Inline with Russel Hardin, Gran conceptualizes trust as a function of risk and knowledge (Gran 2002: 420-422), that is to say that the truster’s perception of his own knowledge, and the risk the originates from the necessity to make an choice, serves as predicaments for the level of trust the truster will have in an trustee (see Figure 2).

Gran’s model focuses on generalized trust in the sense that the model aims at explaining variables that constitutes the boundaries that delineates trust from other attitudes which citizens might have towards political institutions (Gran 2002: 422). Nevertheless, since risk and knowledge can be described as the constituting elements of particularized trust as well, a modified version of Gran’s model (see Figure 3) might very well be an excellent analytic tool for a descriptive analysis of how well the recent changes within the Norwegian health care system, seen from a perspective of trust, enable patients to make use of their right to choose hospital (cf. research question Q-2).
As mentioned ingressively in this chapter, it is necessary to develop an analytic framework that enables distinctions between the term of trust and its counterparts within the context of the study. Gran’s original model was developed as an analytic model of the relationship between citizens and governmental land reform authorities in South Africa, whilst the study in question in this thesis is the Norwegian free choice policy, and the probabilities for the patients’ choice within the Norwegian specialized health care sector. That is not to say that the citizens of South Africa and the citizens of Norway necessarily behave in different ways. Nevertheless, it is a fact that the relationship between South African citizens and the government, in a not so distant past, have been characterized by enmity and hostility, whereas the relationship between Norwegian patients and the specialized health care sector, not can be ascribed a similar history of events. However, the terminology chosen by Gran, and the terminology chosen in the modified version of the model, is not so much in disagreement as it might appear at first glance.

Figure 2 – Gran’s model of trust as a function of risk and knowledge (from Gran 2002: 422).

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Figure 3 – Modified version of Gran’s model of trust.
In the modified model, the level of risk represents the degree of choice available to patients, whilst knowledge refers to the degree in which the individual patient regards his own knowledge of a specific health care provider, although the level of risk also is affected by eventual knowledge indicating that the specific hospital not should be trusted. Nevertheless, if we follow the model, withdrawal will occur if the patients have alternatives, which based on the patients knowledge are to be preferred. Enmity, or perhaps more accurate deliberation, will occur if patients have substantial and dense knowledge of the specific hospital, regardless of an additional alternative of choices, as the patients then have the possibility to act upon their knowledge in an attempt to negotiate more preferable conditions of service.

Nevertheless, if additional alternatives are available to the patients, withdrawal might occur if the risk consequently is enhanced by prolonged deliberations, as unlimited time not always is a feature associated with medical conditions. As Edward Banfield puts it:

“The effort an interested party makes to put its case before the decision maker will be proportion to the advantage to be gained from a favourable outcome multiplied by the probability of influencing the decision” (Banfield quoted in Hirschman 1970: 39).

On the other hand, if patients do not have alternatives and the level of knowledge is limited, then the patients find themselves in a situation governed by faith. That is to say in a situation of political poverty, as the patient then does not have any means of influence on his own situation. This will also be true if the patients, although without any choices, have dense information of the service provided, as this might lead to a situation characterized by apathy and passivity (Jacobsen 1970: 175-177).

In sum, access to choices, and access to more than a limited level of knowledge, is essential if “a relationship based on trust between patient and the health service” (cf. Act of July 2nd 1999 no. 63 § 1-1), are to be developed and maintained.

Exit, Voice, and Loyalty
Albert O. Hirschman’s Exit, Voice, and Loyalty21 (1970), has much in common with Thorvald Gran’s model of trust as a function of risk and knowledge. Just like Gran’s theory, Hirschman elaborates different options open to disgruntle citizens (Scott 1998: 337), or perhaps more accurate customers (Hirschman 1970: 3-4), dissatisfied “with the types and quality of services received” (Scott 1998: 337). The similarity between these two theories becomes apparent if we apply Gran’s model of trust to Hirschman’s theory (see Figure 4).
Exit and voice as expressions of distrust

The cornerstones in Hirschman’s theory are the options of exit and voice, which becomes available to the population when services are submitted to some sort of choice mechanism introducing choice between options to the public, which then can be applied if there is a dissatisfying decline in quality of the service provided (Dowding, et al. 2000: 469). The interaction between these two options, and loyalty as well, makes Hirschman’s theory an obvious choice when attempting to analyse public services submitted to market oriented reforms, in so far as exit represent the logic of the marked adopted from the sphere of the private firm, whilst voice represents the realms of politics (Hirschman 1970: 15).

The core element of the exit function within Hirschman’s theory is that customer exit alert managers of failure in the organizations performance compared to the expectations of its customers as regards to the quality of services provided. However, the effect of the customer exit upon the managements restructuring of activities depends upon the extent and rapidity of customer withdrawal, which indicates a decline in quality, as an insignificant decline in demand will escape the managements attention, whereas a significant and rapid decline very well might leave no room, neither in time nor in space, for the management to react (Hirschman 1970: 24); e.g. the eradication of Arthur F. Anderson and Enron. If quality is to decline then it would be favourable if the decline is significant enough to alert the management, whilst not causing liquidation (ibid.).

Voice on the other hand represents any attempt to alter the functions of the organization in question. As Hirschman defines it:

“… any attempt at all to change, rather than to escape from, an objectionable state of affairs, whether through individual or collective petition to the management
directly in charge, through appeal to higher authority with the intention of forcing a change in management, or through various types of actions and protests, including those that are meant to mobilize public opinion” (Hirschman 1970: 30).

In the case of the patient the option of voice might not be available, either due to excessive costs in form of enhanced medical risk caused by delay, or simply the fact that the patient have little self-efficacy and do not believe that any attempt to influence decisions will have an effect, which when paired leads to apathy and resignation (Albert Bandura cited in Bernstein, et al. 1997: 473-474). In other words political poverty as defined by Knut Dahl Jacobsen (1970). As now might be apparent, the difference in terminology between the modified and the original version of Gran’s model, is simply contextual specifications of the function of voice.

Loyalty
Whereas both the terms of exit and voice, as introduced and explained by Hirschman are not contested in any significant degree, the notion of loyalty is the most criticized element of Hirschman’s theory (Dowding, et al. 2000: 476). Although Dowding et al. put forward an profound attempt to restore Hirschman's notion of loyalty (ibid., 476-478), they fail to do so.

Based on the theories of trust discussed above, I suggest that the term of loyalty should be associated with a situation that is different to both the notion of exit, and the notion of voice. That is to say a situation in which there is no choice, either due to factual non-existence of options, or simply lack of knowledge of options as in the case of the Swedish health care system (cf. Spångberg 2003), and where voice regardless of character, is proven too costly or deemed in vain. A telling though perverse example would be the loyalty of a chained dog that by brute force has learned not to bite his owner. This interpretation of the term of loyalty encapsulates the criticism put forward by Brian Barry in his review of Hirschman’s theory (1974).

Trust then, originating from the costumers non-calculus assessment of risk and knowledge in the process of choice as illustrated in Figure 4, encapsulates the definitions of loyalty discussed by Dowding et al.(2000). In other words, trust can be viewed as a vouluntary form of loyalty.

The Limitation of Choice
Before we move on to discuss how institutionalized organizations react in relation to public reforms, one important notion put forward by Barry R. Weingast, on the limitation of choice as an correctional tool available for the citizens in their relationship with the state, has to be noted.

“[...], citizens can police the state only if they react in concert to violations of fundamental limits by withdrawing their support from the sovereign or political officials. The natural diversity of interests and experiences hinders the ability of citizens to react in concert; they are unlikely to have similar views about the appropriate limits on state action and the rights of citizens. Problems arising from
disagreement are exacerbated because violations of the rights of one group often benefit another group” (Weingast 1997: 261).

A transformative perspective

A transformative perspective is a broad institutional perspective that incorporates instrumental, cultural and institutional elements, as well as external constraints, into one analytical perspective (Christensen & Lægreid 2004: 7). Within the context of this thesis, the transformative perspective brings into view the fusion of these elements in the transitional process, where international reform ideals are transformed into a new national reality, and where different reform ideals tends to be easier to adjust then it is to change established practice (Christensen & Lægreid 2003b: 7).

Instrumental elements

One popular element often inherent in public reform ideals is New Public Management. In the same way as other segments within the public sector, public health care has tasted the somewhat inhospitable flavour of new public management (Wilkinson 1995: 982-983). In countries worldwide, such as Australia (Webster & Hoque 2001: 3-4), Canada (Rathwell & Persaud 2002), Mexico (Frenk, et al. 2003: 1669), Sweden (Byrkjeflot & Neby 2003: 13-15), Switzerland (Thom, et al. 1999), and the UK (Hannigan 1998), NPM reforms have significantly changed how the work of health professionals is organized (Hewison 1999: 1383). Just as physicians prescribe interventions to heal sick patients, politicians and governmental officials often prescribe New Public Management as a remedy for the ineffectiveness of public services, as the elements of NPM are intended to reduce, or eradicate, the differences between the public and the private sector, by shifting the public focus from process accountability to accountability in terms of results (Pallot 1996: 2). However, New Public Management is hardly an analytic perspective; nevertheless, NPM highlights the instrumental aspects of the transformative perspective.

New Public Management is an instrumental approach where there is a clear perception of ends and suitable means of change. The NPM label encompasses a collection of reform elements, which based on economical principals, are intended to improve the services provided to the public, by increasing the organizational productivity and thereby reducing costs related to public services (Christensen & Lægreid 2003b: 6; Giauque 2003: 573-574; Wilkinson 1995: 981).

Common features within the NPM ranges from autonomization through devolution, clear-cut ends and specific means, performance measurement and assessment, as well as market-type mechanisms such as contracting-out, privatization, and user choice e.g. by the means of vouchers, to centralization of control, both in an administrative and political sense (Christensen & Lægreid 2003b: 6; 2003c: 8; Lægreid, et al. 2003: 10; OECD 1993: 11; 1995: 28). Within this range of NPM features, there is one paradox, as autonomization through devolution; which means both increased administrative decisional freedom and increased distance to centres of control, and centralization of control; which means increased political control, both are common as well as important
elements of most modern reform initiatives. Within the context of the Norwegian free choice policy, this paradox highlights a potential struggle of power between the three main stakeholders within the specialized health care sector; the patient, the hospital, and the central government.

Whatever might be the outcome of this struggle of power, wherever NPM inspired reforms enter into reality, its done through a transitional process where ideals are attuned with a specific contextual framework (Christensen & Lægreid 2003b: 7-8; Giauque 2003: 574; van de ven 1996: 655-656). Consequently, the final outcome of the transition process is, always, a new “quasi-commercial” organizational reality (Bradshaw 2003: 85-86; Giauque 2003: 586).

Institutional and cultural elements

The contextual framework mentioned here, is compiled of cultural and institutional elements, that is to say institutional and cultural values that evolve within an organization, or a system of organizations, over time. The institutional element within the transformative perspective, refers to the process in which an organization becomes an institution by being “infused with value beyond the technical requirements of the task at hand” (Selznick 1957: 17) The cultural element, on the other hand, refers to the interrelation between the organization and its actors, between the self and the structure (March & Olsen 1989: 22-26; Selznick 1997: 40-42). Within this perspective, institutions are not viewed merely as the result of a planned construction, but more as an mechanism that evolves over time in a natural way from the interrelation between the structure and its actors (Christensen & Lægreid 2003c: 9). Through this process, beliefs, identities, informal norms, and values are fused into the formal aspects of the organization, and as a result; a logic of appropriateness emerges. The element of appropriateness refers to a matching of action and context, and inhere an element of morality (March & Olsen 1995: 30-32). As this element of morality suggest, the logic of appropriateness is based on a shared conception of norms and values (Habermas 1990: 65; March & Olsen 1995: 34-35). Nevertheless, the logic of appropriateness does not defy autonomous cognitively based action on behalf of individual actors. It simply constitutes a framework, or rather a feasible set of options, wherein autonomous action might be limited and situational dependent. Actors within such an institutional framework ask themselves: Who am I? What kind of situation is this? What does some one like me do in a situation like this? (Brunsson 1985: 28-30; March & Olsen 1989: 21-26; 1995: 32-33; Scott 2001: 67-68).

Stability and change

From the point of view of this perspective, institutions are seen as inertial organizations evolving persistently, changing their direction at a snail’s pace when faced with an external force. They are viewed as path-dependent mechanisms paying tribute to their history and past experiences, and thereby resistant to reforms and other changes imposed by elements in their environment. Consequently, reforms initiatives might trigger conflicts between the institutions internal norms, rules, and values on one hand, and new
norms, rules, and values, as well as demands and expectations, put forward by elements in the organizational environment. Although such conflicts might have several solutions, institutions often attempt to implement the new ideas through a test of compatibility, where the reform feasibly, either partially or entirely, might be discarded (Brunsson & Olsen 1993: 4-5; March & Olsen 1995: 40-44; Olsen 1988: 24).

Nevertheless, institutions legitimize their existence by promoting norms and values that are in accordance with expectations in their environment (March & Olsen 1995: 41-42; Meyer & Rowan 1977: 355-356). Consequently, institutions needs to, at least, portray as acting in accordance with the latest order of affairs, or perhaps more accurate the latest in organizational “haute couture” (Røvik 1998: 309). This might lead to what Meyer & Rowan (1977) have described as decoupling.

“Because attempts to control and coordinate activities in institutionalized organizations lead to conflicts and loss of legitimacy, elements of structure are decoupled from activities and from each other” (Meyer & Rowan 1977: 357).

This solution to conflicts involves an adoption of the new ideas in the formal structure of the organization, although decoupled from the activities carried out within the organizational core. By doing so the organization perform a kind of window dressing putting on a varnish concealing their real order of affairs (Christensen 1991: 85).

In this conflict of interests lies a bond to the distinction between trust and confidence as discussed in the first part of this chapter. The trustworthiness of an institution lies in its ability to conform to plural expectations instigated by new reforms as well as societal development in general. However, institutions tend to avoid the thorough scrutiny through which such conformity normally is enforced. That is to say that even though there might be an increased demand for information concerning the efficiency of the organization, e.g. in terms of the cure rate achieved by an hospital, the hospital might try to ignore information on cure rates (Meyer & Rowan 1977: 356-357). Instead institutions tend to rely on “the confidence and good faith of their internal participants and their external constituents” (1977: 358), in their struggle to survive in the rapidly developing pluralistic society of the post modernity. Although societies “learns to live with a certain amount of such dysfunctional or misbehaviour”, such aversive behaviour might lead to a society in general decay (Hirschman 1970: 1). That is to say a society in which the apathy and passivity of the citizens offers no incentives for societal development (Jacobsen 1970).

In sum

The theoretical perspective elaborated in this chapter will not to be used in a juxtaposed competitive manner in the sense that the theory of trust and the transformative perspective represents competing perspectives on the reality. Quite the contrary, rather than competition the elaborated theories will be used in a collaborative manner in the analysis of the two research questions stated in chapter 1, and the relationship between them. The reason for this is that the analysis in relation to the second question is
dependent on the outcome of the analysis in relation to the first question. The transformative perspective enables an analysis of the first research question as far as this perspective highlights problems that emerge when instrumental and optimistic reform ideas are paired with cultural and institutional features of the specialized health care sector through a transformative process. The “quasi-commercial new reality” which might be the result of this process, defines the framework in which the patients will have to make their free and critical choice. Consequently, this framework will be decisive for the probabilities for choice. In the analysis in relation to the second research question, the model of trust developed in the first part of this chapter, applied within a transformative perspective, will provide an analytic tool that enables a distinction between plausible outcomes of the patients’ process of choice. Combined the analysis might indicate whether or not the legislators intentions have been to create real possibilities for choice, or if the free choice policy is just an attempt to conform to the plurality of expectations originating from the political and societal development in the post modernity.
Paradigmatic changes within the field of Medicine

Although New Public Management is an important element in the reform process outlined in this thesis, NPM is not the only driving force promoting major changes within public health care. The push for accountable quality and improved patient outcomes is also driven by paradigmatic changes within the field of medicine (Murray & Frenk 2001; Vienonen, et al. 1999; WHO 1996a, 1999b, 2000a, 2000d). Nevertheless, some have argued that the driving force behind those pandemic health reforms swiping the global arena in the past few decades, is not the progress and success of biomedical or socio-medical science (Hill 1996: 783). It seems more likely that the key element in the development of public health care is shifts in political ideology and societal values, and the failure of existing health systems to be contingent in relation to a changed demographic reality (Davis & Howden-Chapman 1996; Hill 1996). Hence, the subject of paradigmatic changes within the field of Medicine is discussed separately from both New Public Management; which is discussed in the previous chapter, and international reform movements; which is the subject of the next chapter.

Evidence-Based Medicine (EBM) and Patient Centred Medicine are important examples of internationally recognized paradigms within the field of medicine that have made impacts on global public health reform movements in the last decades. In this Chapter, the development and essence of Evidence-Based Medicine and Patient Centred Medicine, as well as some notions of criticism, will be discussed.

Introduction

Evidence-Based Medicine and Patient Centred Medicine are two different contemporary paradigms within the field medicine (Battista & Hodge 1999; Denny 1999: 251-253; Hope 1996: 1; Montori & Guyatt 2001; Morecroft, et al. 2003; Parker 2001: 87), which both have been associated with the logic inherent in new public management (Ferlie & Shortell 2001: 304-308; Rathwell & Persaud 2002: 16; Skinner, et al. 2003: 8). Nevertheless, in their ideal form these paradigms are to a certain extent inter-related. Within both paradigms, the patient is put in the centre of attention although in different ways. Evidence-based medicine can be described as the technical and scientific approach towards the compilation, validation and implementation of evidence of current best practice with reference to individual patients’ outcomes (Alderson, et al. 2003: 13; Davidoff, et al. 1995; Ghali, et al. 1999: 133; Sackett, et al. 1996). Whereas patient centred medicine best can be described as the pragmatic and clinical approach towards

Evidence-based medicine and patient centred medicine can be imagined as counterbalancing forces challenging the more conventional and to some degree hegemonic paradigm usually labelled “the biomedical model”, or in more common language; “textbook medicine” (Denny 1999: 247; Ghali, et al. 1999: 134-136; Malterud 2002: 125; Mead & Bower 2000: 1088; Norman 1999: 139 & 144; Stewart & Weston 1995: xv; Upshur 2002: 117). Neighbour’s (1987) description of the biomedical model is sketchy, but nevertheless apt and illuminative:

“In the ‘biomedical model’, patients’ reports of illness are taken to indicate the existence of disease processes. This dictates a clinical method focused on identifying and treating standard disease entities. To this end, the patient’s illness is reduced to a set of signs and symptoms which are investigated and interpreted within a positivist biomedical framework. Accurate diagnosis of the pathology permits selection of appropriate therapy which restores the diseased processes to (or near to) ‘normal’, thus curing (or improving) the patient’s illness” (Neighbour 1987 quoted in Mead & Bower 2000: 1088).

Although evidence-based medicine and patient centred medicine both are opposing the prevailing paradigm (Parker 2001: 87; Stewart & Weston 1995: xv), they do so along a sundry path.

Evidence-based medicine

Evidence-based medicine can in fact be viewed as the beneficiary relative of the long-established biomedical tradition that by fine-tuning its academic inheritance is boldly sweeping away the static and incomprehensive nature of the time-honoured “medical textbook” (Denny 1999: 247). In their frequently cited article, “Evidence based medicine: what it is and what it isn’t”, Sackett et al. (1996) take the scientific imperative of cumulative research into account by tracing the origins of evidence-based medicine back to the mid-19th century Paris. Steven et al. (2003: 98-99) makes the legitimizing effort made by Sackett and his colleagues seem pale, when describing the historical development of health technology assessment by depicting a timeline ranging from the book of Daniel in the Old Testament to the current list of entries in the Cochran Library in 2003. Nevertheless, since those “very early” days medical science like science in general have experienced more than a few earthshaking revolutions which progressively have added numerous new disciplines to the field of science. Consequently the number of scientific

Figure 5
Balthasar Ab Herden
Med. Doctor (1549-1619)
Courtesy of the National Library of Medicine
publications that today is added to the library of every subsection of science, far exceeds the cognitive capabilities of the rational bounded human being (Davidoff, et al. 1995; Sackett, et al. 1996; Simon 1957). As an example, a total number of 3825 articles were entered in to the Medline database the second week of March 2004.


To overcome these problems evidence-based medicine was introduced (Denny 1999: 247-248; Dickenson & Vineis 2002: 245; Rogers 2002: 277) as a methodology for “systematically finding, appraising, and using contemporaneous research findings as the basis for clinical decisions” (Rosenberg & Donald 1995). A typical EBM inspired study compiles empirical data and models of methodology from more than 300 independent studies and/or meta analyses into a systematic review (Egger, et al. 2003: 1). An excellent example of such reviews is Crow et al.’s (2002) “The measurement of satisfaction with healthcare: implications for practice …”. Based on a screening of approximately 3000 relevant article abstracts, 505 articles was selected and reviewed in relation to review methodology, primary research evidence and instrumental aspects (Crow, et al. 2002: i). Systematic reviews, as the one described here, are not merely a scientific version of “Readers’ Digest”. Although such reviews lessen the burden of information screening for the individual practitioner, they also play a crucial role in what has become known as health technology assessment (HTA). Health technology assessment can be regarded as the link between medical research and health care management, e.g. policy-making (Battista & Hodge 1999: 1464). Evidence-based medicine by the means of HTA enables health service institutions as well as independent practitioners to account for the quality of the health services they provide (Alderson, et al. 2003: 13; Davidoff, et al. 1995; Docteur & Oxley 2003: 19; Mason, et al. 1999: 47-50; Rosenberg & Donald 1995).

Nevertheless, the methodology of EBM and HTA are not without flaws. Although the noble ideal of EBM is to promote individual patient treatments in accordance with the current evidence of best practice (Sackett, et al. 1996), reality tends to remodel reform ideals in accordance with the distribution of power and influence within the reforms’ contextual framework (Davis & Howden-Chapman 1996: 869-871; Ferlie & Shortell 2001: 282-283; Greenhalgh 1998; Horstman, et al. 2002). The conflict between ideals and reality might produce different and loosely coupled interpretations of core elements in the EBM ideology. “Evidence-based medicine on the patient’s bedside” is one popular interpretation based on Sackett et al.’s (1996) definition (Dickenson & Vineis 2002:243). Even though David L. Sackett is commonly recognized as the founding father of the evidence-based movement, “Sackettism” seems to be more or less ignored by the community of evidence-based medicine (Malterud 2002: 121; Miles, et al. 2003: 96).
Another interpretation, inspired by Archie Cochrane, focusing on the regulatory function of evidence-based medicine (Dickenson & Vineis 2002: 243-244), has successfully drawn the attention in direction of randomized controlled trials (Dickenson & Ter Meulen 2002: 232; Malterud 2002: 121; Rogers 2002: 279) as the basis for systematic reviews (Alderson, et al. 2003: 13) and health technology assessment (Stevens, et al. 2003).

The loose coupling between the two core elements of the evidence-based approach might lead to what Stradling & Davies (1997: 99) has labelled “the unacceptable face of evidence-based medicine”. In their review of Wright et al.’s (1997) study on health effects of obstructive sleep apnoea, they show that the conclusions drawn from EBM studies are sensitive to the implementation of methodology. By missing out crucial targets early on in the process, they mistakenly concluded that there is a week link between the treatment of obstructive sleep apnoea and health outcomes. The mistake made by Wright and his colleagues was to review the health outcomes of treatment only in relation to cardiovascular disease and early death, and thereby missing out the positive effect on patients’ daily life situation. According to Stradling & Davies their mistake was probably due to their lack of practical experience with patients suffering of obstructive sleep apnoea (Stradling & Davies 1997: 100-101). Enthusiastic proponents of evidence-based medicine might also overlook societal concerns of fairness in resource allocation (Nord 2002). There is a real possibility that unfavourable, non-significant, unimportant or straight out incorrect results from systematic reviews based on biased studies, will lead to inappropriate health policies or clinical decisions thus imposing unnecessary distress for patients and wasting limited health recourses (Song, et al. 2000: 23).

However, the problem of methodology implementation is not the only problem related to EBM and HTA. Another dilemma is the steadily increased interactions between the science of medicine and commercial interests. This interaction creates a situation where researchers might be tempted not to, or even be hindered from as in the case of Nancy Olivieri, publishing their findings if these are inconclusive or negative in any other way (Horton 2004). Or even worse, in their reviews they might disregard studies reporting negative outcomes (Greenhalgh 1998); e.g. negative health effects of new medicines. In the year 2000 approximately 62 per cent of biomedical research in the US was financed by commercial interests (Bekelman, et al. 2003: 454). This fact indicates that even today there is a real danger for industry intrusion when it comes to the publication of research findings.

The last problem in this incomplete list of potential imperfections in EBM and HTA implementations, is the risk of medical practice becoming “tyrannised by evidence” (Sackett, et al. 1996). This critic is two-fold. Firstly there is the risk of medical evidence becoming (mis-)used (Greenhalgh 1998) when politicians and health executives engages themselves in decision making regarding health service accessibility, health outcomes, possible reductions of public disbursement, or increasing financial profitability for health care investors (Dickenson & Vineis 2002: 256; Docteur & Oxley 2003: 19-20; Hannigan 1998; Hurst & Jee-Hughes 2000: 41 & 58; Kitson 2002: 179-180; Miles, et al. 2002: 99; Or 2002: 8). The evidence-based cookbook, “one remedy fits all”, approach might be an
attractive solution for those looking for possibilities for public service cutbacks or a penny more in return (Goodman 2002; Maynard 1997: 126; Sackett, et al. 1996).

The strong emphasise on evidence-based medicine might lead to a situation where practical knowledge about patients and symptoms becomes second-rated, and junior staff members assisted by computers takes over the role of detecting proper methodology of diagnosis and treatment (Dickenson & Vineis 2002: 256; Ghali & Sargious 2002: 109; Marshall 1997: 136-137; Miles, et al. 2003: 104; Rosenberg 2002: 255-258; Upshur 2002: 113). Consequently there is a risk of individual clinicians’ failing to take the individual patient’s case into consideration when implementing evidence-based technologies, either due to lack of practical experience or lack of time, or even worse, due to limitations influencing the feasible set of interventions set in force by health executives or politicians (Norheim 2002; Norheim & Hunskar 2001: 1387; Straus & McAlister 2000: 839; WHO 2001: 66).

In 1945, James Guthrie Douglas expressed his view on the relation between practical medical experience and textbook knowledge by referring to a Mr. Sydenham:

“Sydenham said ‘Go to the bedside, there alone you can learn disease’ and advises against reading medical books” (James Guthrie Douglas 1945: 202 cited in Blau 1997).

This amusing anecdote might be a good introduction to another medical paradigm offering another and more holistic alternative to the classic biomedical model, that is to say patient centred medicine.

Patient centred medicine

Patient centred medicine has been described as a Copernican revolution (Hope 1996: 1). Just like Copernicus changed man’s perception of the universe, patient centred medicine aim at changing the practitioner’s perception of the essence of medicine, by making the patient the focal point of medical diagnosis and treatment (Evans 2003; Hope 1996: 1; Mead & Bower 2000; Meland, et al. 2000; Stewart 2001; Stewart & Weston 1995: xvi; Wensing, et al. 2002). The late Dr. Michalel Balint (1896-1970) is recognized as the founding father of this medical perspective in modern time (Greco 1972: 5; Norell 1972: 7). In 1972, the first international conference of the Balint Society assembled to recapture his work and ensure that his legacy was carried on. Their discussions were later that year published under the label “Patient-Centred Medicine” (Hopkins 1972: ix-x; Tredgold 1972: 327-328). Moria Stewart and Ian R McWhinney are two other scholars associated with patient-centred medicine. In 1995 they and their associates published their book “Patient-Centered Medicine” (Stewart, et al. 1995), based one the early work of Dr. Ian R. McWhinney, and the South-African practice of Dr. Joseph Levenstein (Stewart & Weston 1995: xix-xx). The status of the patient-centred perspective was reconfirmed in 2003 when the 2nd edition of the book (Stewart 2003) was published.

Even though the origin of patient centred medicine, rather modestly, can be traced back more than thirty years (Meland, et al. 2000), there is no clear and unifying definition of the concept (Mead & Bower 2000: 1087). The reason for this might be the very nature of the patient centred approach. The ethical basis of patient centred medicine is
humanistic values with an emphasis on mutual respect in the relation between health care professionals and patients (Meland, et al. 2000). According to Mead & Bower (2000), who has reviewed the conceptual and empirical literature on the subject, the concept has five distinct features, that is to say bio-psychosocial perspective; “patient-as-person”; sharing power and responsibility; therapeutic alliance; and “doctor-as-person” (Mead & Bower 2000: 1088-1091).


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<td>Patient centredness/centeredness (b)</td>
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10) Medline search string: (PY=1995-2003) and (“patient centred medicine” in *DEF).
13) Medline search string: (PY=1995-2000) and (“patient centred” in *DEF)) not ((approach in *DEF) or (medicine in *DEF)).
14) Medline search string: (PY=1995-2003) and (“patient centred” in *DEF)) not ((approach in *DEF) or (medicine in *DEF)).

The pragmatic nature of patient centeredness becomes apparent if we look at how this approach is treated in academic and medical literature. A quick search in Medline (see Table 6) for papers referring to the term “patient centred medicine” identified 9 papers on the subject, the earliest published in 1971 (Engelhardt 1971). The more general search term “patient centred” produced 375 papers, the earliest published 1968 (Geddes 1968). Even though these searches can not be taken as evidence, it indicates that there are few concerned with general aspects of patient centred medicine compared to the rather high number of papers concerned with more humanistic and personal issues; e.g. “A double
concern: Danish grandfathers’ experiences when a small grandchild is critically ill” (Hall 2004) or “The new asthma guidelines: a patient-centred approach to asthma” (Roberts 2003). Nevertheless, Patient centred medicine has gained popularity during the last few years (see Table 6), and has made a significant impact on the development of the health care sector (Rogers 2002: 278; Stewart 2001: 444-445).

There are some indications from empirical studies that a patient centred approach has positive effects both on health outcomes and on the efficiency of health care (Bauman, et al. 2003: 254-255; Crow, et al. 2002: 3-4; Little, et al. 2001: 468). Even though most patients seems to want a patient centred approach (Crow, et al. 2002: 72; Little, et al. 2001: 470), such an approach might not be what all patients want whenever they seek medical assistance or advise (Stiggelbout & Kiebert 1997). Patient centred medicine taken to the extreme means involving the patients in every decision concerning their treatment and well-being. Furthermore, it makes the patient more or less responsible for these decisions (Wensing, et al. 2002: 2). In such an extreme form, patient centred medicine can really be described as a Copernican revolution were the doctor seeks the patient's advise either for assessing the need for intervention or to decide which type of intervention to apply (Canter 2001; Dingwall, et al. 2001; Parker 2001: 88-90; Stiggelbout & Kiebert 1997).

In Sum

If taken to the extreme both evidence-based medicine and patient centred medicine might be obstructive in relation to individual patients’ health outcomes, and also be major obstacles preventing health care professionals from utilizing the full range of their practical and scientific knowledge to ensure effective treatment for their patients (Dickenson & Vineis 2002: 248-249; Kitson 2002 179-180). Taken to the extreme these paradigms might foster a situation where the development within medical care is at the mercy of commercial and political interests (Greenhalgh 1998; Horton 2004), or at the mercy of fashion driven pluralistic consumer preferences (Horton 2004; Parker 2001: 88).
Public health care reform: a global phenomenon

There is so far in this thesis made several references to international reform ideals. This chapter will be outline health care reform movements that in the past three decades have been manifested internationally. These reform movements have without doubt influenced recent developments within the Norwegian health care sector. In the final part of this chapter, three terms, which are central in the following parts of this thesis, will be presented.

International health care reform movements

During the last 25 years, health reform movements have inspired governments all over the world to address universal challenges facing public health services of any kind (Frenk, et al. 2003: 1669; OECD 2000b: 13; Rathwell & Persaud 2002: 10). Due to increased demographic heterogeneity, unproductive use of resources, inadequate quality of care, declining user satisfaction, and unequal distribution of public health services (Muhamad Hanafiah Bin Juni 1996: 766; OECD 2000b: 3; Twaddle 1996: 641-645), “developed nations must constantly seek a balance between the perceived need for medical care and the acceptable level of national (public plus private) expenditure on that care” (Chernichovsky 2002: 6). In search of solutions to harness increased public expenditure (OECD 2000a: 20-21), and to improve the quality of life as well as the quality and accessibility of public health services (Docteur & Oxley 2003: 15; European Commission 2002; OECD 2000b: 11; UN 2000; WHO 1978, 2000d), global reform movements have frequently been promoted by multilateral organizations such as EU, IMF, OECD, UN, WHO and the World Bank (Banta 2003: 130-131; Borthwick & Galbally 2001: 76; Christensen & Lægreid 2003a: 6; Frenk, et al. 2003: 1669; OECD 2000a: 35).

Nevertheless, it can not be overlooked that there have been and still are major internationally coordinated campaigns to improve health care services through multilateral cooperation (e.g. European Commission 2002; OECD 2002; Paris 21 2000; UN 2000; WHO 1978, 1985, 1988a, 2000d). Without failing to notice the efforts of the European Union, the OECD, the United Nations, and other international organizations, the push forward has primarily been coordinated through the World Health Organization and its regional offices. The point of departure for the global health reform movement is without doubt the legendary Alma-Ata declaration, “Health For All” (HFA), of 1978 (WHO 1978). Even though the Alma-Ata declaration specified primary health care as its main target, it has become a cornerstone upon which numerous other
health care reform initiatives have been created. The reason for this is that by defining
primary health care in relation to an overall health care system (WHO 1978: § VIII ), it
also laid down the road towards a complete restructuring of public health care services
world wide (WHO 1985: 1). In Europe, this was taken literally in a serious sense. The
European region had been selected as the forerunner leading the rest of the world
towards the development of public health care services (WHO 1985: ix). In 1984, a
roadmap was drawn up to guide the development in the region in: “a deliberate attempt
to change the course of European health development” (WHO 1985: 11). Within the
year 2000 all European member states should have achieved their health for all targets
(WHO 1985: 5), which they could chose from a set of 38 targets, according to their
needs, their available economic and health resources, and their administrative, political,
and societal culture (WHO 1985: 8-12).
Regardless of the origin of these health reforms, they all share some common
elements that, dependent of ones perspective of choice, can be categorized, or perhaps
more correctly, ascribed legitimacy. Inspired by the Ljubljana slogan, that public health
services should be “targeted on health, based on sound financing, centred on people and
focused on quality” (WHO 1996e), I have found it useful to divide these elements into
different categories; (1) governmental and managerial elements, (2) elements of
medical quality assurance, and (3) citizen or patient centred elements. Some elements
might be ambiguous in nature, and could have been ascribed another category. Bearing
this in mind, such items are classified according to their main point of focus.

**Governmental and managerial elements**

According to the Alma-Ata declaration the state has the main responsibility for setting in
force reforms by introducing new legislation and fiscal measures (WHO 1978: 2-3; 1996e:
2-3). To do so the government might need a system of health accounts that can provide
an overview of the complexity and the current situation within the health care system.
Furthermore such systems can provide guidance in relation to what needs to be done to
improve the system (OECD 2000b: 11-13).

Major health system reforms are in need of extensive financial support to be able to
deliver substantial care to all citizens (WHO 1996e: 2; 1997b: 5-6; 2000d: 93-95). The
fiscal basis has to be generated in some way (Busse & Schlette 2003: 17-18; WHO 1978:
72-73; 1996d: 34-35), either by lending (Manning & Mukherjee 2002; WHO 1978: 73), or
by restructuring existing systems either by public means or a mixture of public and
private means (Busse & Schlette 2003: 15-16; WHO 1997b: 7-8; 1999a: 133). This is
often done by introducing some form of insurance function either by user subscription,
e.g. individual private health insurance or individual participation in pooling schemes, or
through taxation, e.g. social security funds (WHO 2000d: 96).

Regardless of how the health care system is funded, if we follow the logic of the
Alma-Ata declaration, it is always its objective to distribute scarce resources so to
promote equity for all citizens regardless of economic status and geographical location
(Tragakes & Vienonen 1998: 2-3; WHO 1978: 58-59). To achieve this it is necessary to
focus on cost-effectiveness and priority setting within the health care system (Docteur & Oxley 2003: 23; Norheim 2002; Tragakes & Vienonen 1998; WHO 2000d: 52). Which health services should a health system provide, and how should it provide it to ensure that the scarce resources invested are producing equity and adequate health services for those in need of treatment. These are two different but although interrelated problems that needs to be addressed separately.

Evidence-based medicine has become a common tool when politicians and health executives are involved in decisions regarding what kind of treatment the health care system should offer (Walshe & Rundall 2001: 432-433). Furthermore it has become common to combine calculations of cost with evidence of the effectiveness of interventions in these decisions (WHO 2000d: 53), e.g. by using systematic reviews and health technology assessment (Biller-Andorno, et al. 2002: 261-263). The logic behind such policies is based on the assumption that interventions with no evidence of effect can legitimately be withheld from the public (Norheim 2002: 310). As noted in the previous chapter 433, biased research methods might produce evidence that do not reflect the reality (Buetow & Kenealy 2000: 90; Song, et al. 2000: 1-3; Stradling & Davies 1997: 101). This fact indicates that the assumption of “no evidence – no cure” does not always take the full picture into consideration (Norheim 2002: 315).

Priority setting reduces public cost by limiting the range of interventions available for treatment and thereby limiting the possibility for misusing scarce resources. Nevertheless, priority setting alone will not wipe out unnecessary treatment. Cost-effectiveness can further be improved if there are installed mechanisms to prevent excessive use of prioritized interventions (Shiell & Mooney 2002: 4-5), such as a referral system functioning as gatekeeper34 by refusing access to the system for those who are not in direct need of its services (Brekke, et al. 2003d: 2; Docteur & Oxley 2003: 17, 31-32; WHO 1978: 64-66; 1999a: 123), or by introducing out-of-pocket user fees to demotivate those inclined to over-utilize health care services (Liu 2003: 53; Shiell & Mooney 2002: 4).

Priority settings and mechanism limiting access, do not alone determine the cost-effectiveness of the health care system. The cost-effectiveness will also be influenced by how the distribution of health care services is organized (WHO 1997a: 7-8; 2000d: 61-62). There are mainly three different ways of organizing a health care system. It can be organized as a hierarchical bureaucracy, organized through long-term contracts in a restricted market, or organized through short-term market-based relations between consumers and providers (Docteur & Oxley 2003: 10; WHO 2000d: 62). All these organizational forms have their strong points and disadvantages. Strict hierarchical systems might be inflexible and resistant to changes, and fully marked-based models tend to be a disadvantage for consumers faced with investors’ interest of profit. A restricted marked-based model seems more flexible than a strict hierarchical model and at the same time seems more capable of safeguarding consumer interests (WHO 2000d:62-63). Nevertheless, most countries have elements of all three models incorporated in their health care system (Docteur & Oxley 2003: 9).

One model that has become more and more popular for organizing public hospitals is to organize hospitals as corporations in accordance with organization principles derived
from private sector. The underlying principle of this NPM inspired model is to reorganize public hospitals by granting them some form of financial and managerial autonomy; e.g. by installing some kind of corporate board (Docteur & Oxley 2003: 36; Eid 2001: 2; Rathwell & Persaud 2002: 11-12). The corporate model emphasises leadership and managerial functions as prime tools for achieving cost-efficient production of public health care services (WHO 1993: 136-137; 1996e: 6). These functions are interrelated although different as regards to what they actually do (Grint 2002; Shortell 2002; Webster & Hoque 2001: 9-11; WHO 1988b). Leaders in fact do not do very much, their role is to be guides on the road towards development and success (Grint 2002: 248-249). Managers on the other hand, are supposed to take control and ensure that the leader’s guidance is reflected throughout the organization (Grint 2002: 248). Leaders therefore rely upon their managers and their managers social network of employees, and upon their access to and analysis of information (Gilbert 1998: 1013). The introduction of corporate management is based on the assumption that managers can socially control the performance of those employed within the organization, and thereby enhance the cost-effectiveness of the production process. Ideally this is done by using legitimate power generated from the loyalty and trust of the workforces (Bolton 2004: 330; Rosanas & Velilla 2003: 56-57; Searle & Ball 2003: 18; Skinner, et al. 2003: 8). Nevertheless, the need for social control can lead to growing social dilemmas within a hospital. The clash between the goals of the organization and the goals of e.g. the individual physician might cause ethical and moral conflicts that extend the boundaries of the organization (Chandler, et al. 2002: 1064; De Cremer & Stouten 2003: 41-42; Giauque 2003: 584). Should physicians be allowed to use their practical experience instead of, or in addition to, administrative diagnostic guidelines when diagnosing patients (Rosenberg 2002: 257). Or, should physicians be allowed to inform patients about other interventions than those being practiced in his/hers hospital, or those prioritized within the health care system (Mechanic 2001: 42-43). To overcome such problems, “gag-rules” prohibiting employees from disseminating information not sanctioned by the organization, and other codes of conduct, have commonly been incorporated in contractual or legislative arrangements between corporations and their workforce (Mechanic 2001: 42-44; Rosenberg 2002: 237-238).

The reorganizing of individual hospitals in accordance to business principles will not in itself ensure cost-effectiveness in the production of health care services within a given geographical area. To achieve optimal cost-effectiveness it may also be constructive to coordinate the activities among different providers within a region. Regional health authorities can add valuable extra productivity and medical quality by allowing “for better organization of the response to medical emergencies and facilitate cooperation between hospitals and with primary health care” (WHO 1996e: 5; 1999a: 124).

No matter which organizational model, or combination of models, are chosen for the health care system, it might be prudent to establish some system of incentives to ensure cost-effectiveness in the production of health care services. One popular way of doing this is by introducing an activity based payment system based on diagnosis related groups (DRGs) (Liu 2003: 29). The logic behind this kind of payment system is that any patient’s
case can be categorized according to a system of mutually excluding diagnosis groups, and subgroups, with a flat payment rate for each DRG. As a consequence any incentive for the hospital to provide more than the necessary treatment for each case is removed, although a payment system based on DRG might give the hospital an incentive for recoding the patient with a diagnosis that produces a more desirable economic outcome for the hospital (Liu 2003: 30).

All the factors discussed in this section do in some way or other influence the performance of the health care system. One question that needs some more elaboration is how to ensure that the cost-efficient health care system also provides health care services of adequate quality.

**Medical quality assurance**

When referred to medical quality often is defined in terms of cost-efficiency, as best care with available resources, and in terms of medical excellence, as well as patients’ outcome (WHO 1993: 141; 1996e: 2; 1999a: 126). In this way, medical quality assurance could have been the caption for all activity and trends concerning public health reforms. Nevertheless, for practical reasons this heading is here referring to activities concerning medical excellence.

Improving medical excellence has become a recurring anthem at more than a few international conferences at various levels (e.g. CE 1976; European Commission 2003; WHO 1978, 1986, 1988a, 1989, 1994a, 1996a, 1996c, 1996e). The Alma-Ata declaration stated that health care should be based on “practical, scientifically sound and socially acceptable” knowledge and technology (WHO 1978: 3-4). This was further affirmed in 1985 when WHO published the first edition of their 38 targets for “Health for All” in Europe (WHO 1985), and in 1988 when “Priority research” for HFA in Europe was presented (WHO 1988e). The strive for medical excellence has not only affected the European region (Vienonen, et al. 1999). In 1995 a multilateral conference was held in Arusha, Tanzania, on the subject of promoting evidence-based health care reforms in Africa (WHO 1996a). Furthermore, in 1996 WHO submitted a global strategy for changing medical education and medical practice, “Doctors for health” (WHO 1996b), based on the legendary Ljubljana Charter (WHO 1996e). The emphasize on education for medical professions (WHO 1996e: 25) is an excellent example of the complexity of medical quality. Both doctors and nurses face a new reality when major health system changes take place. New skills are required to handle new tasks in their everyday work (Borthwick & Galbally 2001: 76-77; WHO 1996b: 5-6). Rapid development within the science of medicine, the new administrative and economic regime, and the new roles for patients and citizens, all put forward new demands that will have to be met by the “five-star” medical professions (Attree 2001: 464; Bauman, et al. 2003: 256; Kitson 2002: 179; OECD 2000c: 28; WHO 1996b: 7-8).

There is no uniform view of how to ensure that the provided health care services within a given health care system are of adequate quality. Although there are significant variations between different national health care systems, most systems share some basic
elements such as licensing systems for institutions and individual practitioners, and national and regional institutions for performance management and control (Hurst & Jee-Hughes 2000: 16).

Publishing information about the quality and performance of both the health care system in general, and of individual health care providers, is becoming a global trend (Docteur & Oxley 2003: 18). A widely shared view is that the development of quality in health care is dependent on the existence of information systems that can provide medical professions and other stakeholders with viable information (Brown 2002: 335; Dudley, et al. 1998: 680; European Commission 2004: § 1.2; Kalfoglou, et al. 2001: 4-5; Liu 2003: 117-118; OECD 2002: 14-16; Runciman, et al. 2003: 976-977; Shortell, et al. 1998: 600; WHO 1978: 29; 1996e: 5). There have been and still are major multinational efforts to develop quality indicators that enable development of comprehensive health information systems both on national and multinational levels (OECD 2000b, 2002; WHO 2000c, 2003). A wide range of different types of indicators are suggested, ranging from indicators for mortality and morbidity, health care expenditure, financing, resource and utilization, to indicators for quality of care (OECD 2002: 296-302; WHO 2000c: 5-9). One factor that has become more important in recent years is patients’ perception of quality as an indicator for health care system performance and level of quality. The patients’ perspective is now recognized as a central element in performance measurements within health care system (Crow, et al. 2002: 1-10).

Not only medical professions are in need of knowledge and medical information. Also patients may need education if they are to take full advantage of their new role (Bauman, et al. 2003: 253; Leong & Euller-Ziegler 2004: 116; WHO 1996e: 4). The new role of patients and citizens in general is perhaps the most important force driving changes within health care systems.

**Patient centred elements**

The main objective of any public health care reform, as with any public sector reform, is to make people the focal point of the health care system (OECD 2000c: 28; WHO 1996e: 2; 2000d: 50-52). This fact correlates with the core element of new public management (Bejerot & Hasselbladh 2001: 5; Tomblin 2002: 12), the ideal of evidence-based medicine (Sackett, et al. 1996), as well as the quintessence of patient-centred medicine (Stewart & Weston 1995: xvi). Modern public sector reforms are founded on ideals, based on ethical values, and aimed at putting values in to practice (OECD 2000c: 31-39).

The movement towards formalized patients’ rights within a revitalized health care sector is an excellent example of efforts to promote ethical values in relation to the public sector. The term patients’ rights originates from the Alma-Ata declaration (WHO 1978: 3), although significant steps forward, as regards to the rights of citizens in general, had been done at an earlier time (e.g. Annas 1975; CE 1950; UN 1948). Nevertheless, the first declaration of patients’ rights was put forward by the European member states of the
World Health Organization in 1994\textsuperscript{36}. Based on six rudiments, several different patients’ rights were recommended in the declaration.

The first rudiment was related to human rights and values in health care and specified six rights concerning respect, self-determination, integrity, privacy, cultural, moral, religious values and philosophical convictions, and finally the right to protection of health. Based on the second rudiment, information, nine different rights was proposed, ranging from rights to information about health services and how to best use them, information about ones own health status, the right to get viable information, the right not to be informed, to the right to a second opinion. The third rudiment was focused on consent and specified ten concerns ranging from the prerequisite of informed consent to the right to refuse or halt treatment, as well as matters concerning legal representation, whilst the fourth rudiment recommended eight different rights concerning confidentiality and privacy. The fifth rudiment proposed eleven rights concerning care and treatment. And finally the sixth rudiment recommended five different rights focused on the application of patients’ rights (WHO 1994a: 10-16).

The development of patients’ rights in Europe, was driven by the broad international understanding “that sick persons may find it difficult to defend their own interests, especially when undergoing treatment in large hospitals” (CE 1976: §3), and acknowledgement of the importance of human and civil rights for societal development (WHO 1994b: 10). A fine example of the cooperativeness in this process is the recommendation issued by the Parliament Assembly of the Council of Europe in January 1976 on the rights of the sick and dying (CE 1976).

At this point in the process patients’ rights was not much more than a specification of general human and civil rights within the health care setting. Although patients and their next of kin were granted some fundamental rights concerning information and treatment, e.g. second opinion and refusal, the 1994 proposal did not do much to empower patients from a consumerist or public choice point of view, although the 1994 proposal did recommend that patients should have the right to file a complaint or to bring their case to court (WHO 1978: §6.5). Nevertheless, considering the long established bureaucratic nature of European courts, the option of suing might not be an option at all if you are short of time. In addition, neither exit nor refusal is good ways to exercise power if the other option for the patient’s is somewhere between agony and death.

The importance of the patients’ opinions and perceptions, as an instrument in the health care reform process, was first recognized in the Ljubljana Charter issued by the European member states of WHO in Slovenia on June the 19th 1996 (WHO 1996e). While reconfirming the prior focus on the health for all principle as well as patients’ rights in relation to health care reforms, the charter emphasized that “the citizen’s voice and choice should make as significant a contribution to shaping health care services as the decisions taken at other levels of economic, managerial and professional decision-making” (WHO 1996e: § 6.2.1). Furthermore, by stating that “the exercise of choice and of other patients’ rights, requires extensive, accurate and timely information and
education”, the Ljubljana Charter appended “the right to chose”, to the entrenched listing of principles and patients’ rights declared in 1994 (WHO 1996e: § 6.2.3).

It might be far fetched to claim that the driving force behind the development of patients’ rights and patient centred perspectives in health care is the cooperative effort of multilateral organizations. Alongside the more general shift in society towards consumerism, pluralism and public choice, the development of patients’ rights should perhaps more correctly be ascribed to the information technology revolution, as well as “formerly intoxicated hippies”37, and other rebellious or politically motivated students, in the 50’s, 60’s and early 70’s, that sobered up and went into public service or politics in the late 70’s, 80’s and early 90’s.

Nevertheless, the instalment of the rights of choice, and the right of participation, as fundamental civil and human rights in health care, marked a radical shift in the way governments, health care officials, and medical professionals perceived the role of patients and citizens in general (Tomblin 2002: 11). In principle, patients and citizens have now the right to participate more forcefully. Consequently the balance of power have changed within the health care system (Mechanic 1998: 283-284). A vision of a new kind of patients has begun to emerge in the discussions on public health care reforms. An image of a patient that perhaps is better educated, more sophisticated, and better informed than medical professionals and patients of past years (Borthwick & Galbally 2001: 79; Busse & Schlette 2003: 17; Mechanic 1998: 282).

Accessibility, Transparency and Public Choice


There are three main targets concerning any kind of development and reform that can be derived from these visions and those reform initiatives that have been discussed above. These are equity through Accessibility of services of prime quality, Transparency through accountability and dissemination of unwarranted and viable information, and Public Choice as a civil right and principle of public services (cf. OECD 2000a: 17-31). These three targets will be the focus of the remaining parts of this thesis.

The values of accessibility, transparency, and public choice introduced above are not chosen without any consideration, as these values in one way or another represent
conditions for the “birthright of freedom” which according to Immanuel Kant is one of the principles of the civil constitution in society; the Civil State (Kant 1887: 56). According to Kant there is only one innate human right, namely the “birthright of freedom” (ibid.). However, the right of freedom encapsulates other rights; liberty, equality, and self-dependency upon which any civil constitution is based as far as these rights are not granted by a State but rather are conditions for the very existence of a Civil State “in conformity with the pure rational Principles of external Human Right generally” (Kant 1891: 33-35). In other words, such a Civil State is a democracy in so far as “democracy is the form of government in which the free are rulers” (Aristotle 1885: 112). A Government not honouring these principles of human right would be a paternal Government where citizens are compelled into passivity as they are forced to accept “all that ought to make them happy” granted them out of the goodness of the Government. “Such a Government would be the greatest conceivable Despotism” as far as it bring to an end all liberty and leaves no rights for its citizens (Kant 1891: 36).

Leaving the classics of philosophy aside, the values of accessibility, transparency, and public choice as conditions for freedom was not defined by Aristotle or Kant, but rather emerged as the complexity and plurality in society increased. An increased complexity in which the character of e.g. “health care products or services offered is becoming more difficult to determine, especially in socio-economically advanced communities” (Chernichovsky 2002: 5). Although these values might be connected to any form of public services (cf. OECD 2000a: 12; 2000c: 220), they have especially been put forward as vital elements that can improve health care by securing equality in health for all (cf. WHO 1996e: 4).
The Norwegian Health Care Reform

In this chapter of the thesis, four major health care related reform initiatives instigated by the Norwegian State since 1997, will be outlined. In sum these reforms encompasses the main subjects concerning health care reforms as discussed in the previous chapter. These reforms are:

- The New Financial System introduced in 1997 (St.meld.nr.44 1995-96).

This line of reforms can be viewed as one entity consolidated by the Norwegian Hospital Reform (Ot.prp.nr.66 2000-2001 § 2.1.2). In the remaining parts of this thesis, when referred to, this entity will be referred to as the Norwegian health care reform. Due to the predominant role bestowed upon the Norwegian Hospital Reform, this line of reforms will have to be described in a reversed chronological order.

Norwegian health care development, and consequently the Norwegian health care reform, is strongly influenced by international trends in health care development. Therefore, as an introduction to a more detailed description of the recent changes, it can be helpful to sketch out the Norwegian health care development seen from a longitudinal perspective.

**Norwegian health care development**

Norwegians like to believe that their society is one of the leading welfare nations in the world; that we are on the forefront in the race towards the ultimate modern welfare society. This might be true to some extent. In 1754 when most of the worlds population did not know the meaning of the word hospital, and even fewer had ever seen or been treated at one (WHO 2000d: 3), the first general public hospital opened for business in the very city where I am living, by initiative of the district physician Stadsfysikus Johan Gottfried Erichsen and funded by the city’s municipal poor relief fund (Dobbe 2002: 39). There are even further indications of another hospital in operation within the city somewhere between 1630-1695 (Holberg [1737] 1969: 16; Jansen 1969: 11).

**1885 - 1970**

Although the state today is the dominant actor in the development of the Norwegian welfare system, the state was not a significant actor in the early phase of health care...
development in Norway. Quite the contrary, not unlike the situation in the early days of American communal welfare (Skocpol 1995: 1-3), the entrepreneurial initiative was normally provided by voluntary organizations in collaboration with municipalities and counties, and even a few private firms (Byrkjeflot & Neby 2003: 8). Although the government in 1885 appointed a commission to investigate the Norwegian working-class’ conditions of life, and several different social security schemes aimed at specific groups in the society had been introduced between 1894 and 1957, the first major state initiative in the welfare sector, the Norwegian social insurance scheme, was not introduced until 1967 (NOU 1998:10 § 4.2.1). Throughout the post 2nd world war era the state's dominance grew stronger due to its position as the sole provider of financial support for the health care sector, and stricter control of the sector was a frequent subject in political debates throughout the period (Byrkjeflot & Neby 2003: 8-9).

The 1970’s until 1987

The Norwegian population had grown steadily from the 1800’s and onwards (see Table 7). From Mil 0.88 in 1801 (SSB 2004c), to Mil 3.86 in 1970 (SSB 2004b). Consequently, a second major state initiative went in to force in 1970 when the state by decree transferred the responsibility for the development of the hospital sector to the 19 counties in Norway (EOHCS 2000: 39). From then on the health care sector in Norway, the primary health care at the municipal level, and the specialized health care at the county level, was due to the parliament’s prerogative on taxation, controlled by the central government through annual block grants canalized through county budgets (Byrkjeflot & Neby 2003: 8-9; Grunnloven § 75). As a result, the Norwegian population was covered for needs, and the financial burden of using health care services, although with the exception of small and strictly limited out-of-pocket payments (EOHCS 2000: 19).

<table>
<thead>
<tr>
<th>Year</th>
<th>Population¹</th>
<th>Annual public expenses (NOK)²</th>
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<tr>
<td>1801</td>
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<tr>
<td>1865</td>
<td>1 701 756</td>
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<td>1930</td>
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<td>3 863 221</td>
<td>97 937 000 000</td>
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<tr>
<td>1993</td>
<td>4 299 167</td>
<td>239 252 000 000</td>
</tr>
</tbody>
</table>

1) Source: "Hjemmehørende folkemengde, etter levevei. 1801–1930" (SSB 2004c), and "Folkemengde pr. 1. januar, fødte, døde og flyttinger. 1900–2000" (SSB 2004b).

The regional character of the Norwegian hospital system was further strengthened in 1974 when the country was divided into five health regions as a result of the whitepaper on hospital expansions within a regional framework (St.meld.nr.9 1974-75), although Norway was not formally divided into health regions until February 1st 1999 (HD 2002c; SHD 1999b). The introduction of health regions also constituted a regional health
authority within each health region in Norway (SHD 1999a). Nevertheless, neither hospital executives nor central government had much influence on the quality of the health care services provided by county hospitals. The reason for this was that each county council had the final saying when it came to health priorities due to their role in the prior financial system. County budgeting was primarily conducted through a incremental process where health priorities was in steep competition with other major political priorities within the counties (Biørn, et al. 2002:4-5; HD 2002c).

The 1987 and onwards

In the late 1980's the parliament became aware the significant inequity concerning the accessibility of specialized health care services (St.meld.nr.44 1995-96 § 2.1). Patients’ experienced major differences in wait time, both between different geographical regions, and between different medical disciplines. Moreover, the long wait time had a significant impact on the recovery-rate for certain groups of patients. To overcome this problem the government introduced a waiting list guaranty in 1990 (St.meld.nr.44 1995-96 § 2.1), which was supposed to assure that those patients most in need got necessary treatment within six months. This was commenced by categorizing patients according to first, second, and “other” priorities (St.meld.nr.44 1995-96).

The new awareness of the situation as regards to the inequity in the distribution of health care services got the debate going concerning how the Norwegian health care system should be organized so to be able to meet present and future challenges (HD 2002c). The population had continued to grow steadily throughout the 1970’s, 1980’s and the early 1990’s, and in 1993, the Norwegian population had reached Mil 4.29 (SSB 2004b). In the same period the annual total of public expenses had more than doubled from Mil 97 937 in 1970 to Mil 239 252 in 1993 (SSB 2004a), and consequently the state had strong incentives for rethinking the organization of public services such as the public health care sector (HD 2002c; St.meld.nr.50 1993-94).

In this period, the Council of State commissioned ten independent national enquiries into the current situation within the specialized health care service. The mandates also included recommendations as regards to improvements. Among these reports, four are of particular interest within the context of this thesis, as they became cornerstones for the further development of Norwegian specialized health care services.

In 1992, two years before the WHO regional office for Europe published their first recommendations, one of these commissions proposed a independent patients’ rights act (NOU 1992:8). Although this proposal did not enter in to the Norwegian legislation, it became a cornerstone for further development of patients’ rights in Norway.

A second report concerned the organizational structure of Norwegian hospital. The subject of how the Norwegian hospital sector should be organized was a difficult matter, as it concerned one of the principles of the Norwegian model of decentralized democracy; the political balance of power from a “central ↔ regional” perspective. The Helandsvik report, “Who should own the hospitals?” (NOU 1996:5), attempted to elucidate the central elements of this debate. The subject was further discussed in a third
national enquiry report “How close should it be?” submitted by the Sørensen commission in 1999 (NOU 1999:15).

The fourth report, “The patient first” (NOU 1997:2), was perhaps the most important of these national enquiries, as it concerned the internal organizational structure of Norwegian hospitals, both in an administrative and a medical sense. At the point of time, the normal organizational structure of Norwegian hospitals was based on cooperative management model, where the responsibilities of the top management were shared between the CEO, the chief medical officer, and the chief nurse. This mixture of responsibilities, alongside the complex structure of the political management, created, according to the Steine commission, an unhealthy environment for specialized care, if judged from a patient centred perspective. The solution proposed by the commission was that the organizational structure should be based on unified leadership, as this model would promote development and simplify the implementation process in relation to new technologies e.g. from evidence-based medicine or health technology assessment (NOU 1997:2 §§ 2.1 - 2.6).

In the aftermath of “The patient first”, the Ministry of Health established a forum for organizational development within hospitals (Hofsli, et al. 2000: 3). The forum was based on a broad coalition of health professionals and top-level health administrative personnel from the Ministry of Health, National health agencies, and county health administrations (Hofsli, et al. 2000: 75). The primary focus of the forum was practical implementations of new organizational models, by providing professional guidance and financial support for more than 50 pilot projects within different Norwegian hospitals. In 1998 the forum commissioned a document of strategy in relation to a development project at the regional hospital in Trondheim, RIT 2000 (Kristiansen & Wætthen 1999: 1), that has had a significant impact on how Norwegian hospitals’ perceive their patients (Hofsli, et al. 2000: 19-20). Based on a typology of patients, the document stipulated five different types of patients, ranging from the humble and easy to please to the demanding and high-powered PIRK- patient, which represented the main challenges facing Norwegian hospitals in the future (Kristiansen & Wætthen 1999: 11-13). Based on the overall experiences from the fifty pilot projects, the forum published its guidelines for further hospital development in 2000 (Hofsli, et al. 2000: 3).

The development towards a complete restructuring of the Norwegian specialized health care sector was also heavily influenced by international trends in health care reform; this is especially true for recommendations issued by the World Health Organisation; particularly the WHO Regional Office for Europe. The WHO influence was further strengthened when the former Prime Minister of Norway, Dr. Gro Harlem Bruntland, was appointed to the position as the WHO General Secretary from 1998 until July 21st 2003 (WHO 2004).

The spirit of the Alma-Ata declaration has been put forward as the main inspiration for the Norwegian reform movement. In 1994, the Norwegian government stated that the primary goal for development within the Norwegian health care sector was to secure good access to health care services of good quality for the whole population, regardless of
age, sex, or residence, and provided by a publicly governed health care sector\textsuperscript{44} (St.meld.nr.50 1993-94).

The Norwegian Hospital Reform

On January 1st 2002 (SR 2001a), the responsibility and ownership of Norwegian hospitals was transferred from the nineteen counties in Norway to the State, represented by the Ministry of Health, and its department of ownership, as the consequence of an act past by the law chamber of Stortinget\textsuperscript{45} on June 6th 2001 (Besl. O. nr. 123 2000-2001). Conjunctively, the parliament’s decision also reconstituted the five Norwegian health regions\textsuperscript{46} (Lov av 15. Juni 2001 nr 93 § 4). Furthermore, on July 1st 2001 the Council of State constituted five Regional Health Authorities\textsuperscript{47} (RHAs), through which the ownership by delegation is maintained (Lov av 15. Juni 2001 nr 93 § 3; SR 2001b). Nevertheless, the hospital takeover marked a decisive moment in the history of Norwegian health care policy, as it broke a 30-year long tradition of regional health sector governance (Lægreid, et al. 2003: 10-11).

The reform objective

However political significant, the transfer of ownership was just a prerequisite for the implementation of a more principal objective. By reorganizing Norwegian hospitals, from governmental agencies to independent, although publicly owned, health enterprises (HD 2002c; Lov av 15. Juni 2001 nr 93 § 1; Ot.prp.nr.66 2000-2001 § 2.5.1), the intention was to improve the accessibility and quality of Norwegian specialized health care services by consolidation and coordination of the hospital reform and three other health care reforms introduced since 1997 (Lov av 15. Juni 2001 nr 93 § 1; Ot.prp.nr.66 2000-2001 § 2.14), that is to say the Patients’ Rights Act (Act of July 2nd 1999 no. 63), the General Practitioner Scheme (Ot.prp.nr.99 1998-99), and the New system of finance (St.meld.nr.44 1995-96).

The new structure

When Norwegian patients, in 2001, were given the right to choose\textsuperscript{48} which public hospital should be responsible for their treatment, the right of choice also instigated a new market situation within the Norwegian specialized health care system. In support of patients’ rights and the quest for improved health care services (Ot.prp.nr.66 2000-2001 § 2.1.1), the central government decided to reorganize public hospitals according to an enterprise model (Lov av 15. Juni 2001 nr 93 § 9). The decision was based on a repeatedly expressed need to untwine the complicative mixture of national and regional responsibilities that characterized the former system (Ot.prp.nr.66 2000-2001 § 2.2). In essence the core idea was to shape clear roles and form clear lines of responsibility by bestowing administrative and financial responsibilities upon autonomous public hospitals organized as health enterprises (HEs) (Ot.prp.nr.66 2000-2001 § 2.5.2).
Although the autonomical nature of the new enterprise model represents a strong devolutionary feature, the level of autonomy bestowed upon the health enterprises is nonetheless limited. By claiming sole ownership and thereby the position as the chief managerial authority, the central government has strengthened its grip on the health care sector, compared to the prior system where the limited control was maintained primarily through budgetary decisions in parliament, and have now unlimited control over the provision of specialized health care services (HD 2002c; Ot.prp.nr.66 2000-2001 § 2.5.1).

Furthermore, the role played by regional health authorities within the new system, imposes additional limitations on the autonomy of local health enterprises. As the main ministerial instrument of control over public hospitals, the regional health authority has an overall control over public hospitals and other specialized public health care institutions within its region of responsibility (Ot.prp.nr.66 2000-2001 § 4.6.3). This means that it is the regional health authority’s prerogative to decide how to organize the specialized health care services within their domain, either by organizing each institution as a local health enterprise, or by creating larger enterprises by compiling two or more institution in to one enterprise (Lov av 15. Juni 2001 nr 93 § 46-48). Consequently the regional health authority is intended to functions as a Health Corporations streamlining the use of resources, and thereby improving the level, range, and quality of health care services provided within their respective health regions (HD 2002c; Ot.prp.nr.66 2000-2001 §§ 2.8.1 & 2.10.1).

The new organizational structure of the Norwegian specialized health care system is as Figure 6 clearly points out characterized by clear lines of command. At the point of departure, the Norwegian specialized care system encompassed a total of 350 independent institutions of which 85 were hospitals organized as local, county, regional and national hospitals (HD 2002c). In 2003 the total number of independent health care organizations, was reduced to approximately 39, of which 5 were regional health authorities and the remaining 34 were local health enterprises encompassing a variety of health care institutions organized as sub-divisions within enterprises (Lægreid, et al. 2003: 11-12). Consequently, the line of command is simplified compared to the prior system. Each health authority and local health enterprise has their own professional boards. The Council of State represented by the Ministry of Health appoints board members for the regional health authorities (Lov av 15. Juni 2001 nr 93 § 8), which again appoints board
members for each of their respective health enterprises (Lov av 15. Juni 2001 nr 93 § 9). The general assembly for each individual health authority and enterprise, named “Foretaksmøtet”, is the only mean by which the owner, the ministry or the RHA, can enforce its ownership. In addition the ministry have the authority to issue letters of command (Lov av 15. Juni 2001 nr 93 § 16).

The Patients’ Rights Act

The Patients’ Rights Act (Act of July 2nd 1999 no. 63)\(^6\), entered into force on January 1st 2001 (SR 2000). Even though the Patients’ Rights Act of 1999 is a new phenomenon within the Norwegian legal and health care systems, neither legislative patients’ rights, nor the idea of a specific patients’ rights act, are something quit new. The patients’ right to primary health care in addition to several rights concerning complaints, information and medical records were introduced in the early 1980’s as integral parts of the primary health care legislation, in addition to several laws regulating the function of health professionals such as physicians, dentists and midwives (Ot.prp.nr.12 1998-1999 § 2.12). Nevertheless, the introduction of the Patients’ Rights Act and especially the patients’ right to choose hospital has been described by the former Minister of Health, Dagfinn Høybråten, as a grand revolution:

“The revolutionizing feature of the patients right of choice, which this contribute to, is that the hospitals no longer own their patients. That’s the great revolution” (HD 2003c)\(^5\).

The idea of a specific patients’ rights act began to emerge in the late 1980’s. On September 1st 1988, the Ministry of Health and Social Affairs constitute a commission with the mandate to formulate a proposal for a patients’ rights act. The commissions’ proposal (NOU 1992:8) was submitted to the ministry on July 1st 1991 (SHD 1997). Although this proposal did not specify a right of choice, it proposed instruments of power for the patients. One of the major subjects that were thoroughly debated during the evaluation process was rules regarding patients’ right to seek economical compensation if their right to medical treatment was not fulfilled by the primary or specialized health care service. The proposal finally came to a dead-end, even though most of the organizations involved in the hearing process was positive towards implementing patients’ rights (Ot.prp.nr.12 1998-1999 §§ 2.1-2.2).

The 1999 concept\(^5\)

Even though some patients’ rights already were in force, the new act of 1999 installed further rights for patients’ and their next of kin, in addition to strengthening those rights already in force. The predominant feature of this act is stated in the first paragraph:

“The objective of this act is to contribute to ensuring the population equal access to health care of good quality by granting patients rights in their relations with the health service.
The provisions of this Act shall contribute to the promotion of a relationship based on trust between the patient and the health service while having respect for the individual patient’s life, integrity and human worth.” (Act of July 2nd 1999 no. 63 § 1-1).

The act’s main objective is to empower patients by assigning them legal instruments to secure equal access to adequate health care service. Furthermore, the act is intended to promote relational trust between patients and the health care service. The rights installed by this act have to be viewed in light of these general provisions.

The Patients’ Rights Act constitutes several rights concerning: the right to health care (§§ 2-1 - 2-5), rights in relation to participation and information (§§ 3-1 - 3-6), rights relating to consent (§§ 4-1 - 4-9), rights in relation to access to medical records (§§ 5-1 - 5-3), special rights relating to children (§§ 6-1 - 6-4), and rights relating to complaints (§§ 7-1 - 7-6). In addition, the act installs regulation concerning the function of the patient ombudsman (§§ 8-1 - 8-8). Several of these patients’ rights are new occurrences within the Norwegian legislation. The following four paragraphs describe new rights that are central within the context of this thesis.

The act’s § 2-1, constitutes a right to specialized health care services. Nevertheless, this right is limited. The act explicitly states that the right to specialized health care do only apply if the cost of treatment is not reasonable in comparison to the expected benefits of the treatment:

“The right to health care only applies if the patient can be expected to benefit from the health care, and that the costs are reasonable compared to the expected effect that can be gained from the relevant medical measure” (Act of July 2nd 1999 no. 63 § 2-1).

Another interesting new feature is the patient’s right to get an evaluation of his condition within 30 workdays after being referred by a GP. Furthermore, the patient has the right to be referred to the specialized health care service for a second evaluation, or perhaps more correctly a second opinion, although, only once per condition (§ 2-2 - 2-3).

The most predominant feature of this act is the patients’ right to choose which public hospital should be responsible for his treatment, which may be considered as a revolution within the Norwegian health care system.

“The patient is entitled to choose which public hospital […] shall be responsible for his treatment”52 (Lov av 2. Juli 1999 nr. 63 §2.4).

Although there are limitations to this choice, these limitations have little effect on the possibilities for choice. The first limitation, which amusingly enough have been lost in the English translation published by the Ministry of Health (cf. Act of July 2nd 1999 no. 63 § 2.4), concerns the type of hospitals patients can choose from, that is to say publicly owned hospitals only. However, as will become apparent below, the way in which this paragraph have been interpreted, and the revision of this act that will be in force on September 1st 2004, have diminished the importance of the delineation between privately
and publicly owned hospitals. Another limitation, which similarly has little effect, concerns the treatment level:

“The patient may not choose treatment level” (Act of July 2nd 1999 no. 63§ 2-4).

The term treatment level, as used here, refers to the classification of hospitals as respectively local, regional, or university hospitals (SHD 2000 § 3), which all might be offering the same services within the medical field in question. Due to the reorganization of the publicly owned hospitals, as health enterprises, and cost-efficiency strategies, involving an evaluation of the division of labour, which have been implemented by most regional health authorities, the importance of this limitation have been reduced significantly.

Paragraph 3-1 constitutes the patients right to participate as regards to the implementation of his medical treatment, such as to choose between available and medical sound methods of examination and treatment. This right is closely linked to the right constituted by paragraph 3-2 as this paragraph constitutes the right to information. The patient is entitled the information required for him to be able to participate. Furthermore, the information must be presented in a form that is viable for the patient, and profound enough to give the patient insight into his medical condition, in addition to possible risks and side effects of the treatment (Act of July 2nd 1999 no. 63).

Future development

On December 2nd 2003, the law chamber of the Norwegian parliament passed a new act that changed several of the paragraphs in the patients’ rights act of 1999. In addition, this decision appended new paragraphs both to the patients’ rights act, and to other acts supporting the patients’ rights act (Besl. O. nr. 23 2003-2004). When these changes went into force on September 1st 2004 (SR 2004), some of these changes strengthened the patients’ rights, while others weakened these rights.

There are three major changes to § 2-1 relating to the patients’ right to specialized health care. The first constitutes that the specialized health care service is to determine a time limit, within which the necessary treatment needs to be provided.

”The specialized health care service is to determine a time limit inline with sound medical practice, within which the patient is to be treated” (Besl. O. nr. 23 2003-2004).

Secondly, if the regional health authority (RHA) responsible for the patient does not provide the necessary treatment within the time limit, the patient has the right to be transferred without delay to a private health care provider or to a health care provider abroad.

“If the regional health authority have not made sure that a patient, having the right to health care from the specialized health care service, is provided necessary treatment within the time limit determined according to the second section, then the patient have the right to receive necessary health care without delay from
private health care providers or from health providers abroad" (Besl. O. nr. 23 2003-2004).55.

Thirdly, if the RHA is not able to provide adequate treatment at a Norwegian facility, the patient has a right to be administered the necessary treatment abroad within the time limit given.

"If the regional health authority is unable to provide health care for a patient having the right to health care, due to non-existence of adequate medical services within the country, then the patient have the right to receive such health care from health care providers abroad, within the time limit determined in accordance with the rules in the second section" (Besl. O. nr. 23 2003-2004).56.

The change in relation to § 2-2 in the patients’ rights act, which guarantee evaluation within 30 workdays of the referral, weakens the patients’ rights by excluding other patients then those eligible for patients choice according to § 2-4.

“Patients that are referred to a hospital, or a specialized day-patient clinic, in accordance with § 2-4, have the right to receive preliminary examinations within 30 workdays of submission” (Besl. O. nr. 23 2003-2004).57.

In contrast, the changes to § 2-4 extends the patients’ right to choose between different health care providers, by including sub-divisions within any public hospitals and any private hospitals that have a contract with any Norwegian RHA.

"The patient’s right to choose which hospital [...], or ward within such an institution, the treatment is to take place. It is conditional that the hospital [...] is owned by a regional health authority, or have an contractual arrangement with a regional health authority that grant the patient such an right of choice” (Besl. O. nr. 23 2003-2004).58.

The decision of December 2nd 2003 appended a new § 2-7 to the patients’ rights act, that severely weakens the patients’ rights as regards to protection by law. The new paragraph states that the Public Administration Act (cf. Act of February 10th 1967) do not apply to the rules in the second chapter of the patients’ rights act, that is to say §§ 2-1 – 2-6 (cf. Act of July 2nd 1999 no. 63).

"The new § 2-7 shall be:

Application of the Public Administration Act

The Public Administration Act do not apply to the rules constituted in this chapter” (Besl. O. nr. 23 2003-2004).59.

The last change to the patients’ rights act of 1999, is the constitution of a special national commission for decisions regarding complaints filed by patients’ concerning the patients’ right to health care (cf. Act of July 2nd 1999 no. 63 § 2-1).
"A patient, or the patient’s representative, believing that the rules stated in paragraph 2-1, fifth sentence, not have been upheld, my file a complaint to the commission appointed by the ministry” (Besl. O. nr. 23 2003-2004)\textsuperscript{61}.

The remaining changes installed by the Odelsting decision referrers to §§ 2-4 and 5-2 of the act regulating the specialized health care service (cf. Lov av 2. Juli 1999 nr.61), and concerns the new financial obligations for regional health authorities regarding the appendication of private and foreign health care providers in §§ 2-1 and 2-4 of the patients’ rights act of 1999 (Besl. O. nr. 23 2003-2004).

However, to be considered in relation to the patient’s rights act, the patients are dependent on their local general practitioner (Act of July 2nd 1999 no. 63 § 2-2).

The Regular General Practitioner Scheme

The Regular General Practitioner Scheme (RGPS) was originally intended to be introduced by January 1st 2000 (Ot.prp.nr.12 1998-1999 § 2.7), but due to unknown reasons the scheme was not set in operation until June 1st 2001 (HD 2001b). The core idea of the RGPS is that by introducing Regular General Practitioners (RGP), it constituted a way of providing continuity in the relation between health care services and patients by a system of contracts (HD 2004c: §§ 1-6). Both the relation between the GP and the primary health service, in other words the municipality, and between the GP and the patient is of a contractual nature (HD 2004c §§ 3-6, §§ 11-13; Ot.prp.nr.99 1998-99 § 4.4.1). In the context of this thesis, the latter is of major significance as the RGP represents the link between the patient and the specialized health care service.

The gatekeeping function of the RGP

The patient is dependent on the RGP for being referred to specialized care as regards to evaluation and treatment.

“The evaluation shall be based upon the referral” (Act of July 2nd 1999 no. 63 § 2-2).

This statutory imperative is further strengthened by the regulations concerning reimbursement of the specialized health care service:

“In order for specialists to be reimbursed for a consultation from the National Insurance Fund, the patient does have to be referred to them from a general practitioner. Such referral is equally necessary for reimbursement of other services such as physiotherapy and transportation costs” (NBH 2004b).

The gatekeeping function of the GPS-system in relation to the patients’ right to choose can perhaps best be described by the use of an example. If we imagine a patient suffering from pains in one of his/her hips, the patient will first have to seek out his RGP for advice and primary care (Act of July 2nd 1999 no. 63 § 2-1). While seeing the patient the RGP has to decide whether to prescribe medication if he recons such an
intervention to be adequate, or to refer the patient to specialized care for preliminary examinations (Act of July 2nd 1999 no. 63 §§ 2-2 - 2-3).

If the latter is the result of the RGP’s examination, then the patient is faced with his first opportunity to choose where to get further evaluation (cf. Act of July 2nd 1999 no. 63 § 2-4). The patients’ rights act does not specify preliminary examination as a subject of choice. Nevertheless it has become a common interpretation that the term “responsible for his treatment” (ibid.) defines preliminary examination as an integral part of the treatment. This interpretation is supported by several regional health authorities that have issued statements about their interpretations (Iversen 2002: 13-15). As an example, the Western Norway regional health authority defines the patients’ right to choose as relating to preliminary examination and specialized interventions:

“The right of choice is invoked both in relation to preliminary examination and treatment, […]” (Helse Vest 2004)

In this case, the patient is depending upon the RPG for advice, if the patient himself either does not have the knowledge to decide for himself, or do not have the resources necessary for obtaining such knowledge on his own. Advice or search for information and knowledge might be vital in this situation, as some hospitals have long waiting lists and others do not, and perhaps more important, some hospitals are recognized as centres of excellence and again others are not. The patient’s condition will be an essential element in this decisional process as regards the degree of agony experienced by the patient, especially if the relation between length of waiting lists and level of excellence of respective hospitals do not represent corresponding values.

The second possibility of choice for the patient becomes a reality if the specialized health care service after preliminary examination recommends further specialized interventions (Act of July 2nd 1999 no. 63 § 2-4), e.g. arthroplasty due to the degree of attritional changes in the hip joint. In this case, since hip replacement is a case of elective surgery, the patient will be returned to his RGP either with a stipulated appointment for surgery, or without any appointment (Act of July 2nd 1999 no. 63 § 2-2). Regardless of further appointments, the patient now has the option to choose which hospital to undertake the hip replacement, and consequently the deliberation concerning length of waiting lists, levels of excellence, and the patient’s level of agony, will have to be repeated.

The New Financial System

The mechanism that opened the door for the introduction of patients’ right to choose is the new system of finance (ISF) introduced July 1997. Just as the former system, the new system is also fully tax-based. ISF does not alter the health care coverage, provided by the National Social Insurance Scheme, for the population. Nevertheless, the new system was installed to fulfil the waiting list guarantee by providing an efficiency enhancing incentive for county-owned hospitals. Within the prior system there were no incentives stimulating efficiency neither economical nor related to medical treatment. Block grants as a base for hospital finance led to a situation where a higher level of activity weakened the financial
situation for the hospital (Biørn, et al. 2002: 4-5; St.meld.nr.44 1995-96 §§ 7.4.1 - 7.4.3). In addition to providing financial incentives of efficiency, and a solid foundation for financial control, the main object was to create equal access to health services of good quality for the whole population (HD 2003a: 5 and 32; St.meld.nr.44 1995-96 § 7.4.1).

The 1997 concept

The reality in the new financial system is that block grants’ no longer constitutes the total financial foundation for the specialized health care sector. In contrast to the prior system, ISF is a partially activity-based fee-for-service system where activity is measured in terms of a system of Diagnosis Related Groups (DRG). The logic of the DRG-system is that any hospital admissions can be categorized based on medical and administrative information concerning the patient. The categories are mutually exclusive and approximately homogeneous in an economical sense (Biørn, et al. 2002: 4-5; HD 2003a: 32).

Although the new financial system, when introduced in 1997, still canalized hospital funds through county budgets, a 30 percent fraction of the total was activity-based, and was intended as a foundation for activity-based contracts between the county councils and their hospitals. The activity-based percentage was raised in 1998 to 40 percent, and again in 1999 to a level of 50 percent (Biørn, et al. 2002: 3).

With the introduction of RHAs in July 2001, and State ownership by January 2002, the recipient of the activity-based percentage of the total funding is the regional health authority within the patients’ region of residence. If the number of non-resident patients’ treated raises above the number of resident patients treated outside the region, then the level of reimbursement will not reflect the real level of activity within the region. This inequality will then have to be balanced out by inter-regional compensations, based either on contractual arrangements, or on standard fees. The average standard fee for 2002 was approximately 80 percent of the average total cost of each DRG (NOU 2003:1 § 9.2).

Later developments

The new financial system was a cornerstone as regards to the introduction of the Patients’ Rights Act in 2001, as ISF was intended to open the door for the patients’ right to choose health service provider, without further financial burdens for the hospitals. In 2003, one year after the central government had become the sole owner of Norwegian public hospitals, the activity-based percentage was raised further more. At this point only 40 percent of the total hospital funding was in the form of annual block grants. The remaining 60 percent of the financial foundation was now directly linked to patient related activities (HD 2003a:7). The strengthened emphasise put on efficiency enhancement must be viewed in light of the introduction of patients’ choice as a incitement intended to instigate competition within the Norwegian hospital sector. As a result of the new market situation some hospitals attempted to attract new patients by advertisements in local newspapers (Hafstad 2003).
Nevertheless, Norwegian hospitals experienced problems adjusting to the new health care system. Most local health enterprises experienced financial crises, which lead to a situation where conflicts began to emerge, both between different institutional levels within the health care system (HD 2002b, 2003e), and between some regional or local health enterprises and the population in their local communities, especially in more rural areas (Dahl 2003; FFL 2003; HD 2003d; SN 2003). To overcome these problems, regional and local health enterprises had to re-examine the level of service they could provide (Haaland 2002; Nybo 2003), and most health care enterprises had to announce publicly that they no longer could guarantee adequate health care services within their regions (Berg 2002; Kubens 2004; Martinsen 2002). Within Health-South, the somewhat creative but perverse solution to this problem was to take advantage of the ISF-system by recoding patients’ diagnosis, in an attempt to generate a higher level of reimbursement from the central government (HD 2003b).

During the summer months of 2003, the central government issued a letter of command where regional health enterprises were instructed to ensure that the total level of production of health care services within their respective local health enterprises in 2003, not should be advanced above to the total production level of 2002 (HD 2003f). Furthermore, when the ISF regulations for 2004 were published, the central government had reduced the activity-based percentage of the annual total by 20 points, from 60 percent in 2003 to 40 percent, which is the same level as in 1998 (Biørn, et al. 2002; HD 2004b: 5). Although the parliament have decided to maintain the 2003 level of production for Norwegian hospitals in 2004 (B.innst.S.nr.11 2003-2004: 73), the incentive for competition between Norwegian health regions, and the incentive for further increased production and reduction of wait time, are reduced.
The Ministry of Health

Until now in this thesis, we have focused on the reform process as a global ideal in chapter 5, and as a product of historical development as well as political deliberation and decision-making in chapter 6. In the two following chapters, the focus will be on how these political decisions are implemented at the ministerial level and the hospital level within the Norwegian specialized health care system. In this chapter, we look at the ministerial level; the Ministry of Health and governmental health agencies through which the ministry maintains its authority.

The different roles of the Ministry of Health

Primarily, the Ministry of Health is an executive body, which carries out decisions made by the parliament and the Council of State. Within the context of the specialized health care system, these functions refer to the role as the acting owner, the role as the principal actor of control, as well as the role as the principal guardian and promoter of reform and reform elements such as patients’ rights. Secondly, prior to such political decisions, the ministry is the principal actor in relation to preliminary examinations, decisional recommendations, and background information services (e.g. Ot.prp.nr.66 2000-2001; St.prp. nr. 1 2003-2004).

Our main concerns within the context of this thesis are the executive functions of the ministry in relation to implementation of the health care reform. That is to say the ministry’s roles as the acting owner, as the principal agent of control, and as the central promoter of reform. Although these roles can be difficult to hold apart (HD 2002a: 60), it is necessary to be aware of the difference between these roles, as they closely correspond to the values of accessibility, transparency, and public choice. As the acting owner, the ministry provides accessibility to health care services of quality. Through the role as the principal agent of control, the ministry collects the information necessary to create transparency in terms of a system of health accounts. Finally, as the central promoter of reform, the ministry disseminates information intended to promote public choice.

Providing Accessibility: The role as the acting owner

The perhaps most prominent role bestowed upon the Ministry of Health, in relation to the reformed Norwegian specialized health care sector, is the role as the acting owner of Norwegian public hospital. This role represents the elongated and omnipresent power of the state, and embodies a dilemma caused by the state’s many conflicting roles, conflicts that may cause both unclear signals of governance, centralisation, and inflexibility in conflict with the core idea of the Norwegian health care reform (HD 2002a: 60);
providing the population good access to health care services of good quality for the whole population, regardless of age, sex, or residence, and provided by a publicly governed health care sector (St.meld.nr.50 1993-94).

As the acting owner of Norwegian public hospitals, the ministry plays an active role in the management of the five regional health authorities, both in a direct and an indirect sense. Although, the only legal channels of communication through which the ministry as the acting owner can issue authoritative commands are the general assembly65 and fiscal regulations (Lov av 15. Juni 2001 nr 93 § 16) such as the national budget and the letters of command, all channels of communication between the specialized health care sector and the state runs through the Ministry of Health. Even though, the ministry’s direct means of governance, in relation to the hospital sector, are limited to these three channels of communication, there are no theoretical limits to the number of meetings of the general assembly within each regional health authority. Nor are there any limits to the number of regulations (e.g. letters of command), or the range of such regulations, issued by the ministry or governmental health agencies, as long as these regulations are inline with the delegated authority66 held by the ministry as an executive body within the Norwegian political system. In addition, the ministry have indirect means of governance available through its instructional authority e.g. in relation to the governmental health agencies discussed above. An example of this is the role played by the Norwegian Patient Register in relation to activity-based funding (HD 2004b: 11-15).

In sum, the Ministry of Health has just about full managerial control of all aspects in relation to the development of the specialized health care sector, although with the exception of political issues raised independently by parliamentary committees, or individual members of parliament. The increased central control is intentional and emphasised in the whitepaper concerning the Norwegian hospital reform:

“This proposal forms the basis for increased governmental control, as the ownership, the authority, as well as the fiscal governance, all are held by the same hand” (Ot.prp.nr.66 2000-2001 § 2.1.2).

Since, the fiscal channel, that is to say the national budget and the yearly revision of the ISF/DRG system, already have been described, we focus our attention on the letter of command.

The letter of command, which states the goals of the specialized health care sector within each region, is the central strategic document guiding the functions of the regional health authority68. While the first and the third chapter of the letter refers to fiscal arrangements and priorities, and chapters 4-7 refers to relations with other actors as well as the chain of command, chapter two refers to the owners demands as regards to the responsibilities of the regional health authority in relation to provision of health care services within its region.

Paragraph 2.1 refers to different aspects concerning treatment of patients. In the 2004 edition, the RHAs are commanded not to advance the production of somatic services above the production level achieved in 2003 (HD 2004d: 7). However, this commandment is given with reference to a invalid paragraph (§ 3.1.1) of the proceedings
of the parliament’s committee on health and social affairs\(^6\) regarding the national budget for 2004 (cf. B.innst.S.nr.11 2003-2004). Nevertheless, in the letter of command, the ministry states that the current levels of production are at a satisfactory level as regards to the ambitions of reduced wait time:

“In the last years, there have been significant increases in patient treatments, which have reduced the length of wait time. The need for a strong stimulus in relation to increased production is not as strong now as in prior years. Although there should still be focused on keeping the waiting lists at a low level” (HD 2004d § 2.1).\(^7\)

In fact the commandment in relation to the production of somatic services in 2004, stipulates a level of production similar to the level of production achieved in 2002, as the regional health authorities on June 25th 2003 were instructed not to advance the total level of production in 2003 above the factual level of production achieved in 2002.\(^8\) Moreover, if we look at the 2003 statement (HD 2003g), as regards to the stipulated level of production, we can see that the 2002 level, which is the same level as stipulated for 2003 and 2004, in fact are defined by de increased level of production in the period 2000-2002, that is to say the two last years prior to the state’s takeover:

“...The activities within the hospitals have been estimated to be increased by approximately 6 per cent from 2000 to 2002 (measured as the average of 24-hour hospitalization and day-patient treatment). The total fiscal framework, which the regional health authorities have been granted for the year 2003, is intended to keep the level of activities at the approximately same level as in 2002...” (HD 2003g § 3.1).\(^9\)

Nevertheless, we have to bear in mind that the level of production in this context is defined in an economical sense, and not in terms of the number of patients treated. In this regard, the predominant demand articulated in the 2004 version of the document requires that the public hospitals’ budgetary deficits are to be recovered before year-end 2005 (HD 2004d: § 3.1.1). Such a focus on economical efficiency, especially when paired with a focus on reduced wait time, might not be beneficial, neither in terms of health care outcomes, nor in terms of the peoples trust in the publicly governed health care system. Although there are no evidence of causation at the present, statistics have shown that whilst the number of patients treated in the first four months of 2004 have increased by 7 per cent (NPR 2004a), the number of patients seeking recompense have increased by 33 per cent (NPE 2004), compared to the corresponding period of 2003.

Leaving the commandments in relation to the level of production aside, the significant commandments for 2004 in relation to somatic services, relates to quality. In paragraph 2.1.1, the ministry states specific demands in relation to the individual hospitals’ achievements as regards to three different quality indicators. That is to say, in 2004, 80 percent of medical records are to be submitted to the patients RGP within 7 days of dismissal (q1), secondly, there are in principle not to be any patients in corridors (q2), and finally, in relation to femoral neck fractures (q3), no patients are to experience preoperative hospitalization for more than 48 hours (HD 2004d: 9).
Perhaps the most significant changes concerning the 2004 edition of the document are the elements left out. If we compare the letter of command for 2004 with the corresponding document for 2003, we find some significant changes. Firstly, the 2004 document contains only 20 pages, while the 2003 version of the document contained 40 pages. Among the pages removed in the 2004 edition are pages concerning the basic values of the health care service, the level of legitimacy of the health care service, and especially, pages relating to the enhancing and maintaining trust as regards to patients and citizens in general. In the 2003 edition, legitimacy and trust were linked to most aspects of the specialized health care service, both at the regional and at the local level. As a main guiding principle, the 2003 edition stated that:

It is important that the individual health enterprise, and medical units within such enterprises, gain and maintain its legitimacy, and the trust of the population” (HD 2003g: 11) 74.

In addition, legitimacy and trust were linked to several aspects of the health care service, such as effective use of resources, quality, individual treatment of patient, as well as the enhanced power of the patients:

“An effective use of resources enhances the accessibility of the health care service, as well as the trust bestowed upon health enterprises and the health care service.

[…] To gain and maintain trust, it will be necessary to strengthen the focus on the quality of the health care services, especially in regard, and respect, of the patient’s integrity” (HD 2003g) 75.

In total, there are 10 references to the term of trust in the 2003 edition of the document, whereas the 2004 edition only uses the term twice, that is to say in relation to the decree concerning open board meetings (HD 2004d: 18), and the general principle of an communicative attitude as regards to public relations (HD 2004d: 1).

In sum, the recent development in the health care policy proclaimed by the Ministry of Health is characterized by an omnipresent focus on economical efficiency in terms of increased treatment related activity, funded by a fiscal framework at standstill76.

Although the Ministry of Health through its role as the acting owner can enhance accessibility and equity, transparency is equally important if the Norwegian health care reform is to promote relationships based on trust between patients and the specialized health care sector (cf. Act of July 2nd 1999 no. 63 § 1-1).

Providing Transparency: The role as the principal agent of control

Through its role as the principal agent of control, the ministry acts as the main coordinator and executive authority in relation to control functions within the health care system. The role of control is a fundamental function within the health care sector, as functions of control is the backbone of any system of health accounts, which according
to the OECD is a prerequisite for good health care sector governance (OECD 2000b: 11-13). Control through a system of health accounts is moreover a prerequisite for the transparency necessary for patients in the process of choice, as such a system makes hospitals as well as other actors within the health care sector accountable for the quality of the services they provide, not only in terms of economical efficiency and medical quality, but also in terms of accessibility and equity through public choice. In other words, as the principal agent of control the ministry acts as a guardian of the core values of the Norwegian health care sector. That is to say:

"securing the whole population, regardless of age, residence, and sex, good access to health care services of good quality provided by an publicly governed health care sector" (St.meld.nr.50 1993-94).

The importance of the functions of control, in terms of a system of health accounts, makes it difficult to separate functions of control from functions of information. Nevertheless, as control and transparency obviously are not the same, and the difference between these to functions of governance is vital in relation to the reality of the patients’ right of choice, these roles will be discussed separately.

The Ministry of Health maintains its role as the principal agent of control through delegation of authority to different governmental health agencies (cf. Lov av 30 Mars 1984 nr. 15 § 7). Nevertheless, the ministry has an unlimited instructional authority, e.g. through its fiscal authority, as regards to how these functions of control are performed. Within the scope of this thesis, there are five governmental agencies concerned with these functions of control, that is to say the Directorate for Health and Social affairs, the Norwegian Institute of Public Health, the Norwegian Patient Register, the Foundation for Health Services Research, and the Norwegian Board of Health. In addition, there are a number of so-called national medical quality registries.

The Directorate for Health and Social affairs is, through its department for Priorities, Guidelines, and Quality, responsible for developing quality indicators, and quality control systems for the Norwegian health care sector (Shdir 2003e: 23). In cooperation with the Norwegian Board of Health (Shdir 2003d: 6), the directorate has so far developed seven national quality indicators for Norwegian somatic hospitals (Shdir 2004g). These are (q1) ratio of medical records submitted within seven days (Shdir 2003a), (q2) number of patients in corridors (Shdir 2003c), (q3) preoperative length of hospitalization in relation to femoral neck fracture (Shdir 2003f), (q4) number of planned operations being cancelled (Shdir 2004d), (q5) wait time before primary treatment of colorectal cancer (Shdir 2004e), (q6) number of individual plans for patients in programs relating to habilitation of children (Shdir 2004f), and (q7) prevalence of hospital infections in Norwegian somatic hospitals (FHI 2003).

Although the national quality indicators are developed by the Directorate for Health and Social affairs, the control and registration of data in relation to these indicators are maintained by other governmental health agencies. That is to say, the Norwegian Institute of Public Health, which register data in relation to the national quality indicator prevalence of hospital infections in Norwegian somatic hospitals (FHI 2003: 1-3), and the
Norwegian Patient Register (NPR), which registers data on the other six national quality indicators mentioned above.

The Norwegian Patient Register has furthermore the responsibility for collecting and verifying patient data submitted by somatic hospitals and psychiatric institutions in Norway. Within the patient data definition there is extensive range of different variables\(^\text{79}\), such as age, sex, diagnosis (DRG), length of hospitalization, modes of admissions, types of hospital, and types of hospitalization. A complete list of all variables registered within the patient data definition can be found in 0. Furthermore, NPR also registers data on factual wait time and number of patients currently on waiting lists (NPR 2004d). However significant these registrations are, it is important to be aware of the fact that all data mentioned so far are self-reported either by local health enterprises or by regional health authorities. That is to say that the control function performed by these agencies concerns technical aspects of the registration process only and not the quality of the data in itself. Pecuniary recoding of the patients’ diagnosis is an example of misconducts that this type of controls is unable to disclose due to the self-reported nature of the data.

In addition to national quality indicators, the Directorate for Health and Social affairs has developed four quality indicators concerning patient satisfaction. That is to say (p1) patients' assessment of the standard of buildings, equipment, and more, (p2) patients experience with physicians and nurses, (p3) patients' assessment of how the hospital are organized, and finally, (p4) patients' assessment of the information they have been given by health professionals (Shdir 2004c). The data on these indicators are collected by the Foundation for Health Services Research\(^80\), which is responsible for governmentally sanctioned patient satisfaction surveys in Norway.

Another crucial role in relation to the control of the Norwegian health care sector is played by the Norwegian Board of Health\(^81\), which through its 19 County Medical Officers, is the only health agency that performs onsite monitoring and supervision within the Norwegian health care sector (NBH 2002: 11). In addition, NBH, through the county governors, can issue instructions when health care services are provided in a way that are unfavourable or unacceptable for patients and other stakeholders (NBH 2004a). Within the context of this thesis, the NBH’s survey of how Norwegian hospitals perform as regards to the regulations constituted by the Patients’ Rights Act is of predominant interest, as the report concludes that there are significant needs for improvements both as regards to the patients’ rights to necessary health care\(^82\), and the patients’ right of choice\(^83\) (NBH 2004c: 13-14). It is nevertheless from the patients’ point of view unfortunately that the report does not give any references to the performance of individual hospitals. Although some county governors have published detailed reports covering their region of authority, most users will probably have a hard time getting hold of these reports, as they are only available through the individual county governors’ offices.

Even less available and known, are the national medical quality registries in Norway, which only can be described as a well-hidden secret within the Norwegian health care system. The reason for this is that there is no uniform structure as regards to maintenance or ownership of these registries. It was not until 2001 that the government developed national guidelines in relation to how these registers were to be organized and
maintained (cf. HD 2001a). Although several of these registers still are “the property” of individual medical specialists’ organizations (Aarseth 2001), 16 are transferred to different governmental health agencies. Of these, the perhaps best known are The Cancer Registry of Norway; which incorporates 9 different registries (CRN 2004), The Norwegian Arthroplasty Register (NAR 2004), and The Medical Birth Registry of Norway (MF 2004). Nevertheless, none of these registries, or the information they contain, are publicly available, although both publicly funded and owned.

As regards to information accessibility, the situation is quite the opposite, at least to some extent, when it comes to governmentally sanctioned information intended as enlightenment for patients in the process of choice.

Providing Public Choice: The role as the central promoter of reform

Another role bestowed upon the Ministry of Health is the role as the central promoter of reform. Leaning on the terminology of genetics, the promoter is the part that secures a safe connection between ideal and reality, that is to say the function that within the context of the public health care sector makes sure that reform ideals becomes reality. This can be viewed as a function of information and support, where the ministry is responsible for coordinating information and support activities in relation to the Norwegian health reform as regards to hospitals, medical professionals, and not at least, as regards to patients in the process of choice.

Governmentally sanctioned and public available information concerning the elective services within the specialized health care sector is available from several sources such as individual hospitals, local health enterprises, and regional health authorities, which are the only actors obligated by law to provide information (cf. Lov av 2. Juli 1999 nr.61 § 3-11), and from different governmental health agencies including the ministry itself. The information available through these different channels differs as regards to content, technical level, and intended audience. Whereas information published by individual hospitals and local health enterprises mainly are of a pragmatic nature, and intended for patients already admitted, or patients waiting for treatment at that particular hospital, information published by regional health authorities, and the Ministry of Health as well, tends to be tailored for the press and the general public, and are often of a more general nature, although RHA’s also publishes some statistical data such as data from patient satisfaction surveys.

The picture is somewhat different when it comes to information published by governmental health agencies, as the information published by these is both more detailed and technically advanced. The reason for this is that this information is intended as support for specific groups in the society, that is to say patients in the process of choice, and health care executives, as well as politicians, in the process of governance. Within the context of this thesis, two of these agencies are of special interest, namely the National Information Service for the Patients’ Right of Choice, which as the name indicates provides patients with information regarding individual health care providers,
and the Norwegian Patient Register, which provides health care executives and politicians with so-called regional governance information.

The National Information Service for the Patients’ Right of Choice87, inaugurated May 8th 2003 by the former Minister of Health Dagfinn Høybråten, is the government’s preferred channel of communication as regards to information intended to enable Norwegian patients to make use of their free choice of hospital. Although the information service was in operation prior to this date, the minister proclaimed that the 2003 upgrades would secure the reality of the patients’ free and critical choice, and thereby also securing the patients’ choice of hospital as a utilization factor for individual patients, general practitioners, as well as the Norwegian society in general (HD 2003c). The patients’ free choice of hospital is according to the Minister an incitement intended to motivate Norwegian hospitals to improve their services, as they no longer own their patients, and now runs the risk of not being chosen by potential patients. Furthermore, he stated that if patients and RGP’s are to make informed choices, they are dependent on easy access to the necessary information. Therefore, to further secure the patients’ right of choice, and thereby the further development of the Norwegian hospital sector, two new features were added to the national information service, that is to say estimated wait time in addition to the prior historical wait time, and national quality indicators (HD 2003c).

The national information service is not organized as an independent body, but as a virtual reality hybrid, an information gateway, with a partially decentralized structure. The newly established88 Directorate for Health and Social affairs, through its Department of IT-strategy and statistics, is the responsible coordinator of the service (FSN 2004f; Shdir 2003b: 1; 2004j). The technical operation of the service’s database and internet gateway is however delegated to the private firm, CSC Solutions Norge AS, through NOK 7 million yearly contracts successively until September 30th 2005 (Shdir 2004a). Whereas the supporting telephone service is maintained by five patient advisors individually employed by the five regional health authorities in Norway (FSN 2004f). Although the National Information Service for the Patients’ Right of Choice have received a lot of attention, the government’s efforts as regards to patient related information seems pale compared to the resources allocated in relation to other publicly funded information services. As an example the National Information Service for Fruit and Vegetables89, has six employees (OFG 2004: 4) and received Nkr 28.5 mil90 through public funding in 2003 (OFG 2004: 21), the National Information Service for Diary Products91 has six employees (OFM 2004), and the National Information Service for Meat92 has 12 employees (OFK 2004).

As the National Information Service for the Patients’ Right of Choice is a rather new occurrence within the Norwegian specialized health care system, it is unsurprisingly not without flaws, although some have argued that these flaws are not due to the greenness of its years (cf. NRK 2004b). Nevertheless, the main areas of concern are the accessibility of the service and the quality of the information published by the service.

Although users can make use of the service’s database both through a telephone service and by computer through an internet user interface, we have to assume, if we take the Norwegian patient demographic in to account (see Table 8), that the telephone
service is the preferred channel of communication for most users, as not every one have access to a computer or do not know how to use one even if they had access. Hence, approximately 58 per cent of Norwegian patients eligible for choice are 50 years old or more. Moreover, although the telephone service is available through a free-call number, the capacity of the service is limited as the telephone service and its five patient advisors are available workdays between 0800 and 1500 only, and further limited by the fact that referring RGPs are prioritized through a dedicated non-listed telephone number (HD 2003c). In sum, we have to assume that patients and their relatives might have a hard time trying to access the service, even if only a fraction of the approximately 700 00093 patients eligible for choice, and the 3 69594 referring RGPs in Norway, are to make use of the patient advisors’ limited time.

Table 8 – Percentage of 24-hour hospitalizations in relation to normal/elective services, as percentage per age group. Source: Norsk Pasientregister (NPR 2004b).

<table>
<thead>
<tr>
<th>Age</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 15 years</td>
<td>10.74%</td>
<td>10.05%</td>
<td>10.31%</td>
<td>9.80%</td>
</tr>
<tr>
<td>16 - 49 years</td>
<td>30.96%</td>
<td>30.90%</td>
<td>30.82%</td>
<td>31.91%</td>
</tr>
<tr>
<td>50 - 66 years</td>
<td>27.08%</td>
<td>27.81%</td>
<td>28.47%</td>
<td>28.97%</td>
</tr>
<tr>
<td>67 - 79 years</td>
<td>22.75%</td>
<td>22.62%</td>
<td>21.66%</td>
<td>20.53%</td>
</tr>
<tr>
<td>80 years or more</td>
<td>8.47%</td>
<td>8.81%</td>
<td>8.73%</td>
<td>8.79%</td>
</tr>
<tr>
<td>All ages</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Patients 50 years or more</td>
<td>58.30%</td>
<td>59.04%</td>
<td>58.87%</td>
<td>58.29%</td>
</tr>
<tr>
<td>Patients 67 years or more</td>
<td>31.22%</td>
<td>31.23%</td>
<td>30.40%</td>
<td>29.32%</td>
</tr>
</tbody>
</table>

Setting the question of accessibility aside, there is still the question of transparency in terms of the quality of the information published by the information service.

The information service publishes a variety of information including historical and future estimated wait time for approximately 90 different diagnoses, and data on four national quality indicators (HD 2003c). These are (q1) ratio of medical records submitted within seven days, (q2) number of patients in corridors, (q3) preoperative length of hospitalization in relation to femoral neck fracture, and (q7) prevalence of hospital infections in Norwegian somatic hospitals. In addition, the information service also publishes data on four patient reported indicators, that is to say (p1) patients’ assessment of the standard of buildings, equipment, and more, (p2) patients’ experience with physicians and nurses, (p3) patients’ assessment of how well the functions of the hospital are organized, and (p4) patients’ assessment of the information they have been given by the health professionals. The background data for the historical wait time is provided by the Norwegian Patient Register (FSN 2004a), whilst data in relation to estimated wait time is reported directly by the regional health authorities when requested by CSC Solution (Shdir 2003b: 4). Data concerning the national quality indicators are provided by the Norwegian Patient Register (Shdir 2003a, 2003c, 2003f), and the Norwegian Institute
of Public Health (FHI 2004a), whereas the Foundation for Health Services Research provides data on patient reported indicators (Heltef 2004b).

Table 9 – Estimated and historical wait time for coronary bypass surgery. 
Source: Fritt Sykehusvalg Norge (FSN 2004c).

<table>
<thead>
<tr>
<th>Hospital or health enterprise</th>
<th>Median wait time in weeks</th>
<th>Estimated*</th>
<th>Historical**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feiringkliniken</td>
<td>1</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Haukeland Universitetssykehus</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Hjertesenteret i Oslo (Rikshospitalet)</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>St. Olavs Hospital</td>
<td>8</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Ullevål Universitetssykehus</td>
<td>3</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Universitetssykehuset i Nord-Norge</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Explanations
-- data not available
* - Updated May 9th - June 5th 2004
** - Not updated since April 30th 2003

Although those responsible for the service states that the purpose of the service is to enable patients to make informed choices, by providing them with relevant information (FSN 2004c), they point out that the published data on quality indicators do not necessarily provide information about quality in terms of health outcomes (FSN 2004c), that is to say that there is no data indicating the result of medical treatment provided by the different hospitals. In fact, some have claimed that the National Information Service for the Patients’ Right of Choice is deliberately designed so to prevent patients form comparing different hospitals as regards to the quality of the service they provide (NRK 2004b), and they might rightfully be doing so. With the exception of data concerning estimated wait time, there is no option of a tabular view enabling users to compare the values of individual hospitals. If a user wants to compare hospitals as regards to their “score”, he will have to look up each hospital individually while making notes. Nevertheless, the lacking tabular view is not the main problem concerning the information published by the national information service, although such a user interface might have revealed some of the inaccuracy characterizing the published information. An example of this inaccuracy is shown in Table 9, where the discrepancy between estimated and historical wait time is apparent. Moreover, this example also shows that the data on historical wait time have not been updated since the inauguration of the “improved” information service in May 2003.

Nevertheless, problems concerning the way in which wait time is published are not the main problem as regards to the reliability of the information published by the national information service. The main problem is to be found in the way in which data on national quality indicators and patient reported indicators are published, and in fact
registered, as these data are published and recorded as aggregated values at an institutional level only. That is to say that the reported data relates to the hospital, or in some cases the local health enterprise (see Table 10), as one entity. Thereby the published data conceals the factual situation as regards to the performance of individual departments and wards, or individual institutions within a local health enterprise. As there within larger health enterprises might be several institutions providing the same kind of service, we have to assume that there might be differences as regards to the performance of these institutions. Moreover, the published data are not specified as regards to different types of interventions, diagnoses, or DRG-categories. Consequently, the quality of the data is not improved even if the published data is aggregated at the hospital level instead of the enterprise level. As most hospitals have a broad range of different departments specializing in different areas of medicine, it would be fair to assume that there might be significant differences as regards to performance within the same institution. In sum, this might lead to a situation where a patient mistakenly trusts a hospital in the belief that the department in question performs well, when in fact the situation might be quite the opposite. This becomes apparent if we take a closer look at the data provided by the Foundation for Health Services Research and the Norwegian Institute of Public Health.

Inaccuracy is a claim that have been made about the published information on indicators concerning patients’ satisfaction (NRK 2004b), which is collected and compiled by the Foundation for Health Services Research (Heltef) (FSN 2004g). The four patient reported indicators published by the National Information Service for Patients’ Right of Choice is a small sub-set of results from a number of separate surveys covering 60 somatic hospitals in total, which were completed by Heltef in the period from September 1st 2002 until September 28th 2003 (Heltef 2004a), using questionnaires sent to a representative selection of patients two weeks after dismissal (Brekke, et al. 2003c: 8). There are several problems with these surveys, both as regards to methodology, and as regards to the compilation and publication of the results. From a methodological point of view, the main problem is that data are only registered at the hospital level. Earlier patient satisfaction surveys performed by Heltef have shown that there can be significant differences between different wards and departments within a hospital as regards to quality in terms of patient satisfaction (Brekke, et al. 2003c: 6).

As mentioned in chapter 1, patients tends to overrate their satisfaction as regards to the health care services they receive (cf. Jensen, et al. 1992). A good example of this is the so-called “back-project” at the hospital in Hammerfest. Despite the fact that all patients in the project were subjected to an experimental treatment without any scientific justification, an treatment that caused new and more severe sufferings for the patients, many patients still expressed their satisfaction (NBH 2003). To overcome such problems in relation to patient satisfaction surveys, Heltef advised the authorities that using a rating from 1 to 5 would produce more reliable and viable data then the applied methodology. Nevertheless, the authorities waived such an system as it might be demotivating for hospitals scoring low (NRK 2004b). Consequently, the published data incorrectly describe most hospitals as performing very well. As an example audits
performed by the Norwegian Board of health have shown, despite the fact that on average 79 per cent of Norwegian patients are satisfied (see Table 10), that there is an significant need for improvements as regards to the information given by health professionals (p4), including information about wait time, if the patients right of choice is to become a reality, both as regards to the individual patient, and as regards to efficiency enhancement in terms of improved resource allocation (NBH 2004c: 14).

In sum, data from these patient satisfaction surveys, aggregated at the hospital level, do not provide hospital executives with information usable in quality improvement strategies, nor does it provide patients with viable information in a situation of choice, or the central government with viable information usable for political governance. The criticism put forward here as regards to the registration of patient satisfaction does not only concern the information published by the national information service, but also the written reports, which all have been published individually (cf. Brekke, et al. 2003a, 2003b; Brekke, et al. 2003c; Holte, et al. 2003a, 2003b).

The Norwegian Institute of Public Health is responsible for the registration and analysis of data concerning the quality indicator prevalence of hospital infections in Norwegian somatic hospitals (FHI 2004a). Even though data on hospital infections are registered both at department and ward levels within all Norwegian hospitals (FHI 2003: 6), the five regional health authorities in Norway only have to report generated data at the hospital level (FHI 2003: 2). The procedures by which data on this quality indicator is registered and published do not produce reliable nor viable information usable for patients’ utilizing their right of a free and critical choice. This criticism is two-fold, as it concerns both the generated nature of the data as well as the way in which these data are registered. As most Norwegian hospitals have a number of different departments and wards, and the number of infected patients at each ward may vary, the generated data do not enlighten the patient as regards to the danger of hospital infections at the department or ward in question for his or hers treatment.

The reliability and viability of the data is further weakened, as the registration process is prone to flaws as far as the data collected concerns the factual number of patients with infections in hospital at a precise point of time on one specific day. A good example of the inaccuracy of these procedures is the case of Betanien Hospital in Skien. On June 4th, when the first registration of prevalence of hospital infections took place, none of the hospital’s patients had been infected while hospitalized at Betanien. Nevertheless, the hospital had six patients that were infected due to interventions at other hospitals and transferred to Betanien prior to the registration. Despite this fact, when the data was published in September 2003, Betanien Hospital was listed as the hospital with the highest level of hospital infections in Norway (Sandvig 2003), with a score of 16.7 per cent compared to a national average of 5.3 per cent (see Table 10).

Moreover, according to the Minister of health the published data concerning quality indicators are supposed to be updated once a month (HD 2003c). Nevertheless, the data on hospital infections available in May 2004 had not been updated since September 2003 when data on this indicator first was published. Furthermore, the data presented in September 2003 was registered on June 4th 2003 (FHI 2004b), and concerned
hospitalized patients at 0800 that day only (FHI 2003: 4; Sandvig 2003). To make things even worse, the users of the national information service are informed neither about the methodology applied in relation to this indicator, nor about the non-updated aspect of the data. In other words, the published information, concerning prevalence of hospital infections in Norwegian somatic hospitals, do not add any enhancement feature as regards to the patients’ informed choice, as the data is more misleading than guiding for patients in their process of choice.

Table 10 – An example of the data on quality indicators published by the National Information Service for the Patients’ Right of Choice. Source: Fritt Sykehusvalg Norge (FSN 2004c).

<table>
<thead>
<tr>
<th>Hospital or health enterprise</th>
<th>q1</th>
<th>q2</th>
<th>q3</th>
<th>q7</th>
<th>p1</th>
<th>p2</th>
<th>p3</th>
<th>p4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akershus Universitetssykehus HF</td>
<td>*47%</td>
<td>-</td>
<td>*95%</td>
<td>~</td>
<td>76%</td>
<td>81%</td>
<td>66%</td>
<td>78%</td>
</tr>
<tr>
<td>Betanien Hospital, Skien</td>
<td>53%</td>
<td>-</td>
<td>-</td>
<td>**16.7%</td>
<td>~</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Haukeland Universitetssykehus</td>
<td>30%</td>
<td>16p. / 4%</td>
<td>85%</td>
<td>6.3%</td>
<td>81%</td>
<td>85%</td>
<td>67%</td>
<td>79%</td>
</tr>
<tr>
<td>Rikshospitalet</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3.5%</td>
<td>94%</td>
<td>90%</td>
<td>77%</td>
<td>84%</td>
</tr>
<tr>
<td>St. Olavs Hospital</td>
<td>40%</td>
<td>35p. / 4%</td>
<td>94%</td>
<td>5.5%</td>
<td>72%</td>
<td>84%</td>
<td>69%</td>
<td>78%</td>
</tr>
<tr>
<td>Ullevål Universitetssykehus</td>
<td>53%</td>
<td>11p. / 1%</td>
<td>81%</td>
<td>6.0%</td>
<td>76%</td>
<td>84%</td>
<td>68%</td>
<td>80%</td>
</tr>
<tr>
<td>Universitetssykehuset i Nord-Norge</td>
<td>32%</td>
<td>7p. / 1%</td>
<td>93%</td>
<td>7.4%</td>
<td>91%</td>
<td>85%</td>
<td>71%</td>
<td>80%</td>
</tr>
<tr>
<td>National Average</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5.3%</td>
<td>82%</td>
<td>85%</td>
<td>71%</td>
<td>79%</td>
</tr>
</tbody>
</table>

Explanations
1) These are the five largest hospitals in Norway, in addition to Betanien, which is mentioned above, and Akershus University Hospital, which is an example of data aggregated at the enterprise level.

~ - data not available
* - data includes values from more than one hospital
** - all patients infected due to treatment at other hospitals
q1 - ratio of medical records submitted within seven days
q2 - number of patients in corridors as number of patients and percentage of total
q3 - preoperative length of hospitalization in relation to femoral neck fracture (% within 48 hours)
q7 - prevalence of hospital infections in Norwegian somatic hospitals
p1 - patients assessment of the standard of buildings, equipment, and more
p2 - patients experience with physicians and nurses
p3 - patients assessment of how well the functions of the hospital are organized
p4 - patients assessment of the information they have been given by the health professionals

If we compare the methodology applied in the registration of q7 hospital infections with the methodology applied in the registration of another quality indicator similarly prone to daily fluctuation, that is to say q2 number of patients in corridors registered by the Norwegian Patient Register, it becomes clear that the national information service and its information suppliers are aware of the problems related to the methodology applied for q7, as the fluctuating nature of these values are taken into account by the
recording of the number of patients in corridors as a daily average measured over a period of time (FSN 2004d). It would be fair to ask why a similar methodology has not been applied in relation to hospital infections. Nevertheless, the problem concerning the registration of hospital infections is more complex than it might seem so far. I will return to this problem below.

Yet another quality indicator published by the national information service, though registered by NPR, has to be commented, however not due to inaccuracy, as it is the only indicator specified by diagnosis (DRG 235), but due to its nature. The indicator in question is q3 preoperative length of hospitalization in relation to femoral neck fracture, which refers to a condition that always is a case of emergency and consequently not a condition eligible for choice (SHD 2000 § 4). If anything, in relation to the patients’ right of choice, a low score on q3 might indicate that the orthopaedic department in question is morbidly prioritizing patients by the reimbursement value of their diagnosis, as the 40 % reimbursement value for femoral neck fractures is NOK 10132, whereas the corresponding value for an artificial hip replacement (DRG 209AB) is between NOK 42649 and 53135 depending on condition. Leaving the question of applicability aside, there is reason to question the quality described by this indicator. Although there is evidence of significant improvements to be gained, as regards to postoperative complications and mortality, by an preoperative hospitalization less then 48 hours (Kamel, et al. 2003; Zahn, et al. 1999), studies have shown that the survival rate for patients with femoral neck fractures would be increased by 12.2 percentages points, from 79.5 % to 91.7 %101, if preoperative length of hospitalization for such patients were to be reduced from 48 to less than 24 hours (Elliott, et al. 2003: 792). Moreover, in 2001 the County Medical Officer in Sor-Trøndelag published critical remarks as regards to the alarmingly high percentage of patients that had to wait for more than 24 hours in relation to femoral neck fractures (NBH 2001 § 5). In sum, there is reason to question the intentions with the publication of this indicator, as it neither is an indicator of quality, nor applicable in relation to elective somatic services.

In contrast to the data published by the National Information Service for the Patients’ right of choice, data published by the Norwegian Patient Register (NPR) itself, have not been blemished similarly. Based on their detailed database of patient data102, NPR publishes historical wait time and data in relation to the production of health care services within the Norwegian hospital sector. Although publicly available, the information published by NPR is primarily intended as so-called regional governance information (NPR 2004f). However, as the regional governance information project was discontinued in June 2004, the supporting website, http://reginfo.npr.no, is no longer in operation (NPR 2004h). Nevertheless, most of the information is still available103 through NPR’s online statistics generator104.

Compared with the information published by the National Information Service for Patients’ Right of Choice, the information published by NPR requires more of the user, as the data are presented in an advanced statistical form. Although the technical aspects of NPR’s information services may reduce both the accessibility and viability of the
information for most users, the information in general is more detailed, precise, and up to date, then the information published by the national information service.

Let us now return to the problems in relation to hospital infections. The Norwegian Institute of Public Health is not the only agency concerned with data in relation to this indicator. The Norwegian Patient Register has in fact registered and published such data for some time, even prior to the Institute of Public Health’s engagement in relation to the publication of quality indicators through the national information service. Once again we are faced with a situation where the information published by NPR, although out of reach for most patients, is more detailed, reliable, and up to date (see Table 11, and Appendix III), then the information published by the national information service (see Table 10). As Norwegian hospitals in order to get their fair share of the activity-based funding, have to report each case of admission, using the NPR-record (HD 2004b: 11-12), including primary diagnosis and any secondary diagnosis such as hospital infections (HD 2004b: 43), it would be fair to assume that the hospitals’ procedures in relation to the NPR-record are more reliable then the methodology applied by the Norwegian Institute of Public Health. The information published by the two agencies is however not fully comparable, as the Norwegian Institute of Public Health do not use DRG in their definitions of hospital infections (cf. FHI 2003).

Table 11 – Prevalence of hospital infections as regards to 24-hour hospitalization in the period January 1st – April 30th 2004. Source: Norsk Pasientregister (NPR 2004b). See also Appendix III.

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Number of patients treated</th>
<th>Number of patients infected</th>
<th>Percentage of patients infected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akerhus Universitetssykehus</td>
<td>11574</td>
<td>336</td>
<td>2.90%</td>
</tr>
<tr>
<td>Betanien Hospital, Skien</td>
<td>1290</td>
<td>2</td>
<td>0.16%</td>
</tr>
<tr>
<td>Haukeland Universitetssykehus</td>
<td>19572</td>
<td>440</td>
<td>2.25%</td>
</tr>
<tr>
<td>Rikshospitalet</td>
<td>11134</td>
<td>83</td>
<td>0.75%</td>
</tr>
<tr>
<td>St. Olavs Hospital</td>
<td>16504</td>
<td>308</td>
<td>1.87%</td>
</tr>
<tr>
<td>Ullevål Universitetssykehus</td>
<td>16079</td>
<td>269</td>
<td>1.67%</td>
</tr>
<tr>
<td>Universitetssykehuset i Nord-Norge</td>
<td>9048</td>
<td>148</td>
<td>1.64%</td>
</tr>
<tr>
<td>National values / average</td>
<td>289664</td>
<td>7373</td>
<td>2.55%</td>
</tr>
</tbody>
</table>

The published historical wait time is another example of difference as regards to the quality of the information published by the two agencies. Whereas historical wait time published by the national information service are given as median values and not updated since April 30th 2003 (FSN 2004a), the corresponding data published by NPR also includes data from the period May 1st 2003 to April 30th 2004 (NPR 2004i), given as average values specified for patients newly referred, patients treated, and patients on waiting lists (see Table 12). Of these values the values for patients treated depict the factual wait time most correctly (NPR 2004e).

In addition to data on historical wait time, NPR also publishes statistics based on patient data from their extensive database. Although the data published by the national
information service in relation to q1- q3 (see Table 10) are based on this database, most of the available information, which in fact very well may be useful for patients in the process of choice, is not available through the governments preferred channel of communication. The kind of information most Norwegian patients are missing out on, ranges from general information concerning e.g. patient movements as shown in Appendix IV, to detailed data on hospital activity, such as the number of administered interventions specified by diagnosis and hospital. The importance of such information might be significant as studies have shown that the level of experience might influence the quality of provided health care services (Teisberg, et al. 2001: 49).

Table 12 – Average historical wait time, for patients suffering from heart disease, in the period January 1st to April 30th 2004. Source: Norsk Pasientregister (NPR 2004b).

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Newly referred</th>
<th>Treated</th>
<th>On waiting list</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feiringklinikken</td>
<td>33</td>
<td>44</td>
<td>39</td>
</tr>
<tr>
<td>Haukeland Universitetssykehus</td>
<td>48</td>
<td>101</td>
<td>143</td>
</tr>
<tr>
<td>Hjertesenteret i Oslo (Rikshospitalet)</td>
<td>14</td>
<td>16</td>
<td>37</td>
</tr>
<tr>
<td>St. Olavs Hospital</td>
<td>30</td>
<td>403</td>
<td>–</td>
</tr>
<tr>
<td>Ullevål Universitetssykehus</td>
<td>34</td>
<td>48</td>
<td>63</td>
</tr>
<tr>
<td>Universitetssykehuset i Nord-Norge</td>
<td>11</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

Explanations
~– data not available

In light of the discussion in this chapter, it would be fair to question the Ministry of Health’s intentions as regards to its information policy towards Norwegian patients.
Now that we have got an general idea of how the Norwegian health care reform have been put into action by the Ministry of Health, it is time to take a closer look at the Norwegian hospital sector. As hospitals often are the only part of the specialized health care sector that individual patients and their relatives ever experience, implementations of reform elements at this level of the health care system is vital for the patients’ perception of change. Nevertheless, neither patients’ perception of change nor internal changes in hospital procedures, or treatment, are a matters of investigation within the scope of this thesis.

This chapter is divided into two parts. The first part discusses the role of the regional health authorities in relation to the patients’ possibilities for making free and critical choices. This discussion is based on written sources and statistics; legislation, letters of command, documents published by the RHAs, and patient movement statistics.

The second part focuses on how three hospitals, all situated within one of the five health regions in Norway, have adapted to the changed reality imposed by the reform; how the values of accessibility, transparency, and public choice have influenced the empowered hospitals’ strategies in their relation to a redefined outer world of competition. Has their environment become populated with patients on the quest for prime services, and competing hospitals on the quest for profitable patients, or is there other factors governing their new reality? This latter part is based on data from interviews, hospital websites, written sources, and statistics.

Regional Health Authorities

The function of the RHA107 can in a way be compared with the functions of the headquarter within a private corporation, as its main function is to streamline the production of health care services within its region, so to achieve an optimal level of production within the limits of the at any time current available resources (Ot.prp.nr.66 2000-2001 § 2.10.1). Where as the responsibilities of the Ministry of Health discussed in the prior chapter, can be described as holistic, the responsibilities of the RHAs’ are of a more pragmatic nature. Their main responsibility is to secure the population within their respective regions access to specialized health care services of quality. To maintain this responsibility the RHA’s have been given the authority to negotiate contractual relationships with private health care providers, commence measures for quality assurance, as well as the authority to reorganize the division of labour within their respective regions.
The RHAs’ contractual practice

The newly reformed Norwegian hospital sector does not consist solely of publicly owned hospitals. In addition to publicly owned hospitals, private hospitals have been accepted as an integral part of the health care system. Due to their long history in public service, privately owned NGO hospitals (h2) are in a special position compared to private corporate hospitals (h4), as h4 hospitals were not an integrated part of the public health care sector prior to the reform. The pre-reform situation for these hospitals was in fact quite the opposite, as privately owned corporate hospitals for a long time had struggled to maintain an economical sound existence due to political unwillingness within the Norwegian parliament (e.g. Brundtland 1984; Kluge 1998; NTB 1997b, 1998; Unknown 1984), as well as strong opposition against privatization of the health care sector from different non-parliamentary actors within the Norwegian political system (e.g. Furnes & Haugli 2000; NTB 1997a). Nevertheless, the introduction of the hospital reform paved the way to participation for private corporate hospitals (Iversen 2002: 13-14), as regional health authorities were bestowed the authority to negotiate contractual arrangements with privately owned health care providers of any kind, in so far as such arrangements are necessary in relation to their responsibilities regarding the provision of health care services (Lov av 15. Juni 2001 nr 93 § 41; Ot.prp.nr.66 2000-2001 § 2.10.3). Furthermore, any private hospital that obtains public certification is now qualified to enquire such contractual arrangements (Egeland 2003), and thereby has the possibility to become a part of the patients’ right of choice. By July 5th 2004, twenty-nine private hospitals, of which nineteen were corporate hospitals, had become part of the public health care service through contractual arrangements (see Appendix II).

![Figure 7](image-url)

**Figure 7 – Data on h4 hospitals are only available as an additional option. Source: (FSN 2004c).**

The difference between h2 and h4 hospitals, as regards to their pre-reform history, does not only concern the way in which they have entered into the reformed public health care sector. The difference in status is also reflected in the way in which these hospitals are presented through the publicly disseminated information discussed in chapter 7. A good example of this difference can be found at the website of the National Information Service for Patients’ Choice, where h2 hospitals are listed as public hospitals, and pre-selected alongside publicly owned hospitals, whereas data on h4 hospitals only becomes available if the users select private hospitals as an additional option (see Figure 7).

The difference here is not only a question of semantics, as the original paragraph, constituting the patients’ right of choice, limited this choice by stating that patients are entitled to choose between public hospitals (cf. Lov av 2. Juli 1999 nr. 63 § 2.4). Within the definition of public hospitals, h2 hospitals were included (FSN 2004h), whereas corporate hospitals (h4) originally, due to differences in the five regional health
authorities’ contractual practice (Iversen 2002: 13-15), were for the most parts excluded from the patients’ right of choice, as they were only included for patients residing within the respective health regions where h4 hospitals eventually had contractual arrangements (FSN 2004h).

Although the difference has become less apparent during 2003/2004, the span in contractual practice between the different regional health authorities was in fact considerable. The contractual practice of the regional health authorities within the eastern and southern health regions in Norway was from the beginning in January 2002 mostly inline with the interpretation of the then current hospital market regulations that now is formalized through the revision of the Patients’ Rights Act at September 1st 2004, as patients living within these two regions, with a few exceptions, freely could choose between public hospitals and any private hospital that had a contractual relationship with the regional health authority within their region, without having to be referred by a public hospital (Iversen 2002: 14). In contrast, patients living within the central and the western health regions could not originally choose private hospitals freely without first being diagnosed or examined by a public hospital, and as in the case of patients residing within the western health region, not without first having to wait for treatment for a certain length of time at a public hospital (Iversen 2002: 14). However, on March 20th 2003 the western health authority changed their practice and allowed patients to choose freely without any prior engagements with a public hospital (Helse Vest 2003, 2004).

The option of private hospitals was even less a reality for patients residing within the northern health region, as the northern regional health authority by December 13th 2002 had no contractual arrangements with any private hospital (Iversen 2002: 15). Nevertheless, this situation changed during 2003 when the northern health authority negotiated contractual arrangements with three private corporate hospitals (Helse Nord 2004). Furthermore, on January 13th 2004 the northern health authority, in accordance with the Public Procurement Act and EU/EEA regulations, invited both Norwegian private hospitals as well as hospitals situated within the EU/EEA area, to take part in a competition for contracts regarding the provision of specialized health care services within the region (NL 2004 chapter 3 § 2.1).

With the revision of the Patients’ Rights Act, which will be in force on September 1st 2004, the inequity as regards to accessibility and public choice in terms of a private option, will be eradicated, as patients then, regardless of their residence, will have the possibility to choose freely between any public hospital as well as any private hospital that has a contractual relationship with any regional health authority.

Patient movements

The difference in contractual practice between the five regional health authorities is reflected by data on patient movements registered by the Norwegian Patient Register for the period January 1st 2000 to December 31st 2003; the year 2000 being the last year before the introduction of the patient’s right of choice, and 2002 being the first year of governmental ownership (see Table 13).
Table 13 – Percentage of patients treated at a private h3 or h4 hospital in relation to normal/elective surgery involving 24-hour hospitalization in the period 2000 - 2003. Source: See Appendix IV.

<table>
<thead>
<tr>
<th>Region of residence</th>
<th>Period</th>
<th>Eastern</th>
<th>Southern</th>
<th>Western</th>
<th>Central</th>
<th>Northern</th>
<th>All Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td></td>
<td>4.57 %</td>
<td>1.85 %</td>
<td>1.38 %</td>
<td>0.51 %</td>
<td>0.56 %</td>
<td>2.34 %</td>
</tr>
<tr>
<td>2001</td>
<td></td>
<td>6.98 %</td>
<td>2.46 %</td>
<td>1.16 %</td>
<td>0.69 %</td>
<td>0.61 %</td>
<td>3.31 %</td>
</tr>
<tr>
<td>2002</td>
<td></td>
<td>9.97 %</td>
<td>3.22 %</td>
<td>1.83 %</td>
<td>1.59 %</td>
<td>0.91 %</td>
<td>4.81 %</td>
</tr>
<tr>
<td>2003</td>
<td></td>
<td>16.00 %</td>
<td>5.62 %</td>
<td>2.55 %</td>
<td>7.28 %</td>
<td>1.02 %</td>
<td>8.39 %</td>
</tr>
</tbody>
</table>

As we can see in this table, there are major differences between the regions. The most significant changes have taken place in relation to patients living within the eastern health region, where the values changed by approximately 350 per cent, from 4.57 per cent for the year 2000 to 16.0 per cent for the year 2003. The changed pattern of movement has been least significantly changed for patients living within the northern health region, where the corresponding values are 0.56 per cent for the year 2000 and 1.02 per cent for the year 2003.

Quality assurance and the division of labour

Whereas the sub-section above discussed the contractual practise of all of the five health authorities in Norway, this sub-section focuses on the RHA within the region in which the three hospitals in our selection below are situated. The reason for this is that the activities described in this sub-section have significantly influenced the framework in which these hospitals operate.

With reference to ongoing national projects related to quality indicators (SHD 2001a, 2001b), the regional health authority was in 2002 instructed to take measures so to be able to account for the quality of the services provided by the hospitals within the region (cf. HD 2002d § 3.2). To do so, the RHA appointed two committees consisting of members from both the RHA, the public hospitals within the region, as well as an envoy representing h2 hospitals (RHA). The commissions mandate was a dual one, the first was to develop methodology of measurements as regards to both national and regional demands of quality, and the second was to revise the preceding methodology in relation to patient satisfaction surveys. In June 2003, the commissions presented their recommendations in a joint report describing five national quality indicators, including patient satisfaction, in addition to four regional quality indicators (RHA 2003: 3-4). The commission’s recommendations have later on been implemented in relation to the patient satisfaction surveys described in chapter five, as well as in relation to efficiency enhancement programs implemented throughout the hospitals within region. One such program is the project related to the division of labour.

Prior to the Norwegian health care reform, Norwegian county-owned hospitals were divided into three categories based on their fields of expertise, their size, and their geographical location. Based on the traditional three divisions’ model, most hospitals had several chirurgical and medical units, including birth and emergency units. This was
also the case for local hospitals even though most of these were situated in rural areas with a patient base below 40,000 (NOU 1998:9 § 7.1). The heterologous structure of the hospital sector, the county-based ownership, and differences relating to fiscal priorities within the counties, combined, led to a “pre-reform” division of labour that was not necessarily guided by quality in terms of medical excellence and patient experienced outcomes. (NOU 1996:5 §§ 3.1 & 5.1; 1997:2 § 6.1; St.meld.nr.24 1996-97 § 2.1; St.meld.nr.26 1999-20 § 3.2; St.meld.nr.44 1995-96 § 3.4). As an example the treatment of patients with pancreas cancer was performed by many hospitals, “some with a volume of only 1-2 procedures each year” (Teisberg, et al. 2001: 54)

To overcome these problems, one of the central responsibilities bestowed upon the regional health authorities was to implement efficiency strategies that would improve the efficiency of the health care service both in terms of resource allocation as well as medical quality in terms of health care outcomes for the patients (Classified 2003: 20-22). Within the region in question, the RHA’s commission suggested drastic cuts as regards to which type of medical services should be offered at the different hospitals within the region. With reference to reports suggesting a causal relationship between patient volume and the quality of health service, they suggested that most medical emergency services, including birth clinics, should be concentrated at h1-a hospitals in the region (Classified 2003: 26-28). Nevertheless, they pointed out that if these cutbacks were to become a reality, it would be necessary to install e-health technology at smaller hospitals, so to avoid unnecessary distress for the patients at these hospitals (Classified 2003: 24). The new order of affairs, as regards to the division of labour as well as other reform elements, changed the reality for the hospital in the region in a way that created heightened tensions between different hospitals and their staff, as well as political turmoil in terms of an public uproar.

Let us now take a closer look at three hospitals, which historically represents the three most common types of hospitals within the specialized health care sector in Norway.

**Three common types of hospitals**

Three hospitals, of which two are publicly owned and one operates through a contractual relationship with the regional health authority, have been selected for closer examination; how have they adapted to the new regime. The selection is based on the individual hospitals features, which makes them interesting within the context of this thesis. The hospitals are:

- Hospital A – a publicly owned university hospital (h1-a)
- Hospital B – a private diaconal hospital (h2)
- Hospital C – a publicly owned community hospital (h1-b)
Two of these hospitals, Hospital A and Hospital B, are located in close vicinity within the same city, whereas the third hospital, Hospital C, is located within another county. The three hospitals in our selection, are all located within the same health region, and consequently under command of the same regional health authority.

Let us now take a closer look at the three hospitals within our selection, while keeping in mind the terms of accessibility, transparency, and public choice. The description of each hospital starts with a little summary of their history.

The University Hospital – Hospital A
Hospital A is a publicly owned university hospital (h1-a) with a long history dating back to the mid 18th century. In its early days, the hospital was a simple community hospital providing health care services of a general nature only. In the late 19th century, the hospital divided its services into two specialized departments, that is to say a chirurgical and a medical department. Later on, in the early 20th century, the hospital was moved to its present location (Dobbe 2002), and developed overtime into the hospital offering the most extensive spectre within the field of medicine in Norway (Informant A1). The hospital’s specialities include eleven national centres of excellence, five regional centres of excellence, as well as three special functions performed exclusively by Hospital A (Hospital A 2004a).

Table 14 – Number of somatic patients treated at Hospital A in the period 1998-2003 as regards to all types of admissions, diagnosis, interventions, and regions of residence.

<table>
<thead>
<tr>
<th>Period</th>
<th>Hospital A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>53485</td>
</tr>
<tr>
<td>1999</td>
<td>66410</td>
</tr>
<tr>
<td>2000</td>
<td>66089</td>
</tr>
<tr>
<td>2001</td>
<td>70279</td>
</tr>
<tr>
<td>2002</td>
<td>79410</td>
</tr>
<tr>
<td>2003</td>
<td>82543</td>
</tr>
<tr>
<td>All periods</td>
<td>418216</td>
</tr>
</tbody>
</table>

On January 1st 2002, the hospital was reorganized as a local health enterprise, and became thereby the administrative centre of eleven formerly independent health care institutions. As local health enterprise, Hospital A employ approximately 8200 employees (Hospital A 2004b), and administers a yearly budget in the region of NOK 4.6 billion. Hospital A has 18 somatic clinics covering 49 different departments. In addition, the hospital is also the corporate headquarter for a h1-b community hospital; nevertheless, the h1-b hospital is not included in this study as this hospital is run as an independent unit. In contrast, another hospital that prior to the reform was an independent organization, has now been fully incorporated as a department within Hospital A’s orthopedic clinic. If we look at the number of somatic patients treated at Hospital A (see
Table 14), we can see that although there was a substantial increase in production in 2002, the production has increased steadily since 1998.

**Accessibility**

Economical concerns are the predominant problem facing the enterprise, as the hospital in 2002 had a budgetary deficit in the region of NOK 146 million (Hospital A 2003: 10). This was mainly caused by legislative interference imposing financial incapacities, as the hospital is not allowed to facilitate normal depreciation methods as regards to its buildings, which are in need of major renovation. The financial situation is further threatened by medical developments demanding new investments as regards to expensive medical equipment. This might develop into a major problem in relation to the level of service the hospital will be able to offer its patients in the future (Informant A1). Nevertheless, our informants perceive the regional health authority and the ministry of health as the main forces of influence in relation to the hospital's activities.

Even though the hospital does employ productivity measures, such as hiring extra personnel during the summer months to avoid closing down wards or reducing production (Informant A3), the economical situation makes everything difficult and overshadows all activities including any elements of consumer or patient-centred strategies. Nevertheless, there is a strengthened focus on reducing the number of patients waiting in line, and the length of wait time, even though such strategies must be balanced according to the economical possibilities within the current framework (Informant A1). The responsibility for balancing the need for both reduced numbers of patients waiting/length of wait time, and economical elements, is placed on the individual clinic within the enterprise, and was during 2003 formalized as an element in contractual relationships between the CEO and individual clinic leaders (Informant A1). A good example of this is the efforts made by the hospital's orthopedic clinic. By using a strategy resembling an automated assembly line, hiring extra staff, buying into their employee's spare time, renting an operation theatre from a private hospital, and organizing the productions as “left-handed and right-handed days”, the clinic have made significant efforts to reduce the waiting lists (Informant A3). Nevertheless, by April 19th 2004 Hospital A still had more than 3500 patients that had been waiting for more than 180 days. Of these, approximately 1300 were waiting in line for treatment at the hospital's orthopedic clinic (Hospital A 2004c).

**Transparency**

Hospital A has taken on a proactive attitude as regards to the dissemination of information, in more than one way. Prior to the reform, the hospital experienced some internal difficulties as regards to differences of opinion in relation to economical priorities. This led to a situation where hospital employees used the media to front their arguments as regards to resource allocation. Consequently, the hospital's administration had a hard time coping with the situation. To overcome this problem, the hospital has now installed measures that can only be characterized as gag-rules, as all press-related contact, and in fact all contact between hospital employees and external researchers such
as my self, are to be coordinated through the information department. Moreover, whereas the hospital prior to the reorganization had a tendency to be more reactive than proactive in dealing with events that might have been blemishing, the hospital’s strategy nowadays is to be on the forefront of such incidents.

Another interesting feature of the hospital’s information strategy is the hospital’s use of newspaper inserts to distribute their own newspaper, which contains general information and news about the hospital’s activities. The hospital’s newspaper is used deliberately to promote the hospital as an active contributor in the community: The Hospital in the region (Informant A1 and A2).

The information strategy employed by the hospital is not as strict as it might seem so far, as the hospital also makes use of a decentralized structure of responsibilities as regards to disseminating information. Each individual department is responsible for deciding the amount of information, the kind of information that are to be made available for patients and other stakeholders, as well as responsible for deciding how this information is to be made available. Representatives of the information department describe the department’s main role as being an assistant guiding the different medical departments in their efforts to publish information about their activities both as regards to patients and other stakeholders (Informant A2).

Since the reorganizing, the information department has done so by developing new tools for public relation related activities, such as a new enterprise logo and graphical profile, and templates for printed publications such as brochures and leaflets. Moreover, the department has developed a new internet gateway with a predefined user interface and supplementary templates, which the webmaster within each department can facilitate by adding medical information or information about patient procedures, to guide patients and other interested parties in search of information about diagnostics, examination, and treatment (Informant A2). Even though some departments, such as the department of medical genetics, have published some information intended for patients and their relatives, only 11 of the 49 different departments within somatic medicine at the hospital had published any documents by May 10th 2004. At this date the patient information section on the hospital’s website, counted 109 documents in total (see Table 15).

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of listed documents</th>
<th>Factual number of documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Bank</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cardiology</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>Dermatology</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Ergo-therapy</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Eye/Optometry</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>In vitro Fertilization</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Lung</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Maternity</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>Medical genetics</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Neurology</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Physical medicine and rehabilitation</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>All departments</td>
<td>139</td>
<td>109</td>
</tr>
</tbody>
</table>

Table 15 – Number of listed documents vs. factual number of documents in the patient information section, relating to diagnostics, examination and treatment, at Hospital A’s website.
In sum, although the hospital’s information strategy hardly can be described as a pro-
transparency strategy, there is no doubt that the hospital’s efforts represent a step in the
right direction.

Public Choice

When asked directly what the introduction of the patients’ free choice of hospital
represents for the enterprise, one of the informants answered:

“Patients’ waiting in line for treatment. There are still patients waiting for
treatment. […] Waiting in line at Hospital A is a well know story” (Informant
A1).116

With the exception of the department of in vitro fertilization, which commercially
offers services not included in the publicly funded health care system, the information
department does not have the impression that the different departments within the
hospital experience any competition as regards to patients. Quite the opposite, some
departments’ have argued that they do not want more patients as they are more than fully
occupied due to the number of patients already choosing treatment at Hospital A.
Because of this, they do not want to publish any information about their activities in fear
of attracting more patients. Other departments do not state their attitude towards the
patients’ free choice of hospital directly, but argue that they are not able or willing to
publish patient related information due to lack of time, lack of financial resources, or lack
of motivated or qualified personnel (Informant A2).

When asked directly, none of the informants was able to pinpoint any specific activity
within the hospital that had been brought about due to the introduction of the patients’
choice of hospital. Moreover, the hospital does not experience any significant
competition as regards to patients. The hospital’s perception is that the patients living
within its county are loyal and wants to be treated at the hospital. Nevertheless, the
hospital has experienced competition in relation to employment of medical professionals,
especially from Hospital B. However, Hospital A is, according to our informants, a more
attractive employer than Hospital B, and so far, Hospital A has employed more
employees formerly employed at Hospital B than they have lost (Informant A1). The
vulnerability in relation to recruiting qualified employees was also put forward by the
leader of the orthopedic clinic when questioned about problems and pressures in relation
to the reorganization of the hospital sector.

“The current employment situation is a major problem. Loosing one specialist
might force us to close down some of our activities” (Informant A3).117

In the long run the hospital’s management perceives that their focus on enhancing
the hospital’s level of medical excellence through employing more highly qualified staff
members, both as regards to treatment in general and medical research as well, to be the
most important element that can contribute to a strengthened competitive position in the
future as regards to the patients’ right of choice.
The relation between the Hospital A and the closely located Hospital B is problematic, as Hospital B does not have contractual relations with Hospital A, but is an integral part of the public health care system due to a contractual relationship with the regional health authority. The relationship between Hospital A and Hospital B are to a certain degree challenging for the two hospitals’ CEOs, as they do not always see eye to eye on important issues (Informant A1 and B1). As the CEO at Hospital A rather candidly puts it:

“We want to reorganize Hospital B” (Informant A1).\(^{118}\)

In sum, economic problems due to budget deficits represent the main challenges facing the hospital. Nevertheless, the hospital has implemented measures to meet the new demands for increased accessibility, transparency, and public choice.

In terms of accessibility, these measures are focused on reducing wait time. On fine example of this are the orthopedic clinic’s efforts to reduce queues by arranging left-hand and right-hand days, buying into the staff’s spare time, hiring extra staff, and renting operating theatres from private hospitals. Nevertheless, the clinic has still some of the longest wait time in Norway.

As regards to transparency, the hospital has chosen an active strategy. Being a large university hospital, the hospital has its own information department, which proactively has developed an information strategy focused on ease of use, for both users, and those responsible for publishing information. The department do so by producing templates both for printed and online-published material. Moreover, the hospital actively uses the media, e.g. through newspaper inserts, to promote the hospital as the hospital for the region. Nevertheless, although the information department’s strategy is proactive, the decentralized information-responsibility structure results in an overall strategy that is not. As an example, only 11 of the hospitals 40 somatic departments have so far published any information through the patient section of the hospital’s website. The reason for this is that many of the hospitals’ different somatic departments claim that the have more patients than they can cope with, and that they do not want to attract more patients.

This abundance also affects the hospital’s strategies in relation to public choice. All respondents at the hospital claimed that the hospital does not experience any competition as regards to patients. Moreover, none of the respondents was able to pinpoint any activities commenced within the hospital due to the patients’ right of choice. According to them, the significance of the patient’s choice has been more patients’ queuing for treatment. Nevertheless, the hospital regards increasing the hospital’s level of medical excellence by employing more highly qualified employees as the most important element that can strengthen the hospital’s competitive position in the future. However, the hospital has experienced competition in relation to the hiring of qualified employees, especially in relation to Hospital B.
Diaconal hospitals have a long tradition in Norway, dating all the way back to the year 1277\(^{119}\) (NOU 1997:2 § 4.1.1). Although Hospital B cannot trace its history back to the late 13th century, the hospital still has a long history tracing back to the late 19th century. In its early days, the hospital was in fact not labelled as a hospital but rather as a nursing home. Nevertheless, the hospital provided services not unlike those provided by Hospital A in those days. In 1918, the hospital’s position as a significant contributor of health care services was strengthened as a diaconal school of nursing was established. So far, the hospital had no permanent accommodations. In 1926, the hospital moved into its first permanent housing, which with its 20 beds soon proved to be insufficient. A plan for a new hospital was soon on its ways, and on the morning of April 9th 1940\(^{120}\), they moved to their present location. Nevertheless, in 1941, the hospital’s staff, as well as patients, were forced to leave the premises and temporarily move back to their former location (Hospital B 2004a). Since then the hospital has evolved into a modern hospital with both local-hospital functions as well as specialized functions, and has today 710 employees in addition to approximately 200 temporaries and on-call workers. The hospital’s activities are divided into a medical and a surgical unit, in addition to a dedicated unit for terminal patients. In 2003, the hospital had a budget in the region of NOK 370 million with a year-end overdraft of NOK 4.8 million (Hospital B 2004b).

**Accessibility**

The Norwegian health care reform significantly changed the reality for hospital B and its employees. Prior to the reform, the hospital and its administration, although private and to a certain degree independent, was treated as an equal to its county owned counterparts. As our informant puts it:

> “Prior to the reform, when the county was responsible, I had my seat at the county’s table alongside all the other hospital CEOs’. And the county perceived us as very closely linked; hence our own self-perception was that we were almost a part of the county” (Informant B1)\(^{121}\).

Nevertheless, the hospital has yet, 1 ½ year after the reorganization of the hospital sector, to receive the final payment from its former employer, and took during 2003 legal actions in relation to a claim of NOK 50 million. Although the court in 2003 stated that the RHA was responsible for solving the financial crisis the hospital experienced, nothing happened until the hospital’s board threatened to close down the hospital in February 2004 (Hospital B 2004c, 2004d). Nevertheless, even tough the regional health authority has been ordered to take over and maintain the pre-reform relationship with hospitals of this type (Ot.prp.nr.66 2000-2001 § 2.10.3), the hospital administration feels left out of the cooperative network between the different hospitals’ executives within the region\(^{122}\). Nonetheless, the level of production of somatic services at Hospital B has increased significantly since the introduction of the Norwegian health care reform (see Table 16).
Table 16 – Number of somatic patients treated at Hospital B in the period 1998 -2003 as regards to all types of admissions, diagnosis, interventions, and regions of residence. Source: The Norwegian Patient Register (NPR 2004b).

<table>
<thead>
<tr>
<th>Period</th>
<th>Hospital B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>8 112</td>
</tr>
<tr>
<td>1999</td>
<td>9 588</td>
</tr>
<tr>
<td>2000</td>
<td>9 458</td>
</tr>
<tr>
<td>2001</td>
<td>9 921</td>
</tr>
<tr>
<td>2002</td>
<td>10 306</td>
</tr>
<tr>
<td>2003</td>
<td>12 522</td>
</tr>
<tr>
<td>All periods</td>
<td>59 907</td>
</tr>
</tbody>
</table>

In addition to relational problems as regards to the regional health authority and Hospital A, our informant at Hospital B perceives profile related issues to be the most challenging impediment presently facing the hospital. Most people, especially the younger generations, associate the hospital with its activities in relation to geriatrics and terminal patients. However, these activities only count for approximately 7 per cent of the hospital’s total production. Consequently, the hospital has started a dual process of identification, through which they strive to find a way to reach out to the public, and to find their position within the new system. However, the future profile for the hospital is dependent upon the intentions of the regional health authority, as well as the somewhat unspoken struggle of power between Hospital A and Hospital B.

“We are a private independent hospital based on idealistic principles. Nevertheless, in reality we are dependent upon our employer. Therefore, we have to take into consideration what the RHA intentions are in relation to our functions in the future. My impression is that the RHA perceive us as a more specialized hospital, which takes care of functions that are practical to organize within a somewhat independent organization. However, if we are to become more specialized, then Hospital A has to take the large volume of ordinary patients. Moreover, by specializing, we challenge Hospital A, and they might not like that” (Informant B1) 123.

Nevertheless, the administration at Hospital B has its own opinions regarding the future of the hospital. They are especially keen on promoting their chirurgical services in relation to knee injuries, as well as their gastrological unit for patients suffering from cancer. Moreover, the hospital has taken the initiative to create a cooperative forum where private idealistic hospitals can work together in an effort to develop a renewed foundation for such hospitals in the future, not only on a national and regional level, but also on an international level (Informant B1).
Hospital B's strategies in relation to transparency and public choice is difficult to hold apart. The hospital has experienced difficulties reaching out to the public through mass media, as they often are confused with Hospital A, although, this confusion has its positive sides as well, e.g. in relation to issues that might be embarrassing. Being a diaconal hospital, the administration was for instance taken aback when faced with the hospital’s surprisingly weak performance in relation to the patient satisfaction survey described in chapter five, as they had perceived the ability of caring as one of the hospital’s strong points. Compared with other hospitals within the region as regards to caring abilities, and the quality of patient centred information, Hospital B achieved the lowest score. In an effort to improve the hospital’s achievements in relation to these parameters, the hospital has employed new computer technologies, as well as an internal review board. Nevertheless, the methodology employed in the patient satisfaction survey only produced data at the hospital level. In this way, the patient satisfaction survey does not represent a useful tool for improvements and restructuring, as the results do not specify any particular area of trouble. As the CEO puts it:

“The problem with such surveys is that we only have the results at an institutional level. That is to say, there might be just one bad apple, without which we might have been the best” (Informant B1) 124.

In terms of the hospital’s information policy, the hospital perceives the primary health care service, in which the GP’s have a predominant role, as an important collaborator as regards to marketing and maintenance of patient relations.

”There is a lot of public relation in positive cooperative relationships with the primary health care service. It is important that the GP, as the main referring instance and patient adviser, experience a positive collaborative attitude as regards to returned medical records, a viable internet gateway, as well as accessibility and ease when needing advise or submitting patients” (Informant B1) 125.

This seems however to be the only information channel used by the hospital in any serious sense, as regards to potential patients. Paired with a non-existing information policy, as regards to patients as autonomous actors in the 21st century, it seems that the long-standing tradition of health care paternalism is still going strong at Hospital B. A good example of this is the hospitals website, which is totally without any usable information for patients in the process of choice. This might seem as harsh words as the website does contain some information about the hospital’s services. However, the little information there is, is well hidden in a section designed for primary health care personnel. The website has its own patient section; however, this section contains practical information about the post-admission scenario only.

The criticism here is two-fold. Firstly, there is little information as regards to the services provided. Secondly, although this problem easily can be overcome by publishing some more information, it would not improve the situation significantly as long as no
section of the website is designed purposely for the autonomous patient on the quest for first-rate health care services.

In sum
Not unlike the university hospital described above, Hospital B has experienced significant economic problems. However, the hospitals economic problems are mainly due to overdue reimbursements for past performances. Furthermore, the hospital has experienced significant relational problems with both the regional health authority and Hospital A.

As regards to increasing accessibility, the hospital focuses its efforts on shifting the public focus away from the services it has traditionally been associated with; geriatrics and terminal patients, towards other services such as gastronomy and knee injury treatment. Moreover, the hospital has taken an initiative to consolidate the position for diaconal hospitals in Scandinavia through a collaborative forum.

However, the hospitals initiatives to increase accessibility do not seem to transpire into proactive strategies for increasing transparency and public choice. Although the hospital experiences problems reaching out to the public, the hospital focuses its information and marketing activities mainly towards the primary health care service.

The Community Hospital – Hospital C
Hospital C is a small publicly owned community hospital situated in a rural area equidistantly between two of the largest cities in Norway. The hospitals origin can be dated back to 1922, when the local GP no longer could deal with a situation where most seriously ill patients died long before they reached Hospital A, which then was the closest hospital. In an effort to change the situation, the GP started fundraising for a local hospital, and in 1930, the hospital opened for service (see Figure 8). From its humble beginning, the hospital had initially only 38 available beds, of which half were reserved for tubercular patients (NRK 2004a). Since then the hospital has grown and developed into a modern hospital offering a wide range of chirurgical and medical services.

Prior to the Norwegian Hospital Reform, Hospital C was an autonomous county owned hospital, that in spite of the fact of experiencing some severe calamities in the 1970's and 1990's due to medical errors and malpractice, regained the confidence of its owner and the local community, by restructuring its activities e.g. commencing an exchange program for

**Figure 8 – Hospital C approximately 1930.**
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gynaecologists and physician in cooperation with one of the largest university hospitals in Sweden. The hospital and its employees developed a strong sense of identity and a high level of medical excellence (Informant C1), which attracted commercial interests from one of the largest private health corporations in Europe (Informant C2). During this period, the hospital also experienced fierce competition from the largest hospital within the county, as regards to both county funding and referrals from local GPs (Informant C1). On January 1st 2002, Hospital C became a part of Local Health Enterprise Y (LHE-Y) in which their former opponent now is the corporate headquarter (LHE-Y 2004b).

Accessibility
Although the production at Hospital C has increased steadily since the reorganization (see Table 17), the hospital has experienced significant outside-interference from its local health enterprise, as well as from both Hospital A and the RHA.

Table 17 – Number of somatic patients treated at Hospital C in the period 1998-2003 as regards to all types of admissions, diagnosis, interventions, and regions of residence. Source: The Norwegian Patient Register (NPR 2004b).

<table>
<thead>
<tr>
<th>Period</th>
<th>Hospital C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>2 751</td>
</tr>
<tr>
<td>1999</td>
<td>2 964</td>
</tr>
<tr>
<td>2000</td>
<td>3 187</td>
</tr>
<tr>
<td>2001</td>
<td>3 489</td>
</tr>
<tr>
<td>2002</td>
<td>3 979</td>
</tr>
<tr>
<td>2003</td>
<td>3 986</td>
</tr>
<tr>
<td>All periods</td>
<td>20 356</td>
</tr>
</tbody>
</table>

The problems experienced by Hospital C concerns mainly the hospital’s gynaecology and maternity clinic. Based on the argument that the number of births per year at Hospital C was below the security limit necessary to maintain an adequate level of competence associated with classification as a maternity clinic (NRFF 2003), the board of the local health enterprise decided on June 18th 2003, to change the status of the hospital’s birth unit from a gynaecology and maternity clinic to a so-called strengthened maternity ward (HD 2004a). That is to say a ward without any gynaecologists, where midwives, assisted by surgeons in cases of emergency, assists mostly normal births (Informant C2). However, the decision did not take effect until January 1st 2004, as the decision alongside similar decisions anticipated or already passed by other local and health enterprises were brought to the attention of the parliament, due to an public upraise both on the local and national arena (Marifjæren 2003; NTB 2003; Pettersen 2002; Ulvedal 2001). In turn, the parliament ordered the Ministry of Health to investigate the cases further. The dispute concerning the hospital’s future came to an end on January 14th 2004, as the Ministry of Health then, based on this investigation, endorsed the board’s decision of June 18th 2003 (HD 2004a). The new maternity ward opened for
business on March 17th 2004 with a renewed staff, as all former staff members, except one which remains in an 30% position, resigned their positions (LHE-Y).

Although the regional health authority has been the dominant force behind the changes experienced by Hospital C, the relationship between Hospital C and the local health enterprise (LHE-Y) has been problematic since long before the hospital reform. As one of the informants put it:

“We have distasted LHE-Y since before the hospital reform

[…] We would have preferred to be organized as an institution under Hospital A, and not to be a part of LHE-Y, as we for many years have been competing with LHE-Y about patients” (Informant C3) 128.

Nevertheless, there are some disagreements within the workforce at Hospital C as regards to this subject. Another informant expresses satisfaction with the way in which LHE-Y have handled problems that have emerged in the aftermath of the reform, and is instead rather dissatisfied with the interference from the regional health authority. As the informant put it:

“The CEO of LHE-Y had produced a marvellous report, which concluded that Hospital C, within the limits of medical sound practise, very well could have a gynaecology and maternity clinic in the future. This report was supported by all the medical specialists, but was not sanctioned by five of the board’s members, including the CEO of the regional health authority” (Informant C2)129.

Nevertheless, all informants at Hospital C view the problems experienced by the hospital as interrelated elements of one particular strategy. That is to say, a strategy that in the end aims at closing down the hospital (Informant C3). This grim view of the future has broken down the prior strong sense of belonging and identity that the employees at the hospital shared (Informant C2). Just shortly before our visit at the hospital, in the autumn of 2003, a delegation of employees had entered the CEO’s office and demanded the CEO’s resignation (Informant C3), due to what they described as incompetence and a disloyal attitude towards Hospital C, as the CEO according to their view, support, or do not argue against, the strategy to close down the hospital (Informant C2).

Whatever might be true in this case, of who might be disloyal, or who might be the driving force behind the changes already experienced, and those changes anticipated in the future, it stands clear that the position of Hospital C, both in relation to other hospitals within its county (see Table 18), and in relation to other hospitals within the region (e.g. see Table 19), is weakened. Moreover, the hospital has become less autonomic and less able to cope with the current situation within the health care sector.

As mentioned in chapter 7 130, the Ministry of Health has ordered local health enterprises to recover any budgetary deficits before year-end 2005. Based on the regional health authority’s recommendations in relation to this subject, the board of LHE-Y is to decide the future for Hospital C in a board meeting September 30th 2004. The proposal
In question is to close down all orthopaedic and most chirurgical services at Hospital C (LHE-Y 2004d). If this proposal goes through, it will impose dramatic consequences for the hospital’s future existence, as it will affect most of its services (Fimreite 2004; Solem 2004). Moreover, the hospital’s so-called strengthened maternity ward may be closed down at a later point of time in 2004 (LHE-Y 2004d; Solem 2004).

Table 18 – The percentual development of Hospital C’s share of patients treated within hospitals owned by Local Health Enterprise Y as regards to normal elective surgery involving 24-hour hospitalization. Source: The Norwegian Patient Register (NPR 2004b).

<table>
<thead>
<tr>
<th>Patients region of residence</th>
<th>Period</th>
<th>Hospital C</th>
<th>Local Health Enterprise Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Health Region</td>
<td>2000</td>
<td>53.85 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>41.03 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>38.30 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2003</td>
<td>28.57 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Southern Health Region</td>
<td>2000</td>
<td>75.00 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>50.00 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>70.00 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2003</td>
<td>45.00 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Western Health Region</td>
<td>2000</td>
<td>11.95 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>11.99 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>14.76 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2003</td>
<td>13.50 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Central Health Region</td>
<td>2000</td>
<td>0.00 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>8.00 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>13.89 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2003</td>
<td>2.63 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Northern Health Region</td>
<td>2000</td>
<td>0.00 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>0.00 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>25.00 %</td>
<td>100.00 %</td>
</tr>
<tr>
<td></td>
<td>2003</td>
<td>0.00 %</td>
<td>100.00 %</td>
</tr>
</tbody>
</table>

Transparency and Public Choice

The hospital’s efforts to create transparency and public choice have been somewhat stifled as a result of the Norwegian health care reform. A good example of this is the hospital’s efforts to attract elective patients from outside their normal geographical area of operation. In the early months of 2001, when the patients’ right of choice was set in force, the hospital and its administration still enjoyed their relative autonomous position and little changed as regards to outside interference in everyday activities (Informant C1). Nevertheless, the hospital administration realized, due to the anticipated hospital reform,
and the consequential reorganization of the Norwegian hospital sector, that their situation could be drastically changed in the future.

“We realized that we had too few patients. Our planned programmes of operations were too small. We just had to do something to increase the number of patients treated at the hospital” (Informant C3).

As the first statistics concerning the number of patients waiting for treatment, was published later on in 2001, the hospital administration saw an opportunity to facilitate the idle capacity of their gynaecology and maternity clinic, in view of the fact that the number of patients waiting for treatment at other hospitals as regards to illnesses related to the female reproductive organ (HDG 13), was rather high (Informant C1). Patients diagnosed within HDG 13 are from a economical point of view interesting as the level of reimbursement related to these interventions are rather high compared with other DRGs. E.g. the current level of reimbursement as regards to hysterectomy is NOK 44 652, while the current reimbursement for normal birth (HDG 14) is NOK 5 537 (HD 2004b: 52). By using a dual strategy, the hospital actively worked to attract more patients of this type, as a higher number of patients treated in relation to hysterectomy would significantly improve the financial situation for the hospital (Informant C3).

Table 19 – Number of patients treated at Hospital A and Hospital C for illnesses related to the female reproductive organ HDG 13, as regards to normal elective surgery involving 24-hour hospitalization. Source: The Norwegian Patient Register (NPR 2004b).

<table>
<thead>
<tr>
<th>Patients region of residence</th>
<th>Period</th>
<th>Hospital A</th>
<th>Hospital C</th>
</tr>
</thead>
<tbody>
<tr>
<td>All regions of residence</td>
<td>1998</td>
<td>881</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>1999</td>
<td>740</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>2000</td>
<td>870</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>921</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>799</td>
<td>125</td>
</tr>
<tr>
<td></td>
<td>2003</td>
<td>974</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>All periods</td>
<td>5185</td>
<td>376</td>
</tr>
</tbody>
</table>

First, the hospital contacted private specialists that conducted preliminary examinations of such patients, and informed these about the significant shorter wait time at Hospital C compared with other hospitals (Informant C3). Moreover, when the first patients had arrived and undergone their treatment, the hospital invited a journalist from one of the largest newspapers in Norway, and arranged interviews with these patients (Informant C1). This strategy proved to be effective, as the number of hysterectomy-patients increased by 320 per cent from 2000 to 2002. That is to say the number of such patients treated rose by 92 per cent from 39 in 2000 to 75 in 2001, and moreover, by 66 per cent from 75 in 2001 to 125 in 2002 (see Table 19).

The success did not go by unnoticed. Hospital A experienced a significant decrease in the number of patients requesting such treatment. That is to say, the number of
patients treated fell by 122, from 921 in 2001 to 799 in 2002 (see Table 19), which corresponds with a potential deficit in the region of NOK 5.4 million, if we apply the 2004 standards for activity-based funding\textsuperscript{135}.

However, in 2003 the number of patients choosing such treatment at Hospital C decreased by 56.8 per cent, from 125 in 2002 to 54 in 2003. According to the informants at Hospital C, they contacted those specialists, which had referred patients to the hospital, and tried to find out why they did not refer such patients anymore (Informant C2). The answer they got was rather simple although not uplifting. All specialist had been contacted either by Hospital A referring to the regional health authority, or by the regional health authority itself, and instructed to refer such patients to Hospital A instead of Hospital C in the future (Informant C3). As a plausible consequence, by April 19th 2004, 35 patients had been waiting in line for such treatment at Hospital A for more than 180 days (Hospital A 2004c). In the aftermath of this incident, Hospital C received a warning not to perform any such stunts of advertisement in the future (Informant C1).

\textbf{In sum}

Cutbacks due to LHE-Y’s budgetary deficits makes for a grim outlook for Hospital C, as most of the hospital’s specialized health care services are in danger of being closed down\textsuperscript{136}. It is however unclear whether the closedown process is brought about in spite of or due to the hospital’s efforts to increase the level of accessibility, transparency, and public choice.

What however is clear, is that Hospital C, unlike the two other hospitals described in this thesis, has tried actively and successfully to attract selected groups of patients from outside its normal geographical area of operation. Nevertheless, the hospital’s efforts in that regard were abruptly curtailed by the regional health authority, and local health enterprises affected by these efforts.
From values as reform ideals to Norwegian reform reality: Tracing values

So far, the focus in this thesis has primarily been put on the origin and content of the Norwegian health care reform, by describing and analysing the different case studies presented in this thesis. Now that we have an understanding of how the reform process has been played out at the political, the ministerial, and the hospital level, it is time to concentrate on the research questions from an analytical point of view, by drawing on the main findings in the preceding chapters. In this chapter, the focus is put upon research question Q-1:

How have the values of accessibility, transparency, and public choice been translated into the Norwegian reform context, and the different levels of the specialized health care system in Norway?

The question of how these values are translated, is a question about both process and output, as far as the Norwegian health care system can be viewed as hierarchically organized into different levels, where the process at one level produces an output that influence the process at subordinate levels (cf. Scott 1998: 50-51), from the parliament as legislator, to patients as subjects of policy outputs. However, this thesis does not represent an output study.

As discussed in chapter 3, the transformative perspective encapsulates both instrumental and institutional elements, as well as elements of culture, in an analytic framework applicable to systems in change. Whereas instrumental elements are somewhat easy to identify, institutional and cultural elements might be difficult to hold apart137. Keeping this in mind, the following discussion is structured by the instrumental, and the institutional and cultural nature of the elements discussed.

Accessibility

Improving accessibility and quality is perhaps the most important goal for all governments, if they are to ensure equity in health and further development of the health care sector (Feachem 2000). However, as stated in chapter 3, whenever NPM inspired reforms enter in to reality it is done trough a transitional process where ideals are attuned with a specific contextual framework (Christensen & Lægreid 2003b: 7-8; Giauque 2003: 574; van de ven 1996: 655-656), as different reform ideals tends to be easier to adjust than it is to change established practice (Christensen & Lægreid 2003b: 7). In the following discussion, the focus is put upon the State’s takeover of public hospitals, the role of the RGP, elements of privatization, and financial constraints.
Instrumental aspects

From an instrumental point of view, the purpose of the Norwegian health care reform has been to improve the quality of the specialized health care service in terms of creating equity in access to medical services of quality (SHID 2001c: 11).

The perhaps most important element creating an improved level of equity, is the state’s takeover of the ownership of public hospitals through the so-called Norwegian hospital reform. By eradicating county-based differences, the hospital reform created a new situation where the specialized health care resources available within any given health region, became available for patients in need of specialized services. Furthermore, the state’s takeover made specialized health care services located outside the patients region available for the patients.

However, as discussed in chapter 5 and 6, RGP s also function as gatekeepers ensuring that only those in need of specialized interventions actually are referred for such treatment. This gatekeeping function, which is intended to prevent excessive use of specialized health care services, might reduce the accessibility of specialized services as far as it might be incompatible with the patients’ autonomy in the process of choice (Carlsen & Norheim 2003b: 19). The argument here is that patients are dependent upon their RGP’s approval when seeking referral for hospital treatment (NBH 2004b). Nevertheless, if the gatekeeping function prevents access for patients not in need of specialized services, the accessibility for patients in factual need will be increased. However, according to Carlsen & Norheim the gatekeeping function of the RGPs has been weakened as a result of the Norwegian health care reform (Carlsen & Norheim 2003a: 21).

Privatization has been one of the cornerstones of public reforms in the western world. Unsurprisingly this has also been a central element within the Norwegian health care reform context, although not in the sense that previously publicly owned services have been sold-out to private interests, but rather in the sense of outsourcing services previously produced solely by publicly owned agents. Although some private hospitals were an integral part of the public health care system prior to the reform, the reform revolutionized private distribution of health care services in Norway, as 21 corporate hospitals now are taking part in the public provision of health care services. If we look at a graphical view of the data collected by the Norwegian Patient Register about patient movements in relation to elective services and 24-hour hospitalization, without taking the patients region of residence in to consideration (see Figure 9), the impact of private hospitals participation in the provision of public health care services becomes quite apparent, as the percentage of patient treated at private h3 and h4 hospitals has risen from 2.34 percentage points in 2000, to 8.39 percentage points in 2003 (see Appendix IV).

Nevertheless, in itself this kind of privatization does not represent a market mechanism, as the primary intention with this outsourcing practise has been to improve efficiency in terms of increasing the total number of interventions produced, and thereby
reducing wait time for patients in general. As regards to reducing wait time, the recent changes have made significant impacts if we regard wait time as an average.

Figure 9 – Percentage of patients treated at private b3 and b4 hospitals, compared to the corresponding values for patients treated at public hospitals, including private b2 hospitals, pr. Region, in relation to elective services and 24-hour hospitalization in the period 2000 – 2003. Source: see Appendix IV.

It can be claimed that the recent changes within the Norwegian health care system, to some extent, represents significant improvements as regards to the level of accessibility and equity. The pre-reform situation, where e.g. patients suffering from cancer in some cases only were offered treatment at small local hospitals that had an insufficient level of experience, is at least on paper no longer a reality, as the regional health authorities within each region have been ordered to make sure that the division of labour within the region facilitates the regions centres of excellence. In this sense, the hospital reform in a revolutionary way has created improved health care services regardless of an eventual existence of transparency or public choice. That is to say; if we can be assured that decisions concerning the division of labour are based primarily upon medical concerns. Nevertheless, there are indications, as in the case of Hospital C, that other factors than pure medical concerns are influencing decisions concerning the division of labour. I will return to this problem below.

One of the features of the Norwegian health care reform, intended to promote increased efficiency in terms of higher production of specialized health care services, is the new financial system (ISF) introduced in 1997. ISF is a partially activity-based fee-for-service system intended to motivate increased production of specialized health care services. The reality of the new financial system is that block grants now longer represents the full financial base for Norwegian hospitals, as a percentage of the funding now are directly linked to patient related activities. At the point of inauguration, the activity-based percentage was set to 30, but was later on increased several times until it reached 60 % in 2003.
Institutional and cultural aspects

However, the new financial system has made accessibility in terms of medical priorities vulnerable to economical concerns. That is to say; vulnerable without taking misbehaviour in terms of deliberate misuse of the system into account. The reason for this argument is that the focus on ever-increased efficiency in terms of increased production as regards to the factual number of patients treated, combined with a static level of funding\textsuperscript{146}, creates a situation which in Hollywoodish terms almost could be labelled as a “Mission Impossible”. Hence, some Norwegian hospitals state that they are in a situation where they no longer can guarantee adequate health care services, as they are forced to cut back on vital services due to financial problems\textsuperscript{147}. Adding to this problem, is the fact the activity-based percentage of the hospital funding was reduced from 60 to 40 per cent in 2004\textsuperscript{148}, and the government’s demand for budgetary balance in terms of hospitals putting an end to their budgetary deficits within year-end 2005\textsuperscript{149}.

Although there is no evidence of any causation, compared to the corresponding period of 2003 the number of patients treated in the first four months of 2004 rose by 7 per cent (NPR 2004\textsuperscript{a}), whilst the number of patients seeking recompense rose by 33 per cent\textsuperscript{150} (NPE 2004). Furthermore, still without evidence of causation, an increasing number of Norwegian hospitals have made use of creative solutions as regards to assigning incorrect DRG-codes to their patients, which consequently have increased their level of reimbursement (NTB 2004\textsuperscript{b}). The perhaps most horrifying example of such re-coding is the so-called “back-project” at Hammerfest sykehus\textsuperscript{151} where even patients referred for hemorrhoidectomy and gastrostomy were subjected to back surgery (NBH 2003: 6). Here we are at one of the key points discussed in chapter 3 in relation to the difference between trust and confidence\textsuperscript{152}. I will return to this problem in the next chapter of this thesis.

Accessibility in relation to health care services of excellence and geographical distance, are sometimes a contradiction that brings into view a paradox that is inherent in the ideal modern health care reform, especially in rural areas. While city folks in most cases have access to a multitude of facilities offering health care services of some kind, the situation in more rural areas is often quite the opposite. One common view originating from systematic reviews is that to maintain the high knowledge and excellence necessary, physicians have to perform a minimum number of interventions (Teisberg, et al. 2001: 53-53). As the science of medicine becomes more complex and specialization is required to obtain a licence for ever more types of interventions, rural areas experience problems with sustaining the increasingly higher population required. As a result, small community hospitals can no longer provide an environment where physicians can maintain their level of excellence. Consequently community hospitals might have to reduce their range of services and not uncommonly close down some or all of their departments (Tomblin 2002: 17-18).

The problems experienced by Hospital C might be a good example of how this dilemma has influenced the post-reform Norwegian health care sector. As discussed in chapter 0, the Norwegian health care reform dramatically changed the reality for the small
community hospital, as the hospital has been forced to degrade the status of their birth
and gynaecology unit, due to the low number of births per year at the hospital. Moreover, quality concerns are not the only factor influencing accessibility in rural areas. Although a small community hospital, such as Hospital C, very well might be capable of performing a number of specialized interventions above any quality limits, the number of such specialized services performed might not be sufficient to secure efficiency in an economical sense. Due to the budget deficits experienced by LHE-Y, the local health enterprise under which Hospital C is organized, all chirurgical services at Hospital C, with the exception of those related to urology, will be discontinued by year-end 2004 (LHE-Y 2004c: 7).

Transparency

The problems of accessibility as discussed above might be related to issues of transparency. As discussed in chapter 5, a system of health accounts is a prerequisite for a healthy public health care system. Moreover, control through a system of health accounts is a prerequisite for the transparency necessary for patients in the process of choice (Kristensen 2003: 23; SHD 2001c: 12), as such a system makes hospitals as well as other actors within the health care sector accountable for the quality of the services they provide, not only in terms of economical efficiency and medical quality, but also in terms of accessibility and equity through public choice. Transparency as discussed in this thesis is closely linked to public choice in the sense that transparency concerns functions of control through which information is gathered, whilst public choice concerns the dissemination and the quality of the collected information and thereby the empowerment of patients and other stakeholders in their dealings with the health care system. In accordance with this argument, the following section concerns the gathering of information through functions of control.

Instrumental aspects

Within the Norwegian health care system, the main responsibility for transparency, in terms of functions of control and a system of health accounts, is bestowed upon the Ministry of Health (cf. Lov av 30 Mars 1984 nr. 15 § 7), which maintains its responsibilities through delegation of authority to different governmental control and research agencies.

As discussed in chapter 4 in relation to evidence-based medicine, as well as in chapter 5 in relation to medical quality assurance within health care systems, accurate data on performance is a necessity for the development of a sound health care system. Within the post-reform Norwegian health care system, the focus has been put upon developing national quality indicators for the health care sector, a process of development that has been undertaken at both the national and the regional level (Kristensen 2003: 23). In cooperation with the Norwegian Board of health, the Directorate for Health and Social affairs has the main responsibility for the development of national quality
indicators. So far, 7 national quality indicators, and 4 patient reported indicators have been developed. The data relating to these indicators are collected by the Foundation for Health Services Research, the Norwegian Institute of Public Health, and the Norwegian Patient Register. At the national level, the quality indicators mentioned here represent the only functions of control implemented as a direct result of the Norwegian health care reform.

In addition to collecting data on several national quality indicators, the Norwegian Patient Register also collects and verifies patient data submitted by somatic hospitals and psychiatric institutions in Norway in accordance with the so-called NPR-record. As can be seen in 0, the full NPR-record compiles an extensive number of different variables. Although the NPR database is not a product of the Norwegian health care reform as described in this thesis, it constitutes the backbone of the Norwegian system of health accounts, as the NPR database represents the most comprehensive collection of data related to the production of specialized health care services in Norway. Moreover, as the calculation of patient activity related reimbursements partially is based on submitted patient data collected and verified by NPR, it would be fair to assume that the NPR data is more accurate than data collected through some of the other national functions of control. Nevertheless, most of the data contained in the NPR database is not publicly available.

Another governmental health agency producing highly reliable data is the Norwegian Board of Health. Through its 19 county medical officers, the Norwegian Board of Health is the only governmental health care agency performing on-site surveys of hospital activity in Norway. Although the Norwegian Board of Health, similar to the Norwegian Patient Register, is not a product of the Norwegian health care reform, the functions of control performed by the board has become more central due to the reform. One good example of this is the case of Hammerfest sykehus, where approximately 100 patients were subjected to an unauthorized and experimental form of treatment, which was economically beneficial for both the hospital and the surgeons involved in the projects (cf. NBH 2003). Another less perverse example is the board’s report on patients’ rights, which concludes that there still is some need for improvements before patients’ rights can be described as fully implemented into factual hospital practice (cf. NBH 2004c).

Although the Norwegian health care reform without doubt has increased the level of transparency, at least within some areas concerning the specialized health care service, e.g. through the introduction of national quality indicators, there are indications that the current system of control, and the corresponding system of health accounts, might have some flaws.

**Institutional and cultural aspects**

The main problem here is that although the Norwegian Board of Health does perform some on-site surveys as in the case of Hammerfest sykehus, most data in relation to national functions of control are self-reported by the hospitals. This is especially true for
data collected by the Norwegian Patient Register and the Norwegian Institute of Public Health.

However, it would not be fair to ascribe the responsibility of an inadequate system of control to Norwegian hospitals and the conduct of their staff, as it is the government’s responsibility to design a system of checks and balances that in an adequately way provides all stakeholders with trustworthy information. One problem related to transparency is that it is not always in people’s interest to know. This is perhaps especially true in the political sphere where politicians might be held accountable if proven to have known about unfavourable elements in beforehand.

Another serious problem concerning transparency is the fact that it has become a customary practice to curtail public servants by demanding total loyalty in terms of prohibiting them their civil, human, and political right of speech. This goes for any situation where there is just a faint scent of conflict with governmental corporations’ entrepreneurial interests. This is especially true in societies where the new public managed civil service culture has left an ever-lasting impression on most public affairs (Dudley, et al. 1998: 656; Mechanic 2001: 42-44; Schlesinger 1997: 39).

According to the Vice-President of the Norwegian Medical Association, there are indications of a stricter regime within Norwegian hospitals as regards to the loyalty demanded of their employees. Although repudiated by the CEO of the Eastern Health Authority, the Vice-President claims that many physicians do not give notice of any maltreatment within hospitals as they otherwise might be forced to leave their positions (Moland 2004). Whatever might be true in relation to this dispute, introducing gag-rules might seriously hamper attempts to increase the level of transparency as regards to the quality of the health care services provided by Norwegian hospitals.

**Public choice**

Public choice is closely linked to transparency, as the possibilities for choice is dependent upon the accessibility and the quality of the data collected through national functions of control and the system of health accounts (SHD 2001c: 12). However, regardless of the accessibility and the quality of the data, choice as a legislative right does not make much sense if there is no form of legal protection. Whereas the section above discussed the gathering of information through functions of control, this section discusses the dissemination and the quality of the data, as well as the legislative side of public choice.

**Instrumental aspects**

As discussed in chapter 5, the patients’ voice and choice have been put forward as vital instruments in the health care reform process. As stated in the Ljubljana Charter “the citizen’s voice and choice should make as significant a contribution to shaping health care services as the decisions taken at other levels of economic, managerial and professional decision-making” (WHO 1996e: § 6.2.1). Moreover, the Ljubljana Charter stated, “the
exercise of choice and of other patients’ rights, requires extensive, accurate and timely information and education” (WHO 1996e: § 6.2.3).

One of the intentions with the patients’ right of choice was to create a quasi-market situation in which Norwegian hospitals were to compete. As the former Norwegian Minister of Health Dagfinn Hoybråten put it:

“Norwegian hospitals do not own their patients any more” (HD 2003c).162

The logic here is that the patients’ voice and choice should contribute to some kind of a Darwinian process of natural selection, instigating a battle of survival, and thereby securing the survival of the fittest in terms of patients not choosing hospitals producing sub-optimal services.

Within the Norwegian health care reform context, the Patients’ Rights Act is the most important element in that regard, as it installed both the patients’ right of choice and their right to information (cf. Act of July 2nd 1999 no. 63). Through its roles as acting owner, and principal agent of control, the Ministry of Health is bestowed the responsibility for providing patients and other stakeholders with the information necessary for them to exercise their rights, and thereby the means to maintain their new responsibilities. Nevertheless, Norwegian hospitals are the only actors obligated by law to provide such information (cf. Lov av 2. Juli 1999 nr.61 § 3-11). However, as discussed in chapter 7163 and 8164 information disseminated by Norwegian hospitals seems to be mainly targeted on patients already admitted or referred.

Although governmentally sanctioned information is disseminated through many different sources, such as individual hospitals, local health enterprises, and regional health authorities, and from different governmental health agencies including the ministry itself, the governments preferred channel of communication as regards to information concerning the specialized health care sector, is the National Information Service for the Patients’ Right of choice.

Through the National Information Service for the Patients’ Right of Choice, for the first time ever Norwegian patients have gained access to detailed information about the specialized health care sector. The information disseminated through this channel of communication can broadly be divided into three categories; quality indicators measuring hospital activity according to predefined measures of quality, patient reported indicators measuring patient assessments of hospital services, and wait time informing patients about how long they have to queue for specialized health care services.

As regards to wait time the national information service has published both historical and estimated data. Whilst historical wait time was calculated by the Norwegian Patient Register based on patient data submitted by Norwegian hospitals, estimated wait time was reported directly by the hospitals to the information service. However, since the inauguration of the “new” information service in May 2003, the focus has gradually been shifted towards estimated wait time, which is the only information on wait time available publicly after the restructuring of the national information service in September – October 2004 (cf. FSN 2004b).
So far, the National Information Service for the Patients’ Right of Choice publishes data on 4 different quality indicators. These are (q1) ratio of medical records submitted within seven days, (q2) number of patients in corridors, (q3) preoperative length of hospitalization in relation to femoral neck fracture, and (q7) prevalence of hospital infections in Norwegian somatic hospitals. However, of these are only q1, q2, and q7 directly linked to elective services eligible for the patients’ free choice, as q7 concerns femoral neck fractures, which always is a case of emergency and consequently not eligible for choice. Another interesting phenomenon in relation to these indicators, is the fact that although the Norwegian Patient Register for some years has recorded data on the prevalence of hospital infections, those responsible for developing quality indicators has purposefully chosen less accurate methods of measurement for the data published by the National Information Service for the Patients’ Right of Choice. I will return to these problems below.

In addition to data on quality indicators, the information service also publishes data on four patient reported indicators, that is to say (p1) patients’ assessment of the standard of buildings, equipment, and more, (p2) patients’ experience with physicians and nurses, (p3) patients’ assessment of how well the functions of the hospital are organized, and (p4) patients’ assessment of the information they have been given by the health professionals.

As mentioned above, the National Information Service for the Patients’ Right of Choice is not the only governmental agency publishing data concerning the production and the quality of specialized health care services in Norway. The most important examples are reports issued by the Norwegian Board of Health, e.g. the case of Hammerfest sykehus, and the data published by NPR. However, with the exception of data on the quality indicators registered by the Norwegian Patient Register, data collected by the Norwegian Board of Health, and NPR, are not available through the governments preferred channel of communication; the National Information Service for the Patients’ Right of Choice. Moreover, the Norwegian Patient Register’s main channel of communication as regards to statistical information on hospital production, the web-site reginfo.npr.no, was discontinued in June 2004.

Nevertheless, the institutions of transparency and public choice, similarly to the elements of privatization discussed above, can be described as revolutionizing the Norwegian public health care sector, as neither choice of hospital, nor free access to hospital data, such as those provided by the National Information Service for the Patients’ Right of choice, were elements of the pre-reform public health care system.

**Institutional and cultural aspects**

However, although the Norwegian health care reform has created some kind of competition in terms of increased accessibility, transparency, and increased possibilities for choice, the competition with in the Norwegian specialized health care sector is nevertheless not directly focused on patients as autonomous actors empowered with the right of choice, and means to make free and critical choices. In fact, post-reform adjustments of the institutions of transparency and public choice can be described as
reducing the patients’ power as informed consumers of specialized health care services. This argument concerns both changes made to the patients’ rights legislation, and changes made in relation to the gathering and dissemination of information.

As regards to changes made to the patients’ rights legislation, the element reducing the patients’ power is the fact that the patients’ possibilities for enforcing their rights in terms of filing complaints in accordance with the Public Administration Act (cf. Act of February 10th 1967), were removed when the revised patients’ rights act went into force on September 1st 2004. Although this revision also extended the patients’ right of choice to include any private health care provider with a public contract, and even foreign health care providers to some extent, the diminished legal protection has reduced the patients’ ability to enforce their rights.

However, the issue of legal protection concerns more than formal legislative measures (Fredman 1999). In addition to formal legal rights, patients are in need of adequate means if they are to exercise their rights effectively (cf. WHO 1996e: § 6.2.3). According to the Finnish human rights specialist Markku Fredman, there are three questions determining the level of legal protections for most issues concerning rights (Fredman 1999).

Do people have adequate rights?

Do people have the means whereby those rights can be realized?

Are those means effective?

Here we are at a point that links accessibility, transparency, and public choice closely together. If patients are to choose between different hospitals, they need access to more than one hospital providing adequate health care services. Nonetheless, a list of options in itself does not enable patients to make critical and informed choices. In addition, they are in need of information that adequately elucidates differences in how different hospitals provide their services. Within the Norwegian context, the National Information Service for the Patients’ Right of Choice is intended to provide Norwegian patients with a list of options and corresponding information elucidating differences between the options. However, the way in which the service provides information, leaves much to be wanted.

The first problem here concerns the list of options. As discussed in chapter 6 and 8, Norwegian hospitals have so far not been treated equally neither in the Norwegian legislation, nor by the National Information Service for the Patients’ Right of Choice. The origin of this problem stems from the formulation used in initial version of the Patients Rights Act, which stated that the patients could choose between different public hospitals only. Within the definition of public hospitals, privately owned h2 and h3 hospitals, that is to say hospitals owned by NGOs, were included, whilst privately owned corporate h4 hospitals were excluded. Nevertheless, due to the outsourcing practice discussed above, regional health authorities have increasingly negotiated contracts with private h4 health care providers. Consequently, this led to a situation where private h4
hospitals were included in the patients’ list of options as far as the health authority with in the patient’s own region of residence had negotiated such contractual relations. Although the legislation has changed in favour of privately owned h4 hospitals, as they now after September 1st 2004 are fully included in the patients’ right of choice, private h4 hospitals is nevertheless not treated equally by the National Information Service for the Patients’ Right of Choice (cf. FSN 2004c).

Leaving the question of equal representation aside, there are still further problems affecting the legal protection of the patients’ right of choice, as the information published about wait time, quality indicators, and patient reported indicators is somewhat dubious.

As mentioned above, the publication of wait time has changed gradually since the introduction of the patients’ right of choice. Initially only historical wait time was published. These were calculated based on factual patient data submitted by Norwegian hospitals to the Norwegian Patient Register. In May 2003, future estimated wait time, reported directly by the hospitals to the national information service, was added as an enhancement of the available information on wait time. However, when the website of the National Information Service for the Patients’ Right of Choice was reorganized in September – October 2004, information about historical wait time was removed.

As discussed in chapter 7, in the period when both historical and future estimated wait time was published, there were substantial differences in the data168. Although the former Minister of Health might be right when claiming that future estimated wait time gives patients a more accurate prediction of the factual wait time (cf. HD 2003c), future estimated wait time reported without any means of control are without doubt more prone to fraud than historical wait time calculated based on factual patient data, and even more so if data from private providers are not included in the published data, as in the case mentioned above.

Leaving the question of published wait time aside, there are also reasons to question the data on quality indicators and patient reported indicators published by the national information service. As discussed in chapter 7, the published data do not elucidate the factual situation in a way that enables patients to make informed choices169. This problem concerns both the reliability and the applicability of the data.

Firstly, the data are presented as aggregated data at the hospital level. As most hospitals have a substantial number of different departments and wards, providing different services, aggregated data might very well be more misleading than guiding as far as the data might conceal departments or wards with sub-optimal performances.

Secondly, the way in which some of the data have been collected makes data prone to flaws. Examples here are the data on quality indicator q7 prevalence of hospital infections, which at the point of investigation was collected and published without any scientific verification. Not surprisingly, the applied methodology did not depict the factual situation correctly170. Another example is the way in which patient reported indicators have been calculated, which led to a situation where hospitals were incorrectly depicted as performing very well171.

Thirdly, there are reasons to question the applicability of the data. This is especially true for data published on quality indicator q3 preoperative length of hospitalization in
relation to femoral neck fracture, as femoral neck fracture always is a case of emergency and consequently not eligible for choice. Furthermore, the predefined measure of quality, the percentage of patients treated within 48 hours, can hardly be defined as quality as studies have shown that it is vital for such patients to be treated within 24 hours\textsuperscript{172}.

Fourthly, there are reasons to question some of the data sources deliberately selected for publication through that the National Information Service for the Patients’ Right of Choice. This is especially true for the data on quality indicator q\textsuperscript{7} prevalence of hospital infections, as data that are more accurate are available from the Norwegian Patient Register\textsuperscript{173}, although not published through the governments preferred channel of communication; the national information service.

Although those responsible for the national information service claims that the purpose of the service is to enable patients to make informed choices (FSN 2004c), both the national information service and the Ministry of Health state that the quality of the information might not provide a basis upon which hospitals adequately can be compared (FSN 2004c; SHD 2001c: 12). The discussion in this thesis indicates, in accordance with the claim put forward by Heltef (cf. NRK 2004b), that the National Information Service for the Patients’ Right of Choice is purposefully designed to prevent patients from making use of their right to choose hospital.

The lack of competition in terms of hospitals subjected to the power of the peoples free, critical, and informed choice, is reflected in the competitive strategies the hospitals described in chapter 8 have employed. The three hospitals have all employed different strategies to enhance their competitive position, strategies that can be traced back to the hospitals’ institutional core.

Being a large university hospital with a long tradition of medical research, it is not surprising that Hospital A focuses its efforts on strengthening its natural strongpoint by enhancing its level of medical excellence\textsuperscript{174}. Likewisely Hospital B as a diaconal hospital has focused its efforts on enhancing its strongpoint, the hospital’s caring abilities, by attempting to strengthen its relations to the primary health care service and thereby creating a more holistic chain of guidance\textsuperscript{175}. In contrast, Hospital C as a local hospital originally build and funded by the local population itself, has aimed its strategies more directly at individual patients by disseminating information through selected medical specialist and the mass media\textsuperscript{176}. Although this strategy is somewhat similar to the one chosen by Hospital B, there is a significant difference, as far as Hospital B recon the primary health care service as the most important factor guiding patients, whilst Hospital C facilitated medical specialist merely as means for disseminating information towards designated groups of patients.

Instead of competition in terms of the survival of the fittest, the current competition within the Norwegian health care sector can best be described as a battle for the survival of the fattest. Examples of this are the struggles of power between Hospital A and Hospital B, and the conflict between Hospital C and the regional health authority, Hospital A, and LHE-Y. In the first case Hospital A, although being one of the largest university hospitals in Norway, is somewhat annoyed with its neighbour the smaller diaconal hospital. As the hospital’s CEO puts it: “We want to reorganize Hospital B”\textsuperscript{177}. 

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In the second case, the competitive efforts made by Hospital C are not met with similar efforts by competing hospitals, but rather by brute force commanding the hospital to discontinue its competitive efforts\textsuperscript{178}. Although there is no evidence of any causation, most of the services provided by Hospital C will be discontinued by year-end 2004 (cf. LHE-Y 2004e).

**In Sum**

From an instrumental point of view, the Norwegian health care reform has installed institutions that are intended to function as support for patients in the process of choice. Without doubt the most important element in that regard, is the Patients’ Rights Act, which not only constitutes the patients right of choice, but also their right to information, and perhaps most important the right to informed participation in the process. Nevertheless, if choice is to become a reality, the necessary information has to be freely available for patients. Some might argue that this is the case within the present public health care system in Norway, as there are several dedicated institutions providing such information in addition to the information available through hospitals and the patients’ regular GP. However correct this might be, the information provided by the National Information Service for the Patients’ right of Choice, and by The Norwegian Patient Register, do not fully cover the needs for information. Moreover, information from hospitals and GPs is not necessarily freely available, as patients are dependent upon the GP’s or the hospital staff’s willingness to comply. As reported by the Norwegian Board of Health, this is not always the case (NBH 2004e). Such an information dependency cannot be labelled as freedom for the patients.

In sum therefore, from an instrumental point of view, it seems clear that institutions promoting accessibility, transparency and public choice, are installed within the reformed Norwegian specialized health care sector. Nevertheless, it seems similarly clear that institutional and cultural elements are reducing the outcome that otherwise could have been expected.
The reality of choice

Now that we have established how the values of accessibility, transparency, and public choice have been translated into the Norwegian reform context, it is time to take a closer look at the Norwegian health care reform in view of the second research question in this thesis:

Do the recent changes within the Norwegian health care system enable patients to make use of their right to choose hospital?

Based upon the theory of trust as elaborated in chapter 3, and the findings presented in this thesis, this chapter aims at finding an answer to this question.

However, as it might be some controversies as regards to the actual effect the introduction of patients’ choice has had on patient movements, let us first take a closer look at the development in patient movements in the period 2000, one year prior to the reform, to the end of 2003, the third full year of choice, as regards to the percentage of patients treated at private h3 and h4 hospitals (see Figure 10). Although the percentage of patients treated at private h3 and h4 hospitals without doubt has risen, Figure 10 reveals that there are significant differences as regards to the patients region of residence.

![Figure 10](image_url) – Percentage of patients treated at private h3 and h4 hospitals, per year by patients region of residence, in relation to elective services and 24-hour hospitalization. Source: see Appendix IV.

Although these differences reflect differences in the five regional health authorities contractual practice as regards to incorporating corporate hospitals within publicly provided health care services, these values do not tell whether or not these admissions are due to the patients’ own free choices or due to referrals based on their GPs’ medical...
considerations. Nevertheless, the level of production of public health care services within private hospitals is the only indicator available that can indicate changed patterns of movement. However, the subject in question in this chapter is whether we from a perspective of trust are able to say something about the patients’ possibilities to make free, critical, and informed choices. Although such an analysis cannot be taken as evidence of neither failure nor success in that regard, this analysis might indicate whether or not the current institutions intended to support patients’ in their process of choice, and thereby promote relationships based on trust between the patients and the publicly provided health care service, either in a plural or singular sense. Furthermore, this analysis might also indicate whether the institution of public choice within the current health care system, acts as an enhancement feature as regards to increased efficiency within the health care system, as discussed in chapter 5.

The notion of trust within the Norwegian health care legislation

The notion of trust as it is used in the Norwegian patients’ rights act does not elucidate the legislators’ intentions as regards to “the promotion of a relationship based on trust”:

“The provisions of this Act shall contribute to the promotion of a relationship based on trust between the patient and the health service while having respect for the individual patient’s life, integrity and human worth” (Act of July 2nd 1999 no. 63 § 1-1).

In the text quoted here there seems to be references both to trust in a general sense; “a relationship based on trust between the patient and the health service”, and to trust in a particularized sense; “having respect for the individual patient’s life, integrity and human worth”. In the quotation the term while is used to separate the two notions. This might indicate that the legislators are referring to the second notion as being a condition for the first. On the other hand, the term while might indicate that there are two intended provisions that are separate and non-related. If this is the case, the legislators’ intention might be to enhance trust in a general sense, and at the same time to ensure that the focus on patients’ life, integrity, and human worth are not lost in the process. Within this interpretation, patients’ rights are not necessarily intended in a literal sense. Patients’ rights might be seen as incentives, or perhaps more accurately as threats, intended to ensure that health service providers do provide health services of good quality to the population regardless of the patients’ geographical location.

A second interpretation, based on a particularized conception of trust, focuses on the quality of the health care service; “the individual patient’s life”, equality as regards to the accessibility of health care services; “human worth”, and the power of the patients’ free and critical choice as well as other patients’ rights; “integrity”.

As a third interpretation, the legislators’ intentions might be to enhance the level of trust both in a general and in a particularized sense. If we look at the notion of trust as it
is defined in the White Paper concerning the patients’ rights act (Ot.prp.nr.12 1998-1999), this appear to be the most reliable interpretation:

“...The public health service is dependent upon a relationship of fundamental trust between health care providers’ on the one hand, and the patients’ on the other, if the service is to function satisfactorily. This relationship of trust must be maintained both through financial allocations, as well as through formal procedures, e.g. the patients’ right to access their medical records. Possibilities of complaint and second opinions, do also contribute in developing a profound sense of trust between the patients and the health care service. This relationship of fundamental trust, based on equality and respect, should infuse interpretations of the individual rights constituted by the act” (Ot.prp.nr.12 1998-1999 § 3.1) 180.

Exit and voice in a generalized vs. particularized model of trust

In relation to the Norwegian specialized health care system, the model of trust developed in chapter 3, can explain trust both in a general and in a particularized sense, as far as trust in a general sense concerns the relationship between a patient and the specialized health care system in general, and trust in a particularized sense concerns the relationship between a patient and individual actors within the specialized health care system, e.g. a hospital. This might suggests that there according to this model are no major differences between trust in a generalized and particularized sense. Nonetheless, although the definition of trust, and distrust, are the same in both senses, this is not quite so as there are some significant differences when it comes to the options of exit and voice, which in both senses can be viewed as expressions of distrust.

Before we move on, we have to sort out one problem in relation to one of the statements above; “trust in a particularized sense concerns the relationship between a patient and individual actors within the specialized health care system, e.g. a hospital”. Some might argue that the relationship between an individual, in this case the patient, and a hospital, will have to be described using trust in a generalized sense. Nevertheless, there is a long-standing tradition of treating a company, or an organization, as one legal entity, as an artificial legal individual or person, or as some describes it, as a corporate personality. The logic here is that just like a real person, a company or an organization is responsible for its actions in a judicial sense, in so far as the products or services provided by the organization can be viewed as produced by the organization as an entity (Collins 1990: 731-732; Iwai 1999: 583-584; Pickering 1968; Teubner 1988: 130-131). Specialized health care services are in most cases not produced by a single individual. The argument here is that the treatment of hospitalized patients is dependent upon a network of single individuals working in cooperation, e.g. surgeons, nurses, technicians, and even those providing food or cleaning the operating theatre. Based on this, I will argue that the relationship between an individual and an organization such as a hospital can be described in terms of particularized trust.
If viewing the model of trust elaborated in chapter 3 as a model of generalized trust, there are two different though equally probable interpretations. The first focuses on the specialized health care system as an entity, whilst the second takes the political and public feature of the health care system into account.

In the first sense, viewing the health care system as one entity, exit might not be an option for patients, as exiting the health care service might reduce the patient's quality of life, or even prove to be fatal. Nevertheless, exit is an option in more than one sense. Firstly, in accordance with the Ljubljana Charter (WHO 1996e § 6.2.2), the Norwegian Patients' Rights Act gives patients the right to refuse treatment (Act of July 2nd 1999 no. 63 § 4-1). Secondly, some patients might prefer to be treated in accordance with so-called alternative or natural medicine instead of the somewhat more “common” alternative, textbook medicine. Thirdly, as most specialized health care services can be purchased from private health care providers, either domestically or abroad, citizens can exit the public health care system by relying entirely on privately provided health care services. However, this option is only open for patients with a strong financial foundation.

In the second sense, taking the political and public feature of the health care system into account, exit takes on a political character. The argument here is that the health care system can be viewed as a product of the at any time current political leadership. That is to say that although there is a complexity of factors influencing the performance of any health care system, citizens might perceive a public health care system as a political product. Hence, in the case of Norway, the State is the owner, the inspector, and the promoter of the health care system, as well as the sole provider of financial resources for the system. Consequently, exit can be exercised through the ballot box. Although this form of exit might not fit the perspective of patients in critical need of specialized health care services, it might be an effective way through which citizens can influence the development of a public health care system.

In both these senses of generalized trust, voice also takes on a political character. That is to say, that voice will have to be exercised through some kind of political process. Here citizens have several options, ranging from institutionalized channels of influence such as active participation through memberships in political parties or public interest organizations, to more ad hoc activities such as appeals published through mass media, political demonstrations, and even riots. However effective such measures might be, they are hardly effective means by which patients in critical need of health care services can influence the quality of the health care they receive. Nevertheless, although there is no evidence of any causation, it is a fact that the former Minister of Health, Dagfinn Heybråten, has experienced some difficulties in the nomination process leading up to the parliamentary election in 2005 (Hertzberg 2004).

If viewing the model of trust as a model of particularized trust, the options of exit and voice change in character.
In this perspective exit becomes a choice between options. If the patient needing hip replacement, hysterectomy or some other specialized health care intervention, perceives her level of knowledge to be sufficient to act on, and furthermore perceives the level of risk to be high enough to consider options, the patient might consider choosing another hospital than whichever hospital that otherwise would have been the obvious choice; e.g. the local hospital. However, although exit can be viewed as an expression of distrust, exiting following this line of thought does not necessarily express a general sentiment of distrust towards hospitals not chosen, as the patient very well might have chosen otherwise if the case in question concerned some other medical problem.

Voice on the other hand, might occur if the patient perceives her level of knowledge to be sufficient to engage herself in deliberations in an attempt to improve the quality of provided health care services, and furthermore perceives the level of risk as high enough to necessitate such an engagement. If these conditions are met, such deliberations can be made directly with the medical staff or hospital in question, through mass media, or by filing complaints in accordance with the institutions of legal protection. However, as discussed above, filing complaints in accordance with the Public Administration Act (cf. Act of February 10th 1967), is no longer an option for Norwegian patients. In spite of this, patients in critical need of health care services might not resort to voice, as the option of voice might be proven too costly or deemed in vain.

**Trust or political poverty**

As we learned in chapter 3, trust is the truster’s positive expectation as regards to future outcomes of the trustee’s choice of action, and consequently distrust can be described as a negative expectation of the same. Furthermore, we learned in relation to the discussion on stability and change within the transformative perspective that institutions at least needs to portray as being responsive in relation to these expectation, if they are to maintain their level of legitimacy. As expressed by the Norwegian Board of Health (2002), responsiveness as regards to expectation, is vital for the reality of the patients’ right of choice:

> “Responsiveness concerns the capability of the health system to respond to and to meet the populations’ expectations. Choice and responsiveness are important in the perspective of people’s rights and in the perspective of legitimacy and credibility in health care systems” (NBH 2002: 7).

Nevertheless, what if the patients’ expectations are higher than the hospitals’ capacity in terms of the quality of the service they provide? Would we not then be in a situation where trust hardly can thrive? The answer to both of these questions is undoubtedly yes. The central question then concerns whether the institution of public choice within the current health care system in Norway can live up to the promises primarily made by the Ministry of Health as regards to the patients possibilities of making free, critical, and informed choices, and perhaps even more important in that regard, can this institution of
public choice live up to the level and quality of the information now allegedly available from governmentally sanctioned sources?

**Trust**

As we furthermore learned in chapter 3, trust is closely linked to the possibilities of choice, as well as the level of knowledge, or perhaps more correctly within our context, the level, and quality of available information. Some might argue that knowledge in relation to trust also encompasses other sources of information than those discussed in this thesis, e.g. a commonly expressed claim is that the trustor’s eventual prior experiences with the potential trustee might heavily influence the level of trust. Although this might be true in many situations in life; hence, trust is a subjective and contextual phenomenon, the health care sector is in a special situation in so far as it offers services most people only needs once. As an example, patients will never experience a total hysterectomy twice, at least if we leave cases of malpractice out of the equation. That is not to say that such patients do not have prior experiences e.g. in relation to other illnesses themselves, or in relation to some treatments undertaken by some of their next of kin. Nevertheless, it should be apparent from the discussion so far in this thesis, and especially from the discussion in chapter 4, that a hospital’s or a physician’s level of excellence in relation to one particular field of medicine cannot be transferred to another. An analogy would be to make your carpenter do your plumbing, whilst the plumber did the construction of your house. Consequently, although a hospital earlier e.g. have excellently mended a broken knee, following Gran’s model of trust, it would be an instance of faith and not trust if the patient based decisions in relation to e.g. hysterectomy solely on such information. Therefore, in relation to specialized health care services, it would be fair to claim that prior experiences for most patients are of minor importance in relation to trust. The argument here is not that trust is some kind of a rational decisional process. As Russell Hardin points out, trust is not a matter of rational choice. However, the knowledge upon which human beings form their believes might be rational or not (Hardin 1997: 1).

Here we are at a vital point influencing the patients’ possibilities for making free, critical, and informed choices. Is the information published by the National Information Service for the Patients’ Right of Choice a sound foundation upon which patients’ can make their choices? As discussed in chapter 7 and 9, there are several problems connected to the accuracy and the applicability of the information published by the national information service. The question of accuracy concerns both the aggregated nature of the data, as well as the methodology applied in relation to some of the published indicators; q7 prevalence of hospital infections, and patient reported indicators. Moreover, the inaccuracy related to these data makes them less applicable, as the data are more misleading than guiding for patients in the process of making free, critical, and informed choices. Adding to the problem of applicability is the fact that an indicator related to emergency services; q3 preoperative length of hospitalization in relation to femoral neck fracture, is published as a quality indicator for elective services.
Consequently, the information published by the national information service can hardly be described as providing enlightenment for patients in the process of choice. It would for example have been a sad paradox if the patients maltreated at Hammerfest sykehus had chosen treatment at the hospital believing that the hospital performed well, if such a belief was based on information published by the National Information Service for the Patients’ Right of Choice.

What then, is the patients’ right of choice not intended to be taken in a literary sense? Or, since the former Minister of Health at the inauguration of the renewed information service in May 2003 expressed such optimistic outlooks for the patients new role as empowered users of health care services (cf. HD 2003c), is there any hope for improvements?

Political poverty

Unfortunately, as expressed by Meyer & Rowan, institutions tend to rely on peoples confidence and good faith instead of their trust (1977: 358). That is to say, if we apply the modified version of Gran’s model of trust, institutions are prone to promote loyalty, and not trust. Consequently, it would be fair to assume that information on hospital performance, disseminated by governmental agencies, are intended to promote faith and confidence, and not trust, or perhaps more important, intended to prevent distrust.

Quite contrary to providing patients with information about differences in quality between different health care providers, the government’s preferred channel of communication, the national information service, seems to be deliberately indicating that all Norwegian hospitals produce health care services of adequate quality, and furthermore, that the only factor patients needs to be concerned with is the wait time. Consequently, the image depicted by the government is an image of a health care system where there is no need to choose unless the wait time is unnecessarily long. Although there is substantial information indicating otherwise, e.g. the case of Hammerfest sykehus, it seems clear that the government’s incentive for preventing distrust might be stronger than its incentive for promoting trust. Hence, the State through the Ministry of Health is the owner, the inspector, and the promoter of Norwegian public hospitals, and the system in which they function. Moreover, the State is the sole provider of financial resources for the health care service.

The government’s strategy in relation the free choice policy seems unfortunately to have been effective so far. If we take a look at the data on patient movements as regards to the percentage of patients treated at a public or private h2 hospital within their own region of residence, it seems that the concept of trust as developed in chapter 3, fittingly can describe the current situation within the Norwegian specialized health care sector, as the model indicates that a lacking level of knowledge hampers the development of trust, as well as the possibilities for making free and critical choices. Although, Gran’s model of trust, when applied to Hirschman’s theory of exit, voice, and loyalty, also indicates the possibility of exit, exit is hardly a choice for patients in need of vital health care services if not substantial information indicates other options. Consequently, according to this
model of trust, such a situation creates stability in terms of loyalty, which unsurprisingly seems to be the current state of affair as regards to the relationship between patients and the public health care sector (see Figure 11).

![Figure 11](image)

**Figure 11** – The percentage of patients treated at a public or private hospital within their own region of residence, in relation to elective services and 24-hour hospitalization. Source: see IV.

As this figure shows, the relationship between the patients and the public health care service within the patients’ own region of residence is rather stable. Although there are significant differences between the five health regions, we have to notice that even though some private hospitals are located outside the geographical boundaries of the eastern health region, most private hospitals of this type, in addition to the currently only private hospital, are located within the geographical area administrated by the eastern health authority, and that this fact might have a significant influence on the uneven development, as patients living within the eastern health region have a less far distance to journey, when being admitted at these hospitals, than patients living elsewhere.

In view of the relative stability shown in Figure 11, particularly within the Northern region, a frantic campaign in terms of political and public pressure has paradoxically been instigated to diminish the patients right to choose hospital. The paradox here is that there are forces within the Northern region; the region having some of the most loyal patients, that are on the forefront in this campaign. In April 2004, Knut E. Schøder, the CEO at the University Hospital of North Norway, proclaimed that he was fed up with having to subsidise patients choosing treatment at hospitals outside the region. According to the CEO, some patients’ have alternative motives when choosing hospital (Salvesen & Solum 2004).

“If a patient wants to visit a grandchild in southern Norway, whilst only paying discount fares and receiving hospital care, we cannot refuse” (ibid.)

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The claim here is that those patients choosing treatment outside their own region of residence reduce the quality of the health care services local hospitals can provide, as far as such patients draw financial resources out of the region. Surprisingly we can find a similar argument expressed by the Norwegian Board of Health:

Free choice for powerful, outspoken patients may be at the expense of vulnerable groups and thereby jeopardise equity (NBH 2002: 7).

Although these expressed concerns to some degree are inline with Barry R. Weingast’s notion discussed in chapter 318, theses concerns can only be valid if the institutions of transparency and public choice do not support the patients’ free and critical choice in terms of providing detailed and viable information for all layers in the society. In other words, if the patients’ right of choice in its character can only be facilitated by individuals with higher education and knowledge of how to obtain relevant information, then the patients’ right of choice can only be described as a symbol, a varnish, only usable for politicians and health care executives promoting their own excellence.

In Sum

Although the institutions of accessibility, transparency and public choice, as discussed in this thesis, might be prime features on the local as well as the international political arena, an aversive strategy in relation to the implementation of these values does not promote trust, but rather political poverty as defined by Knut Dahl Jacobsen (1970).

In sum, the institutions of accessibility, transparency, and public choice are installed within the reformed Norwegian specialized health care sector. Nevertheless, the implementations of these institutions do not fully enable patients to make use of their right of choice.
Concluding remarks

The first part of this chapter presents some reflections on the role of trust, whilst the second part presents the epitome of the thesis.

The role of trust

The concept of trust is a versatile concept that plays an important role in society. According to George Simmel, trust can be defined as the cement by which the structure of society is built (Simmel & Wolff 1964: 318). The model of trust applied in this thesis takes the versatility of trust into account as it can describe the concept of trust in both a descriptive and a normative sense. The following paragraphs describe this versatility by using empirical examples presented in this thesis.

In chapter 4, we learned that the time honoured medical profession, when faced with a drastically declining level of trustworthiness, developed two new approaches to regain the trust of its patients and the general public. The first one, evidence-based medicine, focused its efforts towards the compilation, validation and implementation of evidence of current best practice with reference to individual patients’ outcomes (Alderson, et al. 2003: 13; Davidoff, et al. 1995; Ghali, et al. 1999: 133; Sackett, et al. 1996). Using the model of trust described in chapter 3, these technical and scientific efforts can be described as a strategy to increase the amount of available knowledge, and thereby increasing the accountability and the trustworthiness of the medical profession through an increased level of transparency.

On the other hand, patient centred medicine can be described as a pragmatic and clinical approach towards optimalization of patient outcomes (Evans 2003; Mead & Bower 2000: 1087; Morecroft, et al. 2003; Parker 2001: 88), by creating a therapeutic alliance between the doctor and the patients, where they share both the power and the responsibility (Mead & Bower 2000: 1088-1091). Using the model of trust, this strategy can be described as an attempt to involve the patients more forcefully in decisions regarding their treatment, and thereby increasing the level of risk through a shared decisional responsibility, though in a positive sense.

Based on the model of trust, we can see that these two strategies combined can contribute to an increased level of trust.

In chapter 5, discussing international reform movements, we learned that efforts to create a public health care system “targeted on health, based on sound financing, centred on people and focused on quality” (WHO 1996e), will have to take a multitude of different factors into account. These factors can be divided into three main categories. Firstly, governmental and managerial factors aimed at providing a sound framework in which the system is to function; accessibility. Secondly, factors aimed at increasing the
level of medical excellence; transparency, and factors aimed at increasing the involvement of the people; public choice. Using the model of trust, we can see that the combined force of these factors can increase the level of trust, as far as accessibility concerns the offerings of health care services, transparency concerns the offerings of knowledge, and public choice concerns the choice and the voice of the people as a forceful factor influencing the development of the health care system.

In chapter 6 to 10, discussing the Norwegian health care reform, we learned that institutions providing accessibility, transparency, and public choice are installed within the reformed Norwegian health care system. Nevertheless, we also learned that the condition under which these institutions are to perform, do not fully enable patients to make use of their right of choice. Using the model of trust, we can see that an aversive strategy in relation to the implementation of these institutions does not promote trust, but rather political poverty.

Epitome

This thesis has described a study of the free choice policy within the Norwegian specialized health care system, structured around the values of accessibility, transparency, and public choice, which is derived from classic theories of democracy as well as major international reform movements.

Using a theory of trust in a transformative perspective, the study has examined how the values of accessibility, transparency, and public choice have been translated into the Norwegian reform context, and the different levels of the specialized health care system in Norway. Furthermore, this thesis has examined how the recent changes within the Norwegian health care system have affected and thus enabled patients to make use of their right to choose hospital.

By depicting a timeline through international influence from paradigmatic changes within the field of medicine, international health care reform movements, and implementation within the Norwegian context at the political level, the ministerial level, and the hospital level, this thesis has discussed the origin, the content, and the outcome of recent Norwegian health care reforms.

The limitations of the study

There are several significant limitations influencing the reliability and validity of the studies presented in this thesis.

The first and foremost factor influencing the reliability and the validity of these studies, is the framework in which the studies have been conducted. That is to say, the perceived reality described in this thesis is influenced by the knowledge I as an individual have accumulated through my education and experiences in life, and the assumptions I have drawn from my image of the world (cf. Medin & Ross 1992: 109-110). Adding to this problem is the two-fold interpretative dilemma, which implies that the interpretations I have made of social facts based on written and verbal sources, in fact are interpretations
of my own perception of some one else’s interpretation of these social facts (cf. Östergren & Müllern 1996: 21-22). However, the two-fold interpretative dilemma does not apply to hard facts.

Secondly, both the reliability and the validity of the study described in this thesis are threatened by the lack of data form patients and patient organizations. Although this thesis presents a study of the free choice policy within the Norwegian specialized health care system, the absence of primary data on patients’ assessment of possibilities for choice as well as level of trust, is an element that affects both the reliability and the validity of this study. Although, time constrains and financial resources available for this study did not allow for such surveys, the lack of such data is nevertheless a major drawback for this study.

Thirdly, the reliability of this study is weakened in so far as the study might not fully live up to the imperative demand of replicability in science, as the identity of the hospitals examined in this study, and those interviewed, have been classified (cf. Hellevik 1999: 16; NESH 2001: 12-14). However, my personal archives can be made available for future studies in line with recommendations issued by the National Committee for Research Ethics in the Social Sciences and the Humanities (NESH).

Finally, the model of trust developed and applied in this study, although applicable in relation to a theoretical analysis of the probabilities for trust, might not be as usable as it might seem in relation to an analysis of the level of trust someone might have in e.g. the health care service.

Towards a new model of trust

The model of trust applied in this study, does not fully take into account the fact that risk might be dependent on knowledge, as far as the level of knowledge might influence the perceived level of risk. Using the patient as an example, if based on prior experiences and information made available for the patient, the patient have no knowledge of differences between hospitals as regards to the quality of the services they provide, then the patient might not perceive any risk in dealing with the health care service. Consequently, there might not be any need to choose between different options as they all seemingly deliver the same quality. On the other hand, if available information reviles differences between health care services in terms of quality; e.g. the cure rate and/or the likelihood for keeping ones breasts in relation to breast cancer treatment, then the patients’ perception of risk might be increased. Such an awareness of risk might motivate the patient to make a choice if this option is available e.g. through a patient’s rights act. Moreover, knowledge is connected to choice as far as the level of knowledge might influence the patient’s awareness of any possibility to make a choice between options. In the case of Sweden, studies have shown that patients in general are not aware of their right to choose health care provider (Spångberg 2003).

Consequently, although trust as a subjective and contextually defined phenomenon within some contexts very well can be conceptualized as a function of knowledge and risk, such an model does not fully take into account the fact that risk and choice are
dependent on knowledge; choice and risk can be viewed as belonging to the knowledge variable. Nor does the model take the truster’s level of self-efficacy into account; the belief that the truster’s own actions can influence outcomes.

A solution to this problem might be to conceptualize trust as a function of perceived knowledge and self-efficacy (see Figure 12). In this model knowledge encompasses choice and risk, while self-efficacy can be described as the individual’s beliefs about its capabilities to produce results by its own actions (cf. Bandura 1997: 162). That is to say the individual’s beliefs about its power to influence outcomes in specific contexts, or in life in general. Whereas individuals with high self-efficacy believe that they can influence outcomes, individuals with low self-efficacy believe that outcomes will not be positively influenced by their own actions. According to Albert Bandura (cited in Bernstein, et al. 1997: 473-474), a state of low self-efficacy can lead to a state of apathy and resignation in relation to ones situation in life, in other words, what Knut Dahl Jacobsen have defined as political poverty (Jacobsen 1970). Moreover, a prolonged state of low self-efficacy can turn in to a state of learned helplessness, which is a common cause for the psychologically defined state of depression (cf. Rizley 1978; Seligman & Schulman 1986: 832).

Figure 12 – Trust conceptualized as a function of self-efficacy and knowledge.

The model of trust shown in Figure 12 takes into account that trust in some degree involves a voluntary transfer of power as far as self-efficacy can be viewed as the individuals believes in its level of power and control. Following this line of argument trust can be defined as a form of “voluntary loyalty”, whilst loyalty as defined in the model can be viewed as loyalty by obedience or conformity.

Based on the model of trust described here, it would have been interesting to conduct a survey study of the level of trust Norwegian citizens have in the health care services. Such a study might provide further enlightenment as regards to the outputs produced by the Norwegian health care reform.
From an instrumental point of view, it seems clear that institutions promoting accessibility, transparency and public choice, are installed within the reformed Norwegian specialized health care sector. Nevertheless, it seems similarly clear that institutional and cultural elements are reducing the optimal outcome that otherwise could have been expected. From a perspective of trust, the current implementations of these institutions do not fully enable patients to make use of their right of choice. This thesis indicates that the way in which these institutions are installed do not promote trust, but rather loyalty in terms of faith and confidence, which in the long run might produce a sentiment of political poverty.

In other words, if the implementation of the patients’ right of choice results in a system that in its character can only be facilitated by individuals with higher education and knowledge of how to obtain relevant information, then the patients’ right of choice can only be described as a symbol, a varnish, usable only for politicians and health care executives promoting their own excellence.

Mondus vult decipi. Sed populus non.
Appendix I - NPR 2003 record v. 41

This appendix gives an overview of variables defined within the patient information record (NPR 2003: 87-94), registered by the Norwegian Patient Register. Although the information is not available in English, the overview will give an idea of the level of detail associated with NPR registered data.


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n | Kortnavn | Klassenavn | O | Datatype | Side | Dokumentasjon |
|---|---|---|---|---|---|---|
|Avdeling
nummer | avdID | Tjeneste | 0.1 | String | 39 | Identifikasjon av den Avdeling som utfører tjenesten. |
|Avdeling
nummer | avdID | Episide | 1 | String | 40 | Den avdeling som har ansvar for pasienten. |
|Avdeling
nummer | avdID | Henvisning | 1 | String | 53 | Identifikasjon av den Avdeling det henvises til. |
|Avviklet
|Avviklingsom
dde | avviklingsom
dde | Henvisning | 0.1 | Kodet | 55 | Kode for avvikling. |
|Barnet | barnet | Henvisnings
grunn | 0.1 | Kodet | 56 | BUP |
|Barnets
miljø | barnetsMiljo | Henvisnings
grunn | 0.1 | Kodet | 57 | BUP |
|Behov for
tolk | tolk | PasientTilsta
tnd | 0.1 | Kodet | 28 | Om pasienten/omsorgspersonen har behov for tolk. |
|Bor
pasilent
alene | pasientBorAl
e | PasientTilsta
tnd | 0.1 | Kodet | 26 | |
|Bydelskode | bydel | Episide | 0.1 | bydelNR | 42 | Den bydel der Pasienten bor, dersom det er i Oslo, Bergen, Trøndelag eller Stavanger. |
|Daglig leder | foretakDagled | Helseforetak | 0.1 | String | 15 | |
|Dato | datoRolle | Barnevernet | 0.1 | Date | 9 | Dato for observasjon av barnevernets rolle. |
|Dato avklart | datoAvklart | Henvisnings
periode | 0.1 | Date | 35 | Henvisningen betraktes som avklart når pasienten/omsorgspersonen har behov for tolk. |
|Dato for bruk av
tvang | datoTvang | Tvang uten vedtak | 1 | Date | 47 | Den dato som er registrert for anvendelse av tvang uten formelt vedtak. |
|Dato for klage | datoKlage | Klage | 1 | Date | 47 | Dato for klage. |
|Dato
specialistved
tak | datoSpecialistved
tak | Specialistved
tak | 1 | Date | 49 | Dato for specialistvedtak. |
|Dato Vedtak | datoVedtak | Vedtak om
tvang | 1 | Date | 46 | Den dato som vedtak om tvang er gjort. |
<table>
<thead>
<tr>
<th>Attributtnavn</th>
<th>Kortnavn</th>
<th>Klassenavn</th>
<th>O</th>
<th>Datatype</th>
<th>Side</th>
<th>Dokumentasjon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deltaker</td>
<td>deltakerType</td>
<td>Deltaker</td>
<td>1</td>
<td>Kodet</td>
<td>30</td>
<td>En klasifisering av type deltakere.</td>
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<tr>
<td>Enhet</td>
<td>enhet</td>
<td>Måleresultat</td>
<td>0.1</td>
<td>String</td>
<td>23</td>
<td>Enhet for måleverdi.</td>
</tr>
<tr>
<td>Episkrisen</td>
<td>episkriseDato</td>
<td>Episode</td>
<td>0.1</td>
<td>Date</td>
<td>43</td>
<td>Den dato episkrisen ble postlagt og sendt fra institusjonen til henvisende instans.</td>
</tr>
<tr>
<td>EpisodetID</td>
<td>episodetID</td>
<td>Episode</td>
<td>1</td>
<td>String</td>
<td>40</td>
<td>Unik identifikator for denne episoden.</td>
</tr>
<tr>
<td>Etisk</td>
<td>etiskTilhørighet</td>
<td>Omsorgsperson</td>
<td>0.1</td>
<td>Kodet</td>
<td>30</td>
<td>Hvilken etisk tilhørighet omsorgspersonen til pasienten har.</td>
</tr>
<tr>
<td>Fagområde</td>
<td>tjenesteTilhørighet</td>
<td>Tjeneste</td>
<td>0.1</td>
<td>Kodet</td>
<td>39</td>
<td>Hvilket fagområde denne Tjenesten i hovedsak tilhører, dersom tjenesten som utføres tilhører et annet fagområde enn Episoden.</td>
</tr>
<tr>
<td>Fagområde</td>
<td>episodeTilhørighet</td>
<td>Episode</td>
<td>0.1</td>
<td>Kodet</td>
<td>41</td>
<td>Hvilket fagområde denne Episode i hovedsak tilhører.</td>
</tr>
<tr>
<td>Fagområde</td>
<td>fagområde</td>
<td>Henvisning</td>
<td>1</td>
<td>Kodet</td>
<td>54</td>
<td>Kategorisering av hvilken type tjenester som etterspøres. Nytt kodeverk for fagområder skal utvikles.</td>
</tr>
<tr>
<td>Fattet av</td>
<td>fattetAv</td>
<td>Spesialistvedtak</td>
<td>1</td>
<td>Kodet</td>
<td>49</td>
<td>Hvilken yrkesgruppe personen tilhører som har fattet spesialistvedtaket.</td>
</tr>
<tr>
<td>Folkeregister</td>
<td>folkeregister</td>
<td>Kommune</td>
<td>1</td>
<td>komnNr</td>
<td>42</td>
<td>Folkeregisterets registrering av patientens hjemestedskommune ved start av Episoden.</td>
</tr>
<tr>
<td>Forholdet</td>
<td>forholdet</td>
<td>Omsorgsperson</td>
<td>1</td>
<td>Kodet</td>
<td>30</td>
<td>Om denne omsorgsperson har forholdet til pasienten/haren.</td>
</tr>
<tr>
<td>FraSted</td>
<td>fraSted</td>
<td>FraSted</td>
<td>0.1</td>
<td>Kodet</td>
<td>14</td>
<td>Beskrivelse av det sted pasienten kommer fra.</td>
</tr>
<tr>
<td>FraDato</td>
<td>fraDato</td>
<td>FraDato</td>
<td>0.1</td>
<td>Date</td>
<td>7</td>
<td>Dato for start av periode denne meldingen gjelder for.</td>
</tr>
<tr>
<td>Frist for start</td>
<td>fristforstart</td>
<td>Henvisning</td>
<td>0.1</td>
<td>Date</td>
<td>54</td>
<td>Seneste dato for forventlig start på nødvendig helsehjelp, i henhold til gjeldende lovverk.</td>
</tr>
<tr>
<td>Fødselsår</td>
<td>fødselsår</td>
<td>Pasient</td>
<td>1</td>
<td>gYear</td>
<td>25</td>
<td>Pasientens fødselsår.</td>
</tr>
<tr>
<td>Fødselsår</td>
<td>fødselsår</td>
<td>Pasient</td>
<td>1</td>
<td>Integer</td>
<td>25</td>
<td>Vært i gram ved fødsel.</td>
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<tr>
<td>Helseforetak</td>
<td>helseforetakNavn</td>
<td>Helseforetak</td>
<td>0.1</td>
<td>String</td>
<td>15</td>
<td>Det offisielle navnet på helseforetaket.</td>
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<tr>
<td>Helseforetak</td>
<td>helseforetakNavn</td>
<td>Helseforetak</td>
<td>0.1</td>
<td>Kodet</td>
<td>10</td>
<td>Identifikasjon av hvilket helseforetak denne institusjonen tilhører.</td>
</tr>
<tr>
<td>Helseforetak</td>
<td>helseforetakNavn</td>
<td>Helseforetak</td>
<td>0.1</td>
<td>FraSted</td>
<td>13</td>
<td>Identifikasjon av Helseforetak. Dersom pasienten kommer fra eller skal til et Helseforetak.</td>
</tr>
<tr>
<td>Attributenavn</td>
<td>Kortnavn</td>
<td>Klassennavn</td>
<td>O</td>
<td>Datatype</td>
<td>Side</td>
<td>Dokumentasjon</td>
</tr>
<tr>
<td>---------------</td>
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<td>----------------</td>
</tr>
<tr>
<td>Helseforetak ID</td>
<td>helseforetakID</td>
<td>Helseforetak</td>
<td>1</td>
<td>Kodet</td>
<td>15</td>
<td>Identifikasjon av helseforetak.</td>
</tr>
<tr>
<td>Helseforetaks sektor</td>
<td>helseforetaks sektor</td>
<td>Annen tjeneste sektor</td>
<td>0.1</td>
<td>Kodet</td>
<td>11</td>
<td>Grov kategorisering av institusjoner innen helsevesenet i hovedområder: somatikk/psykiatri.</td>
</tr>
<tr>
<td>HenvisningID</td>
<td>henvisID</td>
<td>Henvisning</td>
<td>1</td>
<td>String</td>
<td>52</td>
<td>Tilfeldig nummer/tekst generert av institusjonen/sykehuset.</td>
</tr>
<tr>
<td>Henvisnings formalitet</td>
<td>henvisingsformalitet</td>
<td>Henvisning</td>
<td>0.1</td>
<td>Kodet</td>
<td>53</td>
<td>Hvilken formalitet i Psykiatrisk helsevernloven som pasienten er henviset etter. Her skal formaliteten valgt av legen som egenhendig har undersøkt pasienten og som henviser pasienten oppgitt.</td>
</tr>
<tr>
<td>Henvisnings periodeID</td>
<td>henvisningsperiodeID</td>
<td>Henvisnings periode</td>
<td>1</td>
<td>String</td>
<td>34</td>
<td>Tilfeldig nummer/tekst generert av helseforetak. For 2003 aksepteres et tilfeldig nummer generert av institusjon.</td>
</tr>
<tr>
<td>Henvisingst ype</td>
<td>henvisingstype</td>
<td>Henvisning</td>
<td>1</td>
<td>Kodet</td>
<td>52</td>
<td>Viser hva det er henviset til.</td>
</tr>
<tr>
<td>Hjemmespråk</td>
<td>hjemmespråk</td>
<td>PasientTilstanden</td>
<td>0.1</td>
<td>Kodet</td>
<td>27</td>
<td>Hvilket språk som snakkes hjemme hos pasienten.</td>
</tr>
<tr>
<td>Hovedinnromk til skilte</td>
<td>hovedinnromk til skilte</td>
<td>PasientTilstanden</td>
<td>0.1</td>
<td>Kodet</td>
<td>27</td>
<td>Beskrivelse av pasientens viktigste innrømmelser/økonomiske situasjon siste år.</td>
</tr>
<tr>
<td>Indirekte aktiviteter</td>
<td>indirekte aktiviteter</td>
<td>Indirekte pasientarbeid</td>
<td>0.1</td>
<td>Kodet</td>
<td>68</td>
<td>En kategorisering av aktiviteter uten direkte pasientkontakt. Alle slike Kontakter skal rapporteres som indirekte pasientarbeid.</td>
</tr>
<tr>
<td>Initiativtaker</td>
<td>initiativtaker</td>
<td>Kontakt</td>
<td>0.1</td>
<td>Kodet</td>
<td>37</td>
<td>Initiativtaker til ny kontakt med institusjonen. Dette er for tilfeller der nye Kontakter påbegynnes etter at person(or) tar initiativ til ny kontakt med institusjon på grunnlag av en eksisterende Henvisningsperiode.</td>
</tr>
<tr>
<td>InnDatoTid</td>
<td>innDatoTid</td>
<td>Kontakt</td>
<td>1</td>
<td>dateTime</td>
<td>37</td>
<td>Dato og tidspunkt for start av Kontakt.</td>
</tr>
<tr>
<td>InnDatoTid</td>
<td>innDatoTid</td>
<td>Avdelingsopphold</td>
<td>1</td>
<td>dateTime</td>
<td>64</td>
<td>Dato og tidspunkt for start av Avdelingsopphold.</td>
</tr>
<tr>
<td>Innstilstand</td>
<td>innstilstand</td>
<td>Episode</td>
<td>0.1</td>
<td>Kodet</td>
<td>42</td>
<td>Beskrivelse av pasientens tilstand ved ankomst til institusjonen. Personer som er erklært død før ankomst til sykehus rapporteres ikke. Barnet rapporteres ikke ved dødsfødsler.</td>
</tr>
<tr>
<td>Attributtavn</td>
<td>Kortnavn</td>
<td>Klassenavn</td>
<td>O</td>
<td>Datatype</td>
<td>Side</td>
<td>Dokumentasjon</td>
</tr>
<tr>
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<td>------</td>
<td>----------------</td>
</tr>
<tr>
<td>Institution</td>
<td>institID</td>
<td>Tjeneste</td>
<td>0.1</td>
<td>Kodet</td>
<td>39</td>
<td>Identifikasjon av den institusjon som utfører tjenesten, i tilfelle det er en annen institusjon som utfører tjenesten enten den som har ansvar for hensynstig perioden.</td>
</tr>
<tr>
<td>InstitutionID</td>
<td>institSted</td>
<td>Fra/til Sted</td>
<td>0.1</td>
<td>Kodet</td>
<td>13</td>
<td>Identifikasjon av institusjon i henhold til gyldig register.</td>
</tr>
<tr>
<td>Institution</td>
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<td>Institusjon</td>
<td>1</td>
<td>Kodet</td>
<td>6</td>
<td>Identifikasjon av institusjon i henhold til gyldig register.</td>
</tr>
<tr>
<td>Institution</td>
<td>institAndre</td>
<td>Annen tjeneste</td>
<td>0.1</td>
<td>Kodet</td>
<td>11</td>
<td>Identifikasjon av institusjon i henhold til gyldig register.</td>
</tr>
<tr>
<td>Intern overføring fra</td>
<td>internOverføringFra</td>
<td>Avdelingsopphold</td>
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<td>Kodet</td>
<td>64</td>
<td>Angir den type avdeling innen denne institusjon/helseforetak pasienten er overført fra.</td>
</tr>
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<td>internOverføringTil</td>
<td>Avdelingsopphold</td>
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<td>65</td>
<td>Angir den type avdeling innen denne institusjon/helseforetak pasienten er internoverført til.</td>
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<td>ISF refusjon</td>
<td>isRefusjon</td>
<td>Avdeling</td>
<td>1</td>
<td>Kodet</td>
<td>7</td>
<td>Viser om denne avdeling er godkjent for ISF refusjon.</td>
</tr>
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<td>Kjønn</td>
<td>kjønn</td>
<td>Pasient</td>
<td>1</td>
<td>Kodet</td>
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<td>Pasientens kjønn.</td>
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<tr>
<td>Kniv slutt</td>
<td>knivSlutt</td>
<td>Kururgisk ingrep</td>
<td>0.1</td>
<td>dateTime</td>
<td>67</td>
<td>Tidspunkt for avløpeting av kirurgisk aktivitet ved operasjon.</td>
</tr>
<tr>
<td>Kniv start</td>
<td>knivStart</td>
<td>Kirurgisk ingrep</td>
<td>0.1</td>
<td>dateTime</td>
<td>67</td>
<td>Tidspunkt for start av kirurgisk aktivitet ved operasjon.</td>
</tr>
<tr>
<td>Kodeverdi</td>
<td>kodeVerdi</td>
<td>Kode</td>
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<td>String</td>
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<td>Selve kodeverdien.</td>
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<td>kodeverk</td>
<td>Kodeverk</td>
<td>1</td>
<td>Kodet</td>
<td>22</td>
<td>Identifikasjon av hvilket kodeverk denne koden tilhører (ICD-10, NCSP-N, ATC, SNOMED etc.).</td>
</tr>
<tr>
<td>KontaktID</td>
<td>kontaktID</td>
<td>Tilstand</td>
<td>0.1</td>
<td>String</td>
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<td>Referanse til den Kontakt denne Tilstand tilhører.</td>
</tr>
<tr>
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<td>kontaktID</td>
<td>Deltaker</td>
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<td>String</td>
<td>30</td>
<td>Referanse til den Kontakt som deltakerne tilhører.</td>
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<tr>
<td>KontaktID</td>
<td>kontaktID</td>
<td>Kontakt</td>
<td>1</td>
<td>String</td>
<td>37</td>
<td>Tidlig nummer/tekst generert av Institusjonen.</td>
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<tr>
<td>KontaktID</td>
<td>kontaktID</td>
<td>Tjeneste</td>
<td>0.1</td>
<td>String</td>
<td>39</td>
<td>Referanse til den Kontakten denne Tjeneste tilhører, dersom den tilhører en kontakt.</td>
</tr>
<tr>
<td>Kontaktperson</td>
<td>kontPerson</td>
<td>Melding</td>
<td>1</td>
<td>String</td>
<td>8</td>
<td>Den person som NPR kan kontakte angående forhold vedrørende meldingen.</td>
</tr>
<tr>
<td>Kontakctype</td>
<td>kontType</td>
<td>Kontakt</td>
<td>1</td>
<td>Kodet</td>
<td>37</td>
<td>Kategorisering av type kontakter. Gjelder for politikalske konsultasjoner og dagbehandlinger etc.</td>
</tr>
<tr>
<td>Kontaktype</td>
<td>kontTypeSkade</td>
<td>Henvisnings periode</td>
<td>0.1</td>
<td>Kodet</td>
<td>35</td>
<td>Angir tid fra skade inntraff til start av første Episod i denne Henvisningsperioden, det vil si Episodes Start-Dato.</td>
</tr>
<tr>
<td>Attributtnavn</td>
<td>Kortnavn</td>
<td>Klassennavn</td>
<td>O</td>
<td>Datatype</td>
<td>Side</td>
<td>Dokumentasjon</td>
</tr>
<tr>
<td>--------------</td>
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<td>------------</td>
<td>---</td>
<td>----------</td>
<td>------</td>
<td>----------------</td>
</tr>
<tr>
<td>Lokal avdelingskode</td>
<td>avdeling</td>
<td>Avdeling</td>
<td>0.1</td>
<td>String</td>
<td>7</td>
<td>Institusjonens egen lokale kode for avdeling.</td>
</tr>
<tr>
<td>Mottaksdato</td>
<td>mottaksDato</td>
<td>Henvisning</td>
<td>1</td>
<td>Date</td>
<td>52</td>
<td>Dato for mottak av henvisning/seknd av helseforetaket. Mottaksdato benyttes for å beregne institusjonens/sykehusets interne ventetid.</td>
</tr>
<tr>
<td>Ny Tilstand</td>
<td>nyTilstand</td>
<td>Henvisingsperiode</td>
<td>0.1</td>
<td>Kodet</td>
<td>36</td>
<td>Angir om denne tilstanden er diagnostisert tidligere.</td>
</tr>
<tr>
<td>Omsorg for egne barn</td>
<td>egneBarn</td>
<td>PasientTilstand</td>
<td>0.1</td>
<td>Kodet</td>
<td>26</td>
<td>Omsorgsstatus. Har pasienten omsorg for egne barn?</td>
</tr>
<tr>
<td>Omsorgsnivå</td>
<td>omsorgsnivå</td>
<td>Annen tjeneste</td>
<td>0.1</td>
<td>Kodet</td>
<td>12</td>
<td>Grov kategorisering av tjeneste etter hvilken ressursinnsats tjenesten kan tilby.</td>
</tr>
<tr>
<td>Omsorgsnivå</td>
<td>omsorgsnivå</td>
<td>Episode</td>
<td>1</td>
<td>Kodet</td>
<td>43</td>
<td>Grov kategorisering av denne episoden etter ressursinnsats og organisering.</td>
</tr>
<tr>
<td>Omsorgsnivå</td>
<td>omsorgsnivå</td>
<td>Henvisning</td>
<td>0.1</td>
<td>Kodet</td>
<td>53</td>
<td>Grov kategorisering av ressursinnsats som anses som nødvendig på det tidspunkt henvisningen vurderes ved Helseforetak/sykehus.</td>
</tr>
<tr>
<td>Omsorgssituasjon</td>
<td>omsorgssituasjon</td>
<td>PasientTilstand</td>
<td>0.1</td>
<td>Kodet</td>
<td>28</td>
<td>Hvem pasienten/barnet bor sammen mod.</td>
</tr>
<tr>
<td>Oppholdatyp</td>
<td>oppholdatyp</td>
<td>Avdelingsopphold</td>
<td>1</td>
<td>Kodet</td>
<td>64</td>
<td>Kategorisering av type opphold på institusjon. Dette er den tentativt type opphold som er planlagt ved avdelingsoppholdet. Dersom det senere skulle vise seg at et tenkt dagopphold ikkevel ble til et heldagopphold skal denne registrering endres. Motsatt skal et tenkt heldagopphold som viser seg å bli et dagopphold ikke endres.</td>
</tr>
<tr>
<td>Patientnummer</td>
<td>patientnr</td>
<td>Pasient</td>
<td>1</td>
<td>String</td>
<td>25</td>
<td>Tilsledig nummer generert av den enkelte institusjon.</td>
</tr>
<tr>
<td>Permisjonsdøgn</td>
<td>permisjonsdøgn</td>
<td>Avdelingsopphold</td>
<td>0.1</td>
<td>Integer</td>
<td>65</td>
<td>Antall permisjonsdøgn for inneværende år i dette avdelingsoppholdet. Dersom pasienten har permisjon i rapportertidsperioden skal antall døgn i den pågående permisjonsperioden inntil rapporteringstidspunkt regnes med i antall permisjonsdøgn.</td>
</tr>
<tr>
<td>ProsedyreID</td>
<td>prosID</td>
<td>Prosedyre</td>
<td>1</td>
<td>String</td>
<td>22</td>
<td>Unik identifikasjon av en prosedyre innenfor en melding.</td>
</tr>
<tr>
<td>Attributtnavn</td>
<td>Kortnavn</td>
<td>Klassenavn</td>
<td>O</td>
<td>Datatype</td>
<td>Side</td>
<td>Dokumentasjon</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Psykososiale forhold</td>
<td>psykososiale Forhold</td>
<td>PasientTilstand</td>
<td>0.1</td>
<td>Kodet</td>
<td>28</td>
<td>Akse V i Multiaksial klassifikaasjon. Det forutsetter at en bruker WHO's utgave av ICD-10 Classification of Mental and Behavioural Disorders, clinical descriptions and diagnostic guidelines for de kategoriene som ikke er spesifikk for barn og ungdom. Det er mulig å samtidig rapportere ICD-10 kodene som en tilstand.</td>
</tr>
<tr>
<td>Psykososiale funksjonavtalt</td>
<td>psykososiale Funksjonstilstand</td>
<td>PasientTilstand</td>
<td>0.1</td>
<td>Kodet</td>
<td>29</td>
<td>Akse VI i Multiaksial klassifikaasjon. Det forutsetter at en bruker WHO's utgave av ICD-10 Classification of Mental and Behavioural Disorders, clinical descriptions and diagnostic guidelines for de kategoriene som ikke er spesifikk for barn og ungdom. Det er mulig å samtidig rapportere ICD-10 kodene som en tilstand.</td>
</tr>
<tr>
<td>Referansenummer</td>
<td>meldRefNr</td>
<td>Melding</td>
<td>1</td>
<td>String</td>
<td>8</td>
<td>Entydig referansenummer for meldingen. Det skal tas hensyn til at det finnes flere leverandører innen et helseforsøktak, og at den enkelte leverandør også kan operere med flere enn ett system i drift.</td>
</tr>
<tr>
<td>Rekkefølge for kode</td>
<td>kodeNr</td>
<td>Kode</td>
<td>1</td>
<td>Integer</td>
<td>22</td>
<td>Plasmanummer for kode.</td>
</tr>
<tr>
<td>Rekkefølge Prosedyre</td>
<td>prosNr</td>
<td>Prosedyre</td>
<td>1</td>
<td>Integer</td>
<td>22</td>
<td>Rekkefølgen skal eksplisitt uttrykkes i meldingen.</td>
</tr>
<tr>
<td>Rekkefølge Tilstand</td>
<td>tilstNr</td>
<td>Tilstand</td>
<td>1</td>
<td>Integer</td>
<td>21</td>
<td>Rekkefølgen av tilstandene bestemt ut fra medisinske kriterier skal eksplisitt uttrykkes i meldingen.</td>
</tr>
<tr>
<td>Relasjon</td>
<td>relasjon</td>
<td>Omsorgsperson</td>
<td>1</td>
<td>Kodet</td>
<td>29</td>
<td>Hvilken relasjon Omsorgsperson har til pasient. Familierelasjon.</td>
</tr>
<tr>
<td>Retning</td>
<td>retning</td>
<td>Henvist fra/til</td>
<td>1</td>
<td>Kodet</td>
<td>14</td>
<td>Den retning henvisningen går: Fra Annen tjeneste eller til Annen tjeneste.</td>
</tr>
<tr>
<td>Rett til helsehjelp</td>
<td>retTilHelsehjelp</td>
<td>Henvisning</td>
<td>1</td>
<td>Kodet</td>
<td>54</td>
<td>Uførlighet av vurderingen av henvisning/søknad eller vurdering av pasienten ved Ø-hjelp. Vurdering av rett til nødvendig helsehjelp etter pasientrettighetsloven 2-1 art. 6 ved.</td>
</tr>
<tr>
<td>Rolle</td>
<td>rolle</td>
<td>Helseperson</td>
<td>0.1</td>
<td>Kodet</td>
<td>9</td>
<td>Forteller hvilken rolle denne helseperson har i behandlingen av pasienten.</td>
</tr>
<tr>
<td>Rolle</td>
<td>barnevernets Rolle</td>
<td>Barnevernet</td>
<td>0.1</td>
<td>Kodet</td>
<td>9</td>
<td>Dokumenterer om barnevernet er koplet inn i forbindelse med et sykottifelle.</td>
</tr>
<tr>
<td>Samlivesstatus</td>
<td>samlivesstatus</td>
<td>PasientTilstand</td>
<td>0.1</td>
<td>Kodet</td>
<td>27</td>
<td>Pasientens faktiske livssituasjon, dvs. om vedkommende lever, eller ikke lever i parforhold.</td>
</tr>
<tr>
<td>Atributtnavn</td>
<td>Kortnavn</td>
<td>Klassenavn</td>
<td>O</td>
<td>Datatype</td>
<td>Side</td>
<td>Dokumentasjon</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------</td>
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<td>----------</td>
<td>-----</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Samtykkekompetanse</td>
<td>samtykkeko</td>
<td>Pasient</td>
<td>0..1</td>
<td>Kodet</td>
<td>26</td>
<td>Om pasienten har samtykkekompetanse eller ikke.</td>
</tr>
<tr>
<td></td>
<td>kompetanse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>En del pasienter er selv ikke i stand til å vurdere behandlingsperspektivet og/eller avgjøre samtykke. Dette kan gjelde barn, unntykkte, psykisk utviklingsløse, alvorlig sinnstikkende, demente og personer som er sterkt avhengige på grunn av sykdommen. I slike tilfelle må andre foreta valg på vedkommendes vegne. En nøie annekterte situasjon hvor andre må foreta valgen, er når personer som normalt har samtykkekompetanse, er bevisstløse eller ikke selv i stand til å samtykke. For barn vil det være den eller de som har foreldreansvaret, som har kompetanse til å samtykke til behandling.</td>
</tr>
<tr>
<td>Samtykkekompetanse</td>
<td>samtykkekompetanse</td>
<td>Omsorgsperson</td>
<td>1</td>
<td>Kodet</td>
<td>30</td>
<td>Om omsorgspersonen har samtykkekompetanse på vegne av pasienten eller ikke.</td>
</tr>
<tr>
<td>Second opinion</td>
<td>secondOpinion</td>
<td>Henvisning</td>
<td>0..1</td>
<td>Kodet</td>
<td>52</td>
<td>Om denne henvisning gjelder en anmodning om Second opinion</td>
</tr>
<tr>
<td>SerieID</td>
<td>serieID</td>
<td>Dagbehandlingserie</td>
<td>1</td>
<td>String</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>SerieID</td>
<td>serieID</td>
<td>Poliklinisk konsultasjons serie</td>
<td>1</td>
<td>String</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>Sivilstatus</td>
<td>sivilstatus</td>
<td>PasientTilstanden</td>
<td>0..1</td>
<td>Kodet</td>
<td>27</td>
<td>Beskrivelse av pasientens formelle (juridiske) sivilstatus ved innløn.</td>
</tr>
<tr>
<td>Skadestedskommune</td>
<td>komnrSkade</td>
<td>Henvisningsperiode</td>
<td>0..1</td>
<td>komnr</td>
<td>36</td>
<td>Skod (kommune) der skaden oppstod. Datafelt for ulykkesregistrering.</td>
</tr>
<tr>
<td>Slutt-dato</td>
<td>sluttDato</td>
<td>Henvisningsperiode</td>
<td>0..1</td>
<td>Date</td>
<td>36</td>
<td>Slutt-dato for Henvisningsperioden. På det tidspunkt er behandling avsluttet og det er ikke planlagt flere Episoder eller Kontakter, som for eksempel kontroller.</td>
</tr>
<tr>
<td>SluttDatoTid</td>
<td>sluttDatoTid</td>
<td>Tjeneste</td>
<td>0..1</td>
<td>dateTime</td>
<td>40</td>
<td>Dato og klokkeslett for slutt av tjenesten.</td>
</tr>
<tr>
<td>Specialist</td>
<td>specialist</td>
<td>Helseperson</td>
<td>0..1</td>
<td>Kodet</td>
<td>9</td>
<td>Om vedkommende har &quot;relevant specialitet&quot; eller ikke.</td>
</tr>
<tr>
<td>Start-dato</td>
<td>startDato</td>
<td>Episode</td>
<td>1</td>
<td>Date</td>
<td>41</td>
<td>Start-dato for Episoden.</td>
</tr>
<tr>
<td>StartDatoTid</td>
<td>startDatoTid</td>
<td>Tjeneste</td>
<td>1</td>
<td>dateTime</td>
<td>40</td>
<td>Dato og klokkeslett for start av tjenesten.</td>
</tr>
<tr>
<td>Sted for aktivitet</td>
<td>stedAktivitet</td>
<td>Kontakt</td>
<td>1</td>
<td>Kodet</td>
<td>38</td>
<td>Det fysiske sted den polikliniske konsultasjons gjennomføres.</td>
</tr>
<tr>
<td>Atributt navn</td>
<td>Kortnavn</td>
<td>Klassenavn</td>
<td>O</td>
<td>Datatype</td>
<td>Side</td>
<td>Dokumentasjon</td>
</tr>
<tr>
<td>--------------</td>
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<td>------</td>
<td>----------------</td>
</tr>
<tr>
<td>Takstnummere</td>
<td>takstnummer</td>
<td>Takst</td>
<td>0.1</td>
<td>takstNr</td>
<td>66</td>
<td>Takster i henhold til gjeldende takstAdresse for &quot;Takster for offentlige politiklinikker&quot;.</td>
</tr>
<tr>
<td>Telefon</td>
<td>meldTelefon</td>
<td>Melding</td>
<td>0.1</td>
<td>String</td>
<td>8</td>
<td>Kontaktpersonens telefonnummer,</td>
</tr>
<tr>
<td></td>
<td>foretakTelefon</td>
<td>Helseforetak</td>
<td>0.1</td>
<td>String</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>TiilSted</td>
<td>tiilSted</td>
<td>Fra/til Sted</td>
<td>0.1</td>
<td>Kodet</td>
<td>14</td>
<td>Beskrivelse av det sted pasienten sendes til.</td>
</tr>
<tr>
<td>TiilDato</td>
<td>tiilDatoPeriode</td>
<td>Melding</td>
<td>1</td>
<td>Date</td>
<td>8</td>
<td>Data for slutt av periode denne meldingen gjelder for.</td>
</tr>
<tr>
<td>Tiilheft behandlingen dato</td>
<td>tiilheftDato</td>
<td>Henvisning</td>
<td>0.1</td>
<td>Date</td>
<td>54</td>
<td>Data for planlagt start av behandling.</td>
</tr>
<tr>
<td>TiilstandID</td>
<td>tiilID</td>
<td>Tiilstand</td>
<td>1</td>
<td>String</td>
<td>21</td>
<td>Unikt identifikasjon av en tilstand innenfor en melding.</td>
</tr>
<tr>
<td>Tjeneste</td>
<td>tjenester</td>
<td>Annen tjeneste</td>
<td>1</td>
<td>Kodet</td>
<td>11</td>
<td>Grov klassifisering av institusjoner innen helsevesenet og andre institusjoner i samfunnet.</td>
</tr>
<tr>
<td>Trygdenasjon</td>
<td>trygdenasjon</td>
<td>Henvisnings periode</td>
<td>0.1</td>
<td>Kodet</td>
<td>35</td>
<td>Opprinnelsesland for pasienter som ikke er norske statsborgere. Landkode for det land pasienten har trygdeaktighet.</td>
</tr>
<tr>
<td>Tutor</td>
<td>tector</td>
<td>Henvisning</td>
<td>0.1</td>
<td>Kodet</td>
<td>53</td>
<td>Klassifisering av den person, i tillegg til fagperson/henvisende innenfor, som har begjært tvangen psykisk helsevern.</td>
</tr>
<tr>
<td>Type dagbehandling</td>
<td>typeDagbehandling</td>
<td>Dagbehandlinger</td>
<td>0.1</td>
<td>Kodet</td>
<td>66</td>
<td>Klassifisering av dagbehandlingen, type behandling eller type terapi, etter hvem som deltar i dagbehandlingen.</td>
</tr>
<tr>
<td>Type dagbehandling</td>
<td>typeDagbehandling</td>
<td>Dagbehandlinger</td>
<td>0.1</td>
<td>Kodet</td>
<td>68</td>
<td>Klassifisering av dagbehandlingen, type behandling eller type terapi, etter hvem som deltar i dagbehandlingen.</td>
</tr>
<tr>
<td>Type formalitet</td>
<td>typeFormalitet</td>
<td>Specialistvedtak</td>
<td>1</td>
<td>Kodet</td>
<td>49</td>
<td>Specifisering av hvilken formalitet etter Psykisk helsevernloven som er ved mottak og ved utskrivning og alle mellomliggende endringer.</td>
</tr>
<tr>
<td>Type Klage</td>
<td>typeKlage</td>
<td>Klage</td>
<td>1</td>
<td>Kodet</td>
<td>47</td>
<td>Klassifisering av typer klager som kan forekomme, etter type vedtak det klages på.</td>
</tr>
<tr>
<td>Type måling</td>
<td>typeMåling</td>
<td>Måling</td>
<td>0.1</td>
<td>String</td>
<td>67</td>
<td>Denne attributt kan kodes på et senere tidspunkt. Foreløpig benyttes fritest. Typiske målger som kan gjennomføres er blant annet: &quot;GAF-S&quot; &quot;GAF-F&quot; &quot;IQ&quot; &quot;euroscore&quot; &quot;nemsscore&quot;</td>
</tr>
<tr>
<td>Atributtavn</td>
<td>Kortnavn</td>
<td>Klassenavn</td>
<td>O</td>
<td>Datatype</td>
<td>Side</td>
<td>Dokumentasjon</td>
</tr>
<tr>
<td>-------------</td>
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<td>----------</td>
<td>------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Type</strong></td>
<td>tiltak/Behan-</td>
<td>tiltak/Behan</td>
<td>1</td>
<td>Kodet</td>
<td>47</td>
<td>Klassifisjon av typer behandling som er utført i kontakt.</td>
</tr>
<tr>
<td><strong>Til</strong></td>
<td>ling</td>
<td>ling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type tvang</strong></td>
<td>typeTvang</td>
<td>Tvang uten</td>
<td>1</td>
<td>Kodet</td>
<td>48</td>
<td>Om pasienten er utsatt for skjerming - uten at det foreligger vedtak. Alle typer tvang fortsatt vedtak om dette, mod unstak av skjerming mod varighet inntil 48 timer. Dersom det er foretatt skjerming uten at det foreligger vedtak, registreres det her.</td>
</tr>
<tr>
<td><strong>Type vilkår</strong></td>
<td>vilkårType</td>
<td>Vilkår</td>
<td>1</td>
<td>Kodet</td>
<td>48</td>
<td>Klassifisjon av de typer vilkår som er grunnlag for spesialistvedtak. Dette gelder som tilleggskriterium for vedtaket.</td>
</tr>
<tr>
<td>UtDatoTid</td>
<td>utDatoTid</td>
<td>Kontakt</td>
<td>0.1</td>
<td>dateTime</td>
<td>38</td>
<td>Dato og tidspunkt for når Kontakt avsluttes.</td>
</tr>
<tr>
<td>UtDatoTid</td>
<td>utDatoTid</td>
<td>Avdelingsop</td>
<td>0.1</td>
<td>dateTime</td>
<td>65</td>
<td>Dato og tidspunkt for når Avdelingsopphold avsluttes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>phold</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utførende</td>
<td>polUtførend</td>
<td>Helseperson</td>
<td>0.1</td>
<td>Kodet</td>
<td>9</td>
<td>Utførende helsepersonell for denne kontakt (konsekvensen o.l.).</td>
</tr>
<tr>
<td>helseperson-</td>
<td>e</td>
<td>l</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utsettelse</td>
<td>utsettTåo</td>
<td>Utsettelse</td>
<td>1</td>
<td>Date</td>
<td>56</td>
<td>Den dato en utsettelse av pasientmotaket er foretatt</td>
</tr>
<tr>
<td>Kode</td>
<td>utsettKode</td>
<td>Utsettelse</td>
<td>1</td>
<td>Kodet</td>
<td>56</td>
<td>Det planlagte pasientmottaket ved omsorgsiødet er utsett. Dersom pasienten ikke møter til en avialt kontakt skal denne rapporteres som en utsettelse.</td>
</tr>
<tr>
<td>Utskrivings-</td>
<td>utskKlarDa</td>
<td>Avdelingsop</td>
<td>0.1</td>
<td>Date</td>
<td>65</td>
<td>Den dato hvor institusjonen/sykehuset har definert tiltakene som avsluttet, det vil si at pasienten er ferdigbehandlet, og hvor sykehuset har sendt melding til kommunehelsestjenesten eller annen helseinstitusjon om dette.</td>
</tr>
<tr>
<td>tår dato</td>
<td>tår o</td>
<td>phold</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uttskodato</td>
<td>utttDato</td>
<td>Melding</td>
<td>1</td>
<td>Date</td>
<td>8</td>
<td>Dato for uttak av data til melding.</td>
</tr>
<tr>
<td>Uttilstand</td>
<td>uttilstand</td>
<td>Episode</td>
<td>0.1</td>
<td>Kodet</td>
<td>43</td>
<td>Beskrivelse av pasientens tilstand ved utskrivning fra institusjonen.</td>
</tr>
<tr>
<td>Vedtak om</td>
<td>vedtakTvang</td>
<td>Vedtak om</td>
<td>1</td>
<td>Kodet</td>
<td>46</td>
<td>Type tvang som er anvendt.</td>
</tr>
<tr>
<td>tvang</td>
<td>tvang</td>
<td>tvang</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verdi</td>
<td>verdi</td>
<td>Målresultat</td>
<td>1</td>
<td>String</td>
<td>23</td>
<td>Den faktiske måleresultat, ikke kodet.</td>
</tr>
<tr>
<td>Versjon</td>
<td>kodeVersjon</td>
<td>Kode</td>
<td>1</td>
<td>String</td>
<td>23</td>
<td>Hvilken versjon av det aktuelle kodeverk som er benyttet.</td>
</tr>
<tr>
<td>Vurderingsd-</td>
<td>vurdDato</td>
<td>Henvisning</td>
<td>0.1</td>
<td>Date</td>
<td>54</td>
<td>Faktisk dato for ferdig vurdert søknad.</td>
</tr>
</tbody>
</table>
Appendix II - Overview: somatic hospitals in Norway

In the first part of the table below, publicly owned hospitals are listed per health region alongside privately owned hospitals of type h2. The second part of the table lists privately owned h3 and h4 hospitals without reference to health region.


<table>
<thead>
<tr>
<th>Region/health enterprise/hospital</th>
<th>Publicly owned h1-a</th>
<th>Publicly owned h1-b</th>
<th>Privately owned h2</th>
<th>Privately owned h3</th>
<th>Privately owned h4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eastern</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Akershus universitetssykehus HF</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stensby sykehus</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aker universitetssykehus HF</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ski sykehus</td>
<td></td>
<td>1</td>
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## Appendix III - Prevalence of hospital infections

### Table 22 – Prevalence of hospital infections within some Norwegian somatic hospitals as regards to 24-hour hospitalization in the period January 1st – April 30th 2004. Source: Norsk pasientregister (NPR 2004b)

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<th>Number of patients treated</th>
<th>Number and percentage of patients infected</th>
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Explanations: * - Not fully comparable with data published by the National Information Service for the Patients' Right of Choice, as the Norwegian Institute for Public Health do not use DRG in their definitions of those data (cf. FHI 2003). DRG 79 - Infections and Inflammations in the Respiratory System. DRG 80 - Infections and Inflammations in the Respiratory System. DRG 81 - Infections and Inflammations in the Respiratory System. DRG 320 - Renal and Urinary Tract Infections > 17 years old patients. DRG 321 - Renal and Urinary Tract Infections > 17 years old patients. DRG 322 - Renal and Urinary Tract Infections < 18 years old patients. DRG 416 - Sepsis > 17 years old patients. DRG 417 - Sepsis < 18 years old patients. DRG 418 - Sepsis < 18 years old patients.

Table 23 – Number of admissions as percentage of row total in relation to normal elective surgery involving 24-hour hospitalizations within Norwegian somatic hospitals. Source: The Norwegian Patient Register (NPR 2004g).

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<th>All Hospitals</th>
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<td>70.37 %</td>
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<td>65.02 %</td>
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<td>2003</td>
<td>62.28 %</td>
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<td>2000</td>
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<td>95.40 %</td>
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<td>2.90 %</td>
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<td></td>
<td>2001</td>
<td>1.36 %</td>
<td>3.75 %</td>
<td>1.30 %</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>1.40 %</td>
<td>4.09 %</td>
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<td></td>
<td>2003</td>
<td>1.75 %</td>
<td>3.59 %</td>
<td>1.60 %</td>
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<tr>
<td>Northern</td>
<td>2000</td>
<td>0.69 %</td>
<td>4.17 %</td>
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</tr>
<tr>
<td></td>
<td>2001</td>
<td>0.81 %</td>
<td>3.97 %</td>
<td>0.46 %</td>
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<tr>
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<td>2002</td>
<td>0.86 %</td>
<td>4.44 %</td>
<td>0.97 %</td>
</tr>
<tr>
<td></td>
<td>2003</td>
<td>1.35 %</td>
<td>4.43 %</td>
<td>1.28 %</td>
</tr>
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<td>All Regions of Residence</td>
<td>2000</td>
<td>24.39 %</td>
<td>32.23 %</td>
<td>16.87 %</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>24.13 %</td>
<td>31.85 %</td>
<td>16.65 %</td>
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<tr>
<td></td>
<td>2002</td>
<td>23.36 %</td>
<td>32.08 %</td>
<td>16.46 %</td>
</tr>
<tr>
<td></td>
<td>2003</td>
<td>23.00 %</td>
<td>29.71 %</td>
<td>16.67 %</td>
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</table>
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<table>
<thead>
<tr>
<th>Patients region of residence</th>
<th>Period</th>
<th>Public hospitals, and private h-2 hospitals per region</th>
<th>Private h-3-h4 Hospitals</th>
<th>All Hospitals</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Eastern</td>
<td>Southern</td>
<td>Western</td>
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<td>Eastern</td>
<td>2000</td>
<td>52742</td>
<td>18311</td>
<td>144</td>
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<td>2001</td>
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<td>335</td>
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<td>2002</td>
<td>56065</td>
<td>20722</td>
<td>419</td>
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<td></td>
<td>2003</td>
<td>61144</td>
<td>20492</td>
<td>423</td>
</tr>
<tr>
<td>Southern</td>
<td>2000</td>
<td>1095</td>
<td>49271</td>
<td>229</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>1452</td>
<td>51785</td>
<td>327</td>
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<td>54496</td>
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<td>2003</td>
<td>1824</td>
<td>56859</td>
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<td>212</td>
<td>2313</td>
<td>36833</td>
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<tr>
<td></td>
<td>2001</td>
<td>307</td>
<td>2440</td>
<td>38824</td>
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<td></td>
<td>2002</td>
<td>390</td>
<td>2821</td>
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<td>2002</td>
<td>455</td>
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<td>2003</td>
<td>650</td>
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<td>Northern</td>
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<td>184</td>
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<td>2001</td>
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<td>1166</td>
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<td>2002</td>
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<td>293</td>
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<td>All Regions of Residence</td>
<td>2000</td>
<td>54527</td>
<td>72042</td>
<td>37716</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>58046</td>
<td>76602</td>
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</tr>
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<td></td>
<td>2002</td>
<td>58761</td>
<td>80716</td>
<td>41419</td>
</tr>
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<td></td>
<td>2003</td>
<td>64584</td>
<td>83410</td>
<td>46794</td>
</tr>
</tbody>
</table>
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End notes

1 (cf. Lov av 2. Juli 1999 nr. 63 § 2-4)

2 "Med et helsepolitisk mål om likeverdig tilgang til viktige helsetjenester vil det fremdeles være et sterkt behov for nasjonal styring av helsetjenesten. Utfordringen ligger i å finne former for slik styring som også tar hensyn til at virksomhetene skal være myndiggjort og at de vil virke i en situasjon med mye sterkere innslag av brukerstyring (jf. fritt sykehusvalg og utvidede pasientrettsrigheter)" (Ot.prp.nr.66 2000-2001 § 2.1.3).

3 Regular General Practitioners.

4 First six months of 2004 compared to the same period in 2003.

5 "Fritt Sykehusvalg Norge".

6 "Når man spør hvor tilfredse pasientene er med sykehusoppholdet svarer de fleste at de er fornøyd. […] En 0-100 score gir derimot et inntrykk av at alle sykehus kommer bedre ut enn de faktisk gjør, […]" (NRK 2004b).

7 (Vrangbæk & Bech 2004)

8 (Carlsen & Norheim 2003a, 2003b; Spångberg 2003)

9 (Kaarbøe & Østergren 2001; NRK 2004b; Vrangbæk & Østergren 2004)

10 The Organisation for Economic Co-operation and Development. See www.oecd.org for more information.

11 Also known as abduction, although the use of the term abduction steams from an misinterpretation of Aristotle’s ἀπαγωγή (Peirce 1931: 28)

12 See page 10.

13 As a young child, admitted at Hospital A due to a cerebrovascular accident causing apoplexy. A few years later, admitted at Hospital C due to a dislocated finger. While writing this thesis, admitted at Hospital A due to pleurisy.

14 "Ved den statlige overtakelsen av det fylkeskommunale ansvaret for spesialisthelsetjenesten er det forutsatt at alle avtaler med og relasjoner til private virksomheter videreføres. Videre er det forutsatt at det etableres avtaler med de virksomheter som over lengre tid har ingått i de fylkeskommunale helseplanene uten at avtaleforholdene nødvendigvis er formalisert" (Ot.prp.nr.66 2000-2001: § 2.10.3).

15 By December 31st 2001 there were 59 413 man-years within somatic hospitals in Norway (SSB 2003).

16 As printed versions of some of the articles no longer are available, these have been collected as online documents from the publisher’s official website. In principle, there are no differences between the printed and the online versions of these documents.
17 From July 22nd 1946 (WHO 1946).
19 TNM Classification.
20 “Of the state of Nature”, from “Two Treatises of Government”, Book II “Of Civil Government”, Chapter II (Locke 1674).

21 Hirschman’s theory is commonly classified as Public Choice Theory. Nevertheless, ”From a sociological point of view, Hirschman really cannot be labelled part of Public Choice, since he has never attended any meetings of the Society, nor does he cite to the Public Choice literature. Yet, in my view, that is less important than the intellectual connections between his work and that of Public Choice scholars” (Grofman 2004: 41)

22 “The beliefs they hold about their capabilities to produce results by their actions are an influential personal resource as they negotiate their lives through the life cycle” (Bandura 1997: 162)

23 Barry refers to the case of peasants in Cossack-dominated areas in the seventeenth and eighteenth century Russia, as well as the situation of dissidents in the “newly established Communist regimes in North Vietnam, East Germany and Cuba to” (Barry 1974: 83)

24 See Figure 4 page 41.

25 Search performed on March 22nd 2004 using “WinSPIRS 5.00”, the “SilverPlatter Medline March Week 2 2004/03_2004/03” database using the search string: “2004 in PY”.

26 “The symptoms of sleep apnoea are the predictable consequences of years of severe sleep fragmentation and deprivation, often with over 400 brief awakenings from sleep every night” (Stradling & Davies 1997: 99).

27 E.g. patients with untreated sleep apnoea have a 7-fold increase in driving accident rate (Findley, et al. 1989 cited in Stradling & Davies 1997).

28 See the “Report of the Committee of Inquiry on the Case Involving Dr. Nancy Olivieri, the Hospital for Sick Children, the University of Toronto, and Apotex Inc” (Thompson, et al. 2001), for more information.

29 “Industry’s share of total investment in biomedical research and development grew from approximately 32% in 1980 to 62% in 2000, while the federal government’s share fell” (Bekelman, et al. 2003: 454).

30 In 1543 Nicolaus Copernicus publishes “De Revolutionibus Orbium Coelestium” “(On the Revolutions of the Celestial Orbs), were he stated that man was not the centre of the universe. To learn more about Copernicus see Albert Van Helden’s “Copernican System” (1995).

31 Although the World Health Organization is the United Nations specialized agency for health (WHO 1946: 2; 1948: 81, 321), these two bodies issues recommendations as regards to health care policies independently. In most cases, recommendations issued by the UN are of a general nature, whereas recommendations issued by the WHO are of a more detailed and prescriptive nature.


33 See page 50f.

34 There is studies that indicates that the cost-efficiency benefits produced by gate keeping functions not are as significant as it is popular to believe (Brekke, et al. 2003d: 25-26).

35 The five different roles of the medical profession: care provider, decision-maker, communicator, community leader, and manager (WHO 1996b: 7-8)

36 Prior to the Amsterdam declaration of Patients’ Rights there were published some academic texts on the subject (Annas 1992; Froestad & Jensen 1985; Leenen, et al. 1993; Westerhäll & Phillips 1994; Ziegenfuss 1983). Most of these were used as background sources in the WHO process towards the declaration and are referred to in the declaration itself (WHO 1994a), in papers presented at the Amsterdam conference, or in the report from the conference (WHO 1994b).

37 Even former presidents of the United States have admitted that they tasted, although not inhaled, weed during their years on campus.

38 Paris21 is an acronym for the “Partnership In Statistics for development in the 21st century”, a consortium established by the International Monetary Fund, the Organisation for Economic Co-operation and Development, the United Nations and the World Bank Group to act as a catalyst for promoting a culture of evidence-based policymaking and monitoring in all countries. See http://www.paris21.org/ for more information.

39 By decree issued by King Oscar of Sweden (NOU 1998:10 § 4.2.1). In the period January 14th 1814 – June 7th 1905, Norway, although self-governed, was part of the union Norway - Sweden (Anderes 1994: 42-59).

40 De regionale helseutvalgene (SHD 1999a).

41 Statsråd.


43 Forum for organisasjonsutvikling i sykehus.

44 “… sikre hele befolkningen, uavhengig av alder, kjønn och bosted, god tilgang på helse- og omsorgstjenester av god kvalitet i en offentlig styrt helse- og omsorgssektor” (Stmeld.nr.50 1993-94)

45 The Norwegian parliament.

46 See page 64.

47 In the Norwegian terminology the correct term is “regionale helsesforetak” (Lov av 15. Juni 2001 nr 93), which reflect the corporate nature of the organizational model. The five regional
health authorities constituted in 2001 must not be confused with “regionale helseutvalg” that were organized as regional health councils. See page 64 for more information.

48 See page 70.

49 The reference refers to an unofficial English translation of the act. See (Lov av 2. Juli 1999 nr. 63) for the original Norwegian version


51 If not otherwise stated, references refers to the unofficial translation of the act published by the Ministry of health (cf. Act of July 2nd 1999 no. 63).

52 ”Pasienten har rett til å velge på hvilket offentlig sykehus eller distriktssykehus senter behandlingen skal foretas” (Lov av 2. Juli 1999 nr. 63 § 2.4).

53 See page 96f.

54 ”Spesialisthelsetjenesten skal fastsette en frist for når medisinsk forsvarlighet krever at en pasient som har en slik rettighet, senest skal få nødvendig helsehjelp” (Besl. O. nr. 23 2003-2004).

55 ”Dersom det regionale helseforetaket ikke har sørget for at en pasient som har en rett til nødvendig helsehjelp fra spesialisthelsetjenesten, får den nødvendige helsehjelpen innen det tidspunktet som er fastsatt i medhold av annet ledd, har pasienten rett til å motta nødvendig helsehjelp uten opphold, om nødvendig fra privat tjenesteyter eller tjenesteyter utenfor riket” (Besl. O. nr. 23 2003-2004).

56 ”Dersom det regionale helseforetaket ikke kan yte helsehjelp til en pasient som har en rett til nødvendig helsehjelp, ford i det ikke finnes en adekvat medisinsk tilbud i riket, har pasienten rett til nødvendig helsehjelp fra tjenesteyter utenfor riket ettersom den frist som er fastsatt etter annet ledd” (Besl. O. nr. 23 2003-2004).

57 ”Pasient som henvises til sykehus eller spesialistpoliklinikk som omfattes av § 2-4, har rett til å få sin helsetilstand vurdert innen 30 virkedager fra henvisningen er mottatt” (Besl. O. nr. 23 2003-2004).

58 “Pasienten har rett til å velge på hvilket sykehus eller distriktssykehus senter, eller behandlingssted i en slik institusjon, behandlingen skal foretas. Det er en forutsetning at sykehuset eller det distriktssykehus senteret eies av et regionalt helseforetak eller har avtale med et regionalt helseforetak som gir pasienten en slik valgrett” (Besl. O. nr. 23 2003-2004).

59 The reference refers to an unofficial English translation of the act. See (Lov av 10. Februar 1967), ”forvaltningsloven”, for the original Norwegian version.

60 "Ny § 2-7 skal lyde:
Forvaltningslovens anvendelse
Forvaltningslovens regler gjelder ikke for vedtak som treffes etter dette kapitlet” (Besl. O. nr. 23 2003-2004).

61 ”Pasient eller representant for pasienten som mener at bestemmelsen i § 2-1 femte ledd ikke er overholdt, kan klage til en klagenemnd som oppnevnes av departementet” (Besl. O. nr. 23 2003-2004).
192 "Retten til fritt sykehusvalg gjelder ved planlagt undersøkelse eller behandling, […]" (Helse Vest 2004).

62 Arthroplasty is a medical term referring to the construction of an artificial joint (OED 2004a), in this case hip replacement.


64 Representatives of the ministry are the only participants with decisional authority. The CEO and the Chair of the Board of each RHA have both a duty and a right to be present at the general assembly, although without any decisional authority. Other members of the RHA's board have, without any obligations or decisional authority, the right to be present (Ot.prp.nr.66 2000-2001 § 4.8.3). The general assembly is usually held at the Ministry of Health in Oslo (c.g Helse Øst 2004), although such meetings also can take place elsewhere (c.g. Helse Sør 2004).

65 Authority delegated by law or other parliamental decisions.

66 "Dette lovforslaget gir grunnlag for en sterkere statlig styring gjennom at både eierskap, myndighetsrolle og finansieringsansvar plasseres på en hånd" (Ot.prp.nr.66 2000-2001 § 2.1.2).

67 The table of content referred in the following paragraphs refers to the 2004 version of the document. Other versions of the letter of command might be based on different structures. Although a letter of command is issued for each regional health authority (cf. HD 2004e, 2004f, 2004g; HD 2004h, 2004i), most parts of the document are identical regardless of version. Paragraph numbers, applicable to any version of the document will be used as references in addition to page number(s) when applicable.

68 "Det vises til omtale av aktivitet i Budsjett-innst. S. nr. 11 (2003-2004), jf. 3.1.1” (HD 2004d: 7).

69 "De siste årene har det vært en betydelig vekst i pasientbehandlingen, noe som har ført til reduserte ventetider. Behovet for sterk stimulans til videre vekst i pasienttilbudet er ikke like stort som tidligere. Det må fortsatt være fokus på å holde ventelistene på et lavt nivå” (HD 2004d § 2.1)

70 "I budsjettet for 2003 er ISF-bevilgningen fastsatt med utgangspunkt i at aktiviteten skal kunne være på samme reelle nivå som i 2002. Stortingets tilslutning til regjeringens forslag, jf. Innst.S.nr.260, innebærer at forutsetningen opprettholdes. De regionale helseforetakene skal styre sitt aktivitetsnivå inn mot denne forutsetningen” (HD 2003f). Line-break and underlined text are used in accordance with the original text.

71 “Aktiviteten i sykehusene anslås å ha økt med om lag 6 pst. fra 2000 til 2002 (målt som vekst gjennomsnitt av heldøgnsopphold og dagopphold). Den ressursrammen som samlet blir stilt til rådighet for de regionale helseforetakene legger til rette for at aktiviteten skal kunne videreføres i 2003 på om lag samme høy nivå som i 2002” (HD 2003g § 3.1)

72 First six months of 2004 compared to the same period in 2003.

73 “Det er viktig at det enkelte foretak og de ulike faglige enhetene innen foretaket vinner og opprettholder tillit og legitimitet i befolkningen” (HD 2003g: 11).
Effektiv bruk av ressurser gir flere tilgang til helsetjenester, men også større tillit til helseforetaket og tjenestene. [...] Tillit til helsetjenestene krever et skjerpet fokus på tjenestenes kvalitet. Ikke minst tilsier hensynet til og respekten for pasientene dette” (HD 2003g: 11).

Although some might argue that the fiscal framework was increased by one percentage point in the national budget for 2004, the increase is related to activities within psychiatric institutions only (cf. HD 2004e: 7-8; HD 2004f: 7; 2004g: 8; 2004h: 7; 2004i: 8).

Outside the scope of this thesis, there are also other governmental agencies concerned with the control of the specialized health care sector, such as the National Revision Office (Riksrevisjonen).

In Norwegian "Folkehelseinstituttet".

See Appendix I for a full list of variables.

In Norwegian “Helset Stiftelse for helsetjenesteforskning”.

In Norwegian: Statens helsestilsyn (Helsetilsynet).

(cf. Act of July 2nd 1999 no. 63 § 2.1).

(cf. Act of July 2nd 1999 no. 63 § 2.4).

"Mange av våre fagmiljøer har allerede slike kvalitetsregistre. De er bygd opp og drives av entusiaster innen fagmiljøet. Et kjennebegravd disse er at fagmiljøene har et eierforholds til registeret og derved bidrar til å sikre datakvaliteten i registrene” (Aarseth 2001).


"The promoter has been loosely defined as the site on the DNA where the RNA polymerase recognises some signal which allows it to bind tightly and initiate transcription” (OED 2004b).

In Norwegian “Fritt Sykehusvalg Norg”.

Established January 1st 2002 (Shdir 2004b).

In Norwegian “Opplysningskontoret for frukt og grønnsaker”.

The exacte figure was Nkr 28 437 862.

In Norwegian “Opplysningskontoret for melk”

In Norwegian “Opplysningskontoret for kjøtt”

In 2003 a total of 677 133 patients eligible for choice were treated at somatic hospitals in Norway (NPR 2004e)

By June 30th 2002 (HD 2002c).
"Fritt sykehusvalg Norge skal gjøre det mulig å velge på et informert grunnlag. Gjennom dette nettstedet og et gratis telefonnummer, 800 41 004, får du relevant informasjon om behandlingsstedene" (FSN 2004c).

"Disse indikatorene sier ikke nødvendigvis noe om resultater av medisinsk behandling og tiltak" (FSN 2004c).

Some indicators registered by the Norwegian Patient Register are in fact recorded at the department level, as part of the NPR patient data record (NPR 2003). Nevertheless, data on these indicators are only published as aggregated values.

Helse Finnmark HF Hammerfest sykehus

"Arnt Johannessen har fått mange positive tilbakemeldinger fra fornøyde pasienter, men samtliga pasienter som var etterundersøkt i journalverifikasjonen, hadde fått recidiv på annen lokalisation" (NBH 2003: 8).

Alive one year after treatment.

See Appendix I.

Although not specified by ICD-10 anymore. ICD-10 is the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (Bowker & Star 1999).

http://www.npr.no/cognos/cgi-bin/ppdscgi.exe.

See Appendix I.

The National Information Service for the Patients' Right of Choice.

The pseudonym the regional health authority (RHA) refers in the remaining parts of this chapter to this particular RHA.

"Helseforetakene har full anledning til å inngå samarbeid med private leverandører såfremt dette støtter opp om mulighetene til å gi et best mulig helsetilbud. Det er imidlertid lagt inn lovmessige begrensninger på helseforetakenes anledning til å inngå eierdeltakelse med private tjenesteytere. Dette innebærer at foretakene ikke kan selge ut deler av sykehusvirksomheten uten at dette blir forelagt Stortinget" (Ot.prp.nr.66 2000-2001 § 2.10.3)

See page 72.

E.g. plastic surgery (Omnia & Helse Øst RHF 2003 § 5.2).

Lov om Offentlige anskaffelser (Lov av 16. Juni 1999 nr. 69).

The European Union and the European Economic Area (EOS).

community, central, and regional hospitals (NOU 1998:9 § 7.1.1).


The identities of the hospitals are anonymized.
“Koer, de har ikke forsvunnet. […] Det er en gammel historie, stå i kø på [Hospital A]” (Informant A1).

“Den største trusselen sånn som jeg ser det for vårt, fra mitt ståsted, er å miste kompetanse. Altså å miste fagpersonale, for eksempel hvis vi mister et par spesialister vi, kanskje bare en som slutter, så må vi legge ned en hel virksomhet. Vi er veldig såbare, så det å miste spisskompetanse det tror jeg vil være kritisk for oss” (Informant A3).

“Vi vil omorganisere [Hospital B]” (Informant A1).

Trondhjems hospital (NOU 1997:2 § 4.1.1)

Coincidently at the exact same time as German occupational forces entered Norwegian soil. Tidligere i […], så satt jeg rundt fylkeskommunens bord, sammen med alle andre sykehudsdirektører. Og fylkeskommunen oppfattet oss som svært nært koblet, og selvforståelsen her var veldig – vi er nesten fylkeskommunen, […]”(Informant B1).

“Det erfarer vi med at vi ikke er inkludert i en del strategiske samtaler, drøftinger og prosesser, og beslutningssystem. Vi i mindre grad, og liten grad, møter det nettverket av andre sykehusakterører i vest, av samme grunn. Vi er ikke inviter” (Informant B1).

“Og så kommer på en måte spørsmålet, vi er privat ideell virksomhet, selvstendig, vi styrer oss selv. Men i realiteten er man avhengig av oppdragsgiver. Så er det jo sann at vi er nødt til å posisjonere oss i forhold til hva [the RHA] tenker at vi kan brukes til. Og sånn i bunn og grunn tipper jeg at [the RHA] ser oss ideelt sett som mer et spesialisert sykehus, som tar ut en type oppgaver, som det er tjenlig å legge til en virksomhet som ligger litt uavhengig. Men hvordan får det til. For hvis vi spesialiserer oss, så må jo de ta det store volumet akutt. Og ved å spesialisere oss utfordrer vi regionssykehuset. Men det er det ikke sikkert at [Hospital A] ønsker” (Informant B1).

“Men det som er krevende med å følge opp en sånn undersøkelse, det er klart at vi har den på institusjonen, så det kan jo være et råttent egg, også er resten veldig bra, for eksempel på den med omsorg i sykepleietjenesten. Det kan jo være en avdeling her ute som fungerer dårlig. Og ellers hadde vi vært best” (Informant B1).

I tillegg så ligger det jo markedsføring i form av god samhandling med primærhelsetjenesten. Dersom primærlegen, som innsøkende instans og rådgivende instans for pasientene, erfarer god samhandling med oss, være seg epikrisetid, være seg responsen når primærlegen trenger råd og veiledning, være seg våre internett sider som er lette å finne frem på, er det lett å sørge inn pasienten, det tror jeg er viktig” (Informant B1).

The former Bure Helse, now Capio AB. The company offered to invest, and market the hospital commercially.

“Fra fødselsklinikk til forsterket fødestue” (HD 2004a).


“Når det gjelder dette fødestueprosjektet, så hadde jo […] og hans stab skrevet en flott prosjektutgreiing for hvordan en kunne beholde fødeavdelingen, og like vel har det faglig
forsvarlig. Det var en utgreiing som alle fagfolk gikk god for. Men når styrevedtaket skulle fattes så var det 5 personer som gikk mot det vedtaket. Og det var ikke personale, og det var ikke fagfolk, og det var ikke [...], men det [...] som gjennomgående representant for [the RHA]. Det var de 5 som gikk mot det flotte forslaget som [...] hadde utarbeidet for å bevare fødeavdelingen her” (Informant C2).

130 See page 79.

131 All chirurgical services except urology (LHE-Y 2004d).

132 “Vi hadde rett og slett for lite pasienter. Og operasjonsprogrammene var små. Vi måtte rett og slett ha flere pasienter, og det vet en jo at det er lite folk i [...] og mindre vil det bli. Slik at da måtte vi gå ut å gjøre noe aktivt” (Informant C3).

133 Main diagnostic group No. 13 within the Norwegian DRG-system (HD 2004b: 52).

134 Surgical removal of the complete uterus (total hysterectomy) or of the complete uterus except for the cervix (subtotal hysterectomy) (EB 2004).

135 The 2004 standards refers to an reimbursement of NOK 44 652 per patient treated in relation to hysterectomy. In 2002, the activity-based percentage of the total funding was 50 (see page 75ff in this thesis), while the 2004 standards are calculated according to an activity-based percentage of 40 (HD 2004b: 52).

136 See page 108.

137 See page 43 to 45.

138 See page 67 to 69.

139 See page 56.

140 See page 73f.

141 With the exception of private h2 and h3 hospitals, e.g. Hospital B.

142 See Appendix II.

143 See page 97f.

144 See page 110.

145 See page 74ff.

146 See page 79f.

147 See page 76, 99, and 103.

148 See page 75f.

149 See page 79.

150 First six months of 2004 compared to the same period in 2003.

151 See page 87.

152 See page 32 to 34.

153 See page 107f.
"Den store revolusjonen med fritt sykehusvalg, og som dette bygger opp under, det er at sykehusene eier ikke lenger sine pasienter. Det er den store revolusjonen" (HD 2003c).

"Helsevesenet er avhengig av et grunnleggende tillitsforhold mellom tjenesteyterne på den ene siden og pasientene på den andre siden for å fungere tilfredsstillende. Dette tillitsforholdet skal ivaretas både gjennom tildelingsbestemmelser og gjennom bestemmelser som gjelder formelle forhold, f eks journalinnsynsreglene. Muligheten for klage og overprøving bidrar også til å utvikle dypere tillit mellom pasientene og helsetjenesten. Det grunnleggende tillitsforholdet
basert på likevekt og respekt bør gjennomsyre forståelsen av lovens rettighetsbestemmelser” (Ot.prp.nr.12 1998-1999 § 3.1).

181) See page 31.

182) See page 45.

183) Surgical removal of the complete uterus (total hysterectomy) or of the complete uterus except for the cervix (subtotal hysterectomy) (EB 2004).

184) See Figure 2 page 38.


186) See Figure 4 page 41.

187) ”Ønsker en pasient å reise til Arendal for å besøke et barnebarn, og samtidig få en billig tur og behandling på sykehus i Arendal, kan ikke vi nekte, […]” (Salvesen & Solum 2004)

188) See page 42.

189) "M. E. Seligman’s (1975) learned helplessness model postulates that the depressed individual views actions and consequent events to be causally unrelated, […]” (Rizley 1978).
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POLIS
Politikk, Organisasjon og Ledelse i Spesialiserte kunnskapsorganisasjoner

Røkkansenteret
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