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No longer quite as private?

EDITORIAL

TONE ENDEN

tone.enden@tidsskriftet.no
Tone Enden PhD, specialist in radiology and publications editor of the Journal of the Norwegian Medical Association

As public authorities facilitate more agreements between the specialist health service and private healthcare providers, it can be difficult to tell whether health care is public or private. But does it matter?

Photo: Sturlason

In his 2026 health policy speech, the Norwegian Minister of Health and Care Services, Jan Christian Vestre, was as clear as ever about the Waiting Time Pledge: the public healthcare provision is insufficient and is therefore to be 'strengthened through more long-term agreements with non-profit and private institutions, and greater use of contracted private specialists' (1). In other words, even more public funds are set to be diverted to the private sector – raising questions not only of why (which I will leave aside here), but also *how* and by *whom*.

In Norway, specialist healthcare services are delivered by public hospitals, private non-profit hospitals, contracted private specialists and fully private commercial providers. Growth has been observed in all of these categories over the decades. However, when private providers (non-profit and commercial) receive public funding, does the healthcare provision thereby become more public than private? Are commercial providers to be regarded as equivalent alternatives to non-profit organisations, or will some in the private sector be 'more appropriate' than others? Should private providers also have responsibility for determining which patients receive what treatment and when? And how does the Minister envision private providers becoming 'an integral part of our shared healthcare system' (1)?

The National Association of Practising Specialists in Norway has around 1700 members; twice as many as 30 years ago (2). Of these, 80 % are self-employed in the private sector, though still an integral part of the public system as their services are publicly funded and their patients pay out-of-pocket expenses (3). The legal and financial framework is secured through statutory authorisation and individual agreements with the relevant hospitals, and funding is provided via Helfo (Norwegian Health Economics Administration) reimbursements and operating grants from the regional health authorities. Contracted private specialists provide a quarter of publicly funded specialist healthcare services, but there is considerable regional variation: South-Eastern Norway Regional Health Authority has twice as many consultations per capita in these practices as Northern Norway Regional Health Authority (4).

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Whether contracted private specialists should be more evenly distributed, and if so how, remains unclear. It is also uncertain how the increased capacity can best be utilised by patients that public hospitals are unable to accommodate. Experience from the additional funding and resource use to date under the Waiting Time Pledge may prove valuable here.

At the intersection between the public health service and fully private commercial providers, there are also large institutions such as Diakonhjemmet Hospital, Lovisenberg Diaconal Hospital and Haraldsplass Diaconal Hospital, which are well-integrated local hospitals that are predominantly publicly funded. These institutions are owned by non-profit foundations and, following the hospital trust reform and the transfer of responsibilities from county authorities, operate as non-commercial limited companies under operational agreements with the regional health authority.

Commercial providers such as Unilabs and Evidia offer specialist healthcare services (in radiology) through agreements with the public health service for reimbursements and for cases where waiting time guarantees are not met. Meanwhile, the same services are also offered to self-funded patients. It is conceivable that this dual approach could potentially help ensure high standards and build a good reputation. However, the notion that privatisation improves either health or financial outcomes is not well supported by research (5).

While paving the way for increased public funding of private providers, the Minister of Health and Care Services has also expressed concern about whether '...patients and their families can distinguish... what actually constitutes a hospital (or A&E clinic) and what does not' (1, 6). The terms that providers are allowed to use are now regulated by statute, and a fee may be imposed on 'anyone who intentionally or negligently uses the designation "hospital" (or "A&E clinic") in violation of these rules' (7). In other words, certain limits apply.

Two other measures that suggest the Minister is preparing to broaden the private provision are mandatory registration and an expanded approval scheme. To map the use of private services, privately funded specialist healthcare providers are now required to report their activity in the Norwegian Patient Registry, just as public providers are required to do (8). This requirement is being introduced gradually (9).

In addition, a legislative change regarding the approval of healthcare providers has recently been passed (7). This is intended to ensure that there are sufficient healthcare personnel to maintain the standard of the public health service. The Minister also recognises that 'growth in fully private services could lead to even stronger competition for skilled professionals' (6). The legislative change therefore provides a safeguard should the access to qualified personnel in the public health service become critical.

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The Conservative Party and the Progress Party voted against the legislative change (7). This reflects the historical political disagreement over healthcare financing, and both the opposition and the Labour Party's own partners were critical of the health policy speech. The Red Party and the Socialist Left Party noted that 'commercialisation is the wrong medicine, with serious side effects', describing it as an emergency measure when, 'what is needed is to strengthen our shared, public health service' (10).

Whether this policy is good or bad, increasing the use of private services will inevitably enable private institutions to continue expanding. Which healthcare personnel will opt to move to private providers is less predictable, but with rising levels of public funding for private services, healthcare personnel are no longer facing a simple either/or choice.

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