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# The Users' Role in Primary and Secondary Healthcare in Finland and Norway

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## Abstract

Healthcare has traditionally been heavily influenced by health professionals and managers, but it is increasingly recognised that patients' experiences and voices can play key roles in the development and design of sustainable healthcare services. In this article, we take an exploratory approach to user involvement (UI) in healthcare in two Nordic countries – Finland and Norway. Our theoretical and analytical approach draws on recent works by Dent and Pahor (2015) and Vrangbæk (2015), focusing on three types of participation – choice, voice and co-production. According to our results, these three types of UI have become more visible and acknowledged at the level of national policies in both countries. However, it seems that UI is more entrenched in the governance structures of Norwegian healthcare. The types of involvement are also different. In Finland, the emphasis seems to be on the consumerist ways of involvement, while in Norway, the focus has been more on co-production and voice.

## Introduction

Many organisations in sectors such as healthcare or higher education have been characterised as expert organisations or professional bureaucracies or demonstrating organisational professionalism as distinct from occupational professionalism (Mintzberg, 1979; Saks, 2012). Experts, such as doctors or professors, have traditionally occupied leadership positions with social prestige. The expert–user relationship (e.g., doctor–patient relationship) has been characterised as a relationship between "the one who knows" and "the one who does not know" (Berg, 1996). In other words, the medical profession has held a prominent position

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with a relatively high autonomy in healthcare organisations (Abbott, 1988; Berg, 1996), while patients have traditionally been perceived as supplicants (Dent & Pahor, 2015). In the Nordic countries, citizens have traditionally had the possibility to influence decision making through local and regional democracy (Vrangbæk, 2015), and patients' ability to participate has historically been limited to the role of citizens and to indirectly influencing decision making via their patient organisations (POs) or political bodies (Hirschman, 1970). In this paper, we study the healthcare sector and focus on increased user involvement (UI) in two Nordic countries – Finland and Norway.

The users' role in healthcare organisations has gained more influence over the past two decades. Healthcare systems in the Nordic region and elsewhere are at a redesign phase. If we examine the reform of healthcare systems in the broader European context, we can observe that since the 1980s, the chain of healthcare reforms has many times been linked to the neoliberal policy agendas inspired by the new public management (NPM), combining traditional public administration with results and performance management (Aarrevaara, 2015; Hughes, 2012). One essential element of these reforms is the assumption that "*governments should steer but not row*" (Tritter et al., 2010: 32). This has encouraged many reform initiatives to engage in different applications of market governance and to introduce practices such as purchaser–provider splits, contracting out, competition and choice in public service delivery (Pollitt & Bouckaert, 2011; Tritter et al., 2010; Tynkkynen et al., 2016). Along this development, the users' role has started to be viewed in a new light.

Along with the growth of alternative and complementary medicine, the call for new accountability mechanisms and the people's increasing demands for healthcare services, the traditional medical hierarchy and the users' role as supplicants have been challenged (Tritter et al., 2010). It has increasingly been recognised that in a world of increasing ambiguity, knowledge production takes place both inside and outside expert organisations (Beck, 1994; Gibbons et al., 1994) and that patients possess special expertise, especially in terms of their chronic conditions (Coulter, 2011). Moreover, expert knowledge has become increasingly contested, interpreted and acted on by service users and the general public (Giddens, 1991; Williams & Calnan, 1996). It has also been argued that if patients had more autonomy, it would stimulate competition and encourage citizens to adopt healthier lifestyles. Dent and Pahor (2015: 549) discuss "responsibilisation", which they claim to be the "hidden component of patient involvement". They also point out that while patient choice in the general discourse is about empowering the citizens, the key concern behind many policy proposals is cost containment (ibid.: 549).

Therefore, we can observe the growing interest in patient participation both in the health policy agendas of several European countries and among scholars contributing to theoretical and empirical research on the subject. In this paper, we focus on patient participation in two Nordic countries – Finland and Norway. We approach the subject with the theoretical framework presented by Dent and Pahor (2015) and Vrangbæk (2015), in which they distinguish among three types

of participation – *choice, voice and co-production*. Drawing on their works, we ask two research questions: 1) *Which types of UI can be found in the healthcare systems of Finland and Norway?* 2) *In terms of choice, voice and co-production, how has UI been developed in these two countries over the past two decades?* Our focus is on how UI has appeared in legislative reforms and healthcare policies at the national level during the 2000s.

### Theoretical framework of the study

One of the pioneers in UI research is Sherry R. Arnstein (1969), an urban development specialist. She builds on the premise that participation equals citizen power and constructs a ladder typology of user–professional relationships. Arnstein's work on public participation is arguably a product of research in the 1970s on the US government's effort to democratise its social programmes (Contandriopoulos, 2004: 321). Arnstein's model has been refined and adjusted to diverse contexts. For instance, Charles and DeMaio's (1993) framework of patient involvement in healthcare decision making utilises the ladder model when they distinguish among consultation, partnership and lay control. However, this strand of research has more recently been criticised for being too normative and idealistic in its approach to UI (Contandriopoulos, 2004). Arnstein's typology has also been criticised for being too narrowly focused on citizen power (to make decisions) and for emphasising outcomes rather than processes (Tritter & McCallum, 2006: 161). Some scholars have paid attention to the frameworks' tendency to reflect the perspectives and concerns of professionals rather than patients themselves (Thompson, 2007). Tritter and McCallum (2006: 157) point out the necessity of designing more nuanced models to capture the complexity of UI. Contrary to Arnstein's typology, UI can have *multiple* ladders (ibid.: 163) in the sense that participation comes in many shapes. Indeed, it is important to understand that greater levels of UI are not ultimately good or bad (Contandriopoulos, 2004); it is a matter of what kinds of roles and tools of influence are provided to the people and how the process empowers or disempowers the users (Dent & Pahor, 2015).

In the literature on UI in healthcare, many scholars have employed Albert Hirschman's (1970) seminal typology on 'exit', 'voice' and 'loyalty', which aptly describes the different means to influence and participate in the development of healthcare practices. The term 'exit' (or 'choice', which is often used as a synonym in the healthcare context) implies the possibility of withdrawing from a relationship (vote with their feet), while 'voice' entails the possibility to influence decisions (Fredriksson, 2013; Le Grand, 2009). This terminology is especially useful in illustrating that we should not treat UI only as a homogeneous set of activities through which people try to influence the operation of the healthcare system. Rather, it is important to distinguish among the different means of influence and among various roles that people perform when using a particular mechanism of influence.

It has been claimed that over the past decades, many healthcare reforms in some countries that are members of the Organisation for Economic Co-operation and Development have taken markets and competition as the means to reform healthcare systems. Consequently, 'choice' and service users' roles as consumers have gained increasingly dominant functions as ways to influence health policies and their implementation in many healthcare systems (Tritter et al., 2010).

Nonetheless, how can UI be compared in different settings and in healthcare *per se*? The recent contributions of Dent and Pahor (2015) and Vrangbæk (2015) together provide a useful framework for comparing UI in different contexts. They both draw on the idea that UI takes various forms that may be '*consumerist*', '*deliberative*' and '*participative*' and can be exercised either at the individual or the collective level of a system. They distinguish among '*choice*' (referring to individual-level exit mechanisms and the patient as a consumer), '*voice*' (relating to citizens' active involvement in decision-making bodies related to health) and '*co-production*' (describing how patients may individually or collectively engage in the delivery of their own treatment and services in partnership with healthcare professionals). The typology comes close to Hirschman's framework (see also Winblad & Ringard, 2009), but adding co-production in the framework takes the typology beyond that. The distinction between 'choice' and 'voice' builds on the idea that service users and providers are independent actors in the system. 'Co-production' invites participants in management and decision making, even in provision of services (Vrangbæk, 2015). Table 1 provides the framework for our analysis that draws on the works of Dent and Pahor (2015) and Vrangbæk (2015).

Table 1. Types of user involvement in healthcare and examples of their implementation (adapted from Dent & Pahor, 2015; Vrangbæk, 2015).

Level	Choice	Voice	Co-production
<b>Individual</b>	<ul style="list-style-type: none"> <li>· <i>Choice of providers</i></li> <li>· <i>insurers</i></li> <li>· <i>professionals</i></li> </ul>	<ul style="list-style-type: none"> <li>· <i>Patient legislation</i></li> <li>· <i>Feedback and surveys</i></li> <li>· <i>Complaint procedures</i></li> </ul>	<ul style="list-style-type: none"> <li>· <i>Telehealth, e-health, m-health solutions</i></li> <li>· <i>Home-based care (e.g., diagnostics)</i></li> </ul>
<b>Collective</b>	<i>n.a.</i>	<ul style="list-style-type: none"> <li>· <i>Local and regional democracy</i></li> <li>· <i>User democracy (e.g., patient organisations [POs])</i></li> </ul>	<ul style="list-style-type: none"> <li>· <i>POs co-producing care</i></li> <li>· <i>POs providing information and counselling</i></li> </ul>

## Data and methods

In this paper, our empirical analysis draws on secondary data in the form of national policy documents, published research literature and grey literature. It is also based on the authors' intrinsic knowledge of the dynamics within the Finnish and Norwegian health care sectors as a result of various research projects and ongoing studies.<sup>1</sup> We focus on describing the general developments and the most important reforms that have changed the users' position in the service system in Finnish and Norwegian healthcare. Our analysis is not all-encompassing but emphasises how UI appeared in legislative reforms and in national-level healthcare policies during the 2000s.

The Nordic welfare states have been founded on the principles of solidarity, equity and public participation (Magnussen et al., 2009: 11; Vrangbæk, 2015: 612). This is reflected in the Nordic model of healthcare with tax-based financing and universal access to comprehensive and high-quality care, where the distribution of healthcare resources is based on individual needs, not on the ability to pay (Christiansen et al., 2006). Furthermore, the emphasis on welfare system governance with locally and regionally elected bodies among the mix of actors has provided collective voice channels for the citizens (Vrangbæk, 2015).

Nonetheless, we can still observe differences in the actual organisation of healthcare and thus in terms of the users' ability to influence the system. The Finnish healthcare system is built on three parts: 1) a highly decentralised tax-funded system managed by the municipalities, with public and some outsourced private providers and the responsibility for financing both primary and secondary care; 2) an obligatory social insurance (SI) system reimbursing patients for the use of private healthcare and prescription medicine, among other things; and 3) an occupational healthcare system funded by employers and employees. While the problems of the three-tiered healthcare systems are well known, there have been no comprehensive structural reforms in the Finnish healthcare system after the early 1990s. However, there have been several gradual adjustments, which altogether have not changed the healthcare system in any fundamental way but have introduced smaller-scale reforms (Tynkkynen et al., 2016).

Norway's healthcare system is characterised as a semi-decentralised type, in which the municipalities hold responsibility for primary care, while the state health enterprises are in charge of specialist healthcare (Ringard et al., 2013). In the Norwegian context, most of the UI initiatives and developments in the 2000s had taken place in the state-owned health enterprises, but the most recent UI initiatives have unfolded in both primary and secondary healthcare.

Despite the differences in the structure of the healthcare systems, we consider our study on UI in Norway and Finland to approximate the 'most similar' systems design (George & Bennett, 2005; Mill, 1893). Our two cases admittedly do not meet the design's ideal of similarity across all relevant aspects except for one aspect, whose variance might explain the different outcomes.

## User involvement in Norway and Finland

With respect to UI, it seems that the two countries have promoted it in slightly different ways. In Finland, the developments have been most prevalent in the primary healthcare sector, while in Norway, the focus has largely been on specialist care. The Finnish case is therefore empirically grounded on primary care, while the Norwegian case touches on developments in both primary and secondary care. We now describe the results of our study, first in Norway and then in Finland.

### Norway

The Patients' Rights Act (Proposition to the Storting No. 12, 1998–1999), which entered into force in 2001, includes the right to a second opinion and treatment, the right to information and access to medical records and special rights for children and patient representatives. The patient ombudsman scheme has been established on the basis of this act. The 18 ombudsmen are independent of the health authorities and provide advice, investigating faults and injuries, so patients can seek compensation in accordance with the Patient Injury Act (2001) (Molven, 2012).

### Voice

On a collective basis, Norwegian patients have gained many formal representative rights in recent years. Norway reformed its hospital sector into regional health enterprises in 2002. Portrayed as a 'patient reform' (Proposition to the Storting No. 66, 2000–2001), the Health Enterprise Reform Act included a special provision for patients' representation. The mandatory user committees have been established in local and regional health enterprises in the Norwegian healthcare system.

Andreassen and Lie (2007) evaluated the implementation of these collective voice-channels in Norwegian hospitals in 2006. However, the user representatives' legitimacy was primarily related to administrative management and decoupled from clinical departments. In 2006, due to the presence of user representatives at the system level, they were expected to have a stronger role in the near future. A later study in 2008 confirmed the users' limited involvement at the department level, as resource persons in either special projects or educational matters (Steinsbekk & Solbjør, 2008). Later, Norwegian hospitals have been fully accountable for patients' experienced quality; *"their attention must be directed to how patients experience treatment"*, with greater emphasis on patient-perceived quality, not just medical quality (Report to the Storting No. 11, 2015–2016). A recent survey (2016) among user representatives (in user committees) revealed their experience of being heard and consulted by managers and health professionals (Roland, 2016; Torjesen et al., 2016).

The POs have also demanded better coordination between primary and secondary healthcare. Promoting such coordination has therefore been a core concern of Norwegian healthcare reforms over the past 15 years (Romøren, Torjesen

& Landmark, 2011). Part of the reform package of the so-called Coordination Reform has been the transfer of tasks and responsibility for healthcare for the chronically ill and elderly patients from the hospital sector to primary care in the municipalities. To handle the transfer of tasks and to enable the development of new medical services in local communities, primary care and state hospitals have been mandated to cooperate closely (Report to the Storting No. 47, 2008–2009). Thus, in the wake of the Coordination Reform, a number of networking bodies have been established between hospitals and primary healthcare to promote integrated healthcare (Torjesen & Vabo, 2014). Recently, in the realm of primary healthcare, POs have played important roles in problem definition and the implementation of national health reforms. Problem definitions from user organisations were applied directly to policy formulation in the Report to the Storting No. 26, 2014–2015.

### **Choice**

In 1997, activity-based funding (Diagnosis-related groups (DRGs)) and waiting-time guarantee were introduced in the Norwegian hospital sector (Byrkjeflot & Torjesen, 2010). The main arguments for introducing the new funding system were to reduce waiting times and to increase productivity in the hospital sector. The waiting-time guarantee also represents a shift to a more rights-based and individualistic orientation in the healthcare systems (Winblad, Vrangbæk & Østergren, 2010). In 2001, the free choice of hospitals was introduced as a mandatory patient right (Vrangbæk & Østergren, 2006); in 2015, this was extended to include the right to choose private and foreign healthcare providers. In 2001, Norway introduced a primary healthcare reform that entitled each patient to the right to have a permanent family doctor (General Practitioner (GP)). The reform also gave each patient the right to choose among GPs and the possibility to change his or her GP twice a year. This has at least partly decreased the waiting times and enhanced continuity of care (Report to the Storting No. 47, 2008–2009).

As part of the new conservative, right-wing, government-led endeavour to establish "the patients' healthcare", a new reform was introduced in November 2015. The "free choice of treatment" programme in specialist healthcare has now also enabled patients to choose among private healthcare providers who meet the quality requirements of the health authorities. Furthermore, patients who have been referred to the specialist healthcare service are now entitled to receive information within ten days (the previous deadline was 30 days) regarding the date when consultations and/or treatment can start *at the latest* (Norwegian Ministry of Health and Care Services, 2015). If the patients perceive the health centre's waiting time as too long, they can decide to apply for treatment in other centres via the Internet portal [helsenorge.no](http://helsenorge.no). Despite these formal rights, relatively few patients choose hospital care outside their respective home regions. Limited knowledge about their rights, lack of support from their GPs and inadequate information seem to be the main explanations for the low number of patients using their right to choose (Vrangbæk et al., 2007). The Office of the Auditor

General of Norway (2011–2012) estimated that in 2011, approximately 15% of patients used their right to choose a hospital, based on the data from a survey in 2011.<sup>2</sup> According to a media report, since the enforcement of the "free choice of treatment" reform, the Norwegian Patient Registry has registered merely 194 patients making use of the extended entitlements<sup>3</sup> (Nrk.no, 2016).

### **Co-production**

Since the new millennium, a new patient-centred discourse has entered Norwegian health policy. Patients have become more empowered, upgraded and considered 'competent'. Patients are considered important partners in quality improvement, and Norwegian health authorities have begun to use the term 'expert patient'.<sup>4</sup> The following quote from a speech by the Norwegian State Secretary for Health (Norwegian Ministry of Health and Care Services 2014) provides an illustrative example of the increased attention to patients' voices when reforming healthcare:

Our health policy vision can be summarised as follows: We will build the patient's healthcare. Health services will be better and safer when the patient is at the centre: No decisions are [made] about me, without me. Patients, clients and relatives should be just as important as professionals and politicians in the changing work we are starting now (Secretary of State Anne Grethe Erlandsen, 11.02. 2014).

Policymakers and researchers alike now regard patient participation in clinical decision-making, quality and continuous improvement and clinical pathways development as a prerequisite for promoting high-quality healthcare (Coulter, 2011). This means that Norwegian patients are involved as partners in all aspects of healthcare (research, service innovation, quality improvement, shared decision making and even user-led clinics) (Nrk.no, 2015). An early example is the group-based patient education among chronically ill patients, operated through learning and mastery centres. These learning centres have been present in all Norwegian hospitals since 2006 – focusing on empowering patients on self-management, self-diagnosis, nutrition and so on (Strøm, 2010). As 'expert patients', they are also involved in the training of their fellow patients and in designing the programmes together with health professionals.

Users were also involved in clinical expert groups developing Norwegian cancer packages (clinical pathways) in 2014. Furthermore, in 2016, inclusion of user representatives became mandatory in research at all hospitals and clinics when appropriate.<sup>5</sup> In recent years, Norwegian health authorities have also tested and implemented new electronic devices and e-health solutions, which will promote communication and co-production between health professionals and patients (Report to the Storting No. 9, 2012–2013). Among other things, the so-called electronic core health record has been implemented.



## User influence in Finnish primary care

### Voice

Within the healthcare sector in Finland, only few collective channels for users influence decision making. However, there is an increasing interest in establishing user panels and boards that would be involved in planning and designing services. In the healthcare and social service reform that is currently in preparation, it has also been emphasised that in the new service system, "*clients' views and needs are taken into consideration*".<sup>6</sup> This is relatively new in the Finnish healthcare system, which traditionally has been highly system oriented.

In terms of user democracy, POs have been channels through which patients can – at least in theory – influence decision making. In addition to many other tasks, POs are in many ways engaged in social awareness raising and lobbying (Toiviainen, 2005). For instance, over the last 20 years, POs have pushed forward insurance legislation and reforms in drug reimbursements. Many POs have an organised relationship with political decision makers, such as members of parliament. Some POs have even formed networks for their respective 'diseases' within parliament (Toiviainen, 2005; Toiviainen, Vuorenkoski & Hemminki, 2010).

The Act on Status and Rights of Patients took effect in 1993 and introduced the patients' ombudsman system in the healthcare institutions. If patients or their relatives are dissatisfied with their medical care or treatment, they can complain to the authorities responsible for healthcare supervision. The complaint can be addressed to the director of the healthcare institution, Regional State Administrative Agencies or the National Supervisory Authority for Welfare and Health (Valvira). Claims on patient injuries are sent to the Finnish Patient Insurance Centre and if necessary, to the Patient Injuries Board.

### Choice

Alongside many legislative developments in Finland during the late 1990s and 2000s, the discourse around UI has changed. "Putting the patient on the driver's seat" is currently one of the top issues on the Finnish healthcare policy agenda (Tynkkynen et al., 2016: 227). Patient empowerment and patient centeredness have gained increasing prominence in the Finnish political agenda. However, while choice is many times framed as a means for improved UI, critics have suggested that in essence, the choice agenda is based on the political willingness to promote markets and consumerism in healthcare (Tritter et al., 2010; Tynkkynen et al., 2016). This also seems to be the case in Finland.

It was not until the early 2000s that choice accompanied by competition entered the Finnish policy agenda. The Act on Service Vouchers in Social and Health Care, which was first introduced in social services in 2004 and then expanded to apply to all healthcare and social services in 2009, was the first legislative reform that depicted users as consumers in the municipal healthcare system. The act aims to improve patients' ability to choose private providers instead

of the services provided by municipal health centres and to improve private providers' possibilities to enter the market (Junnila et al., 2016).

Another legislation that introduced choice directly at the municipal level of primary healthcare was the Health Care Act, which came into effect in 2011. It allows residents to change their primary care provider within or between municipalities and to choose the hospital where they want to be treated. In essence, each municipal resident is assigned to a primary healthcare unit based on where they live, but after the reform, residents are now allowed to change their unit once a year. Patients can choose between municipal health centres and private healthcare providers commissioned by the municipalities. Research has shown that one of the reasons why municipalities have increasingly contracted out their outpatient services to the private sector is their desire to provide more choices for their residents and increase competition among providers (Tynkkynen et al., 2012). For various reasons, the people have scarcely been willing to exercise their choice. Less than 10% of the population have actually used their right to select a health centre (Sinervo, Tynkkynen & Vehko, 2016).

Despite the relatively limited choices introduced by the Act on Service Vouchers in Social and Health Care and the Health Care Act, it is possible to observe a certain paradigm shift. The legislative initiative before the 1990s (e.g., the Health Insurance Act) framed choice as an important means of enhancing continuity of care, as well as loyalty and trust in terms of the patient–doctor relationship (Tynkkynen et al., 2016). In contrast, since the late 1990s, choice has been referred to as the choice of provider, and the concept implicitly assumes that choice is accompanied by competition (Tritter et al., 2010). Currently, the Finnish government is preparing a reform in which choice will be broadened and competition will be opened for private providers to compete with public providers on patients' choices (Keskimäki & Tynkkynen, 2016).

### **Co-production**

In Finland, the developments and reform initiatives within the healthcare sector have traditionally focused on the service structures and the ways in which services are delivered. Enhancing UI and patient empowerment has not been a national-level priority until recently. It has been mostly dependent on local initiatives implemented in municipal health centres and hospitals. However, it is possible to observe a slight change in the way that patients' role in healthcare is also perceived at the national level.

The patient participation discourse started to emerge on the national health policy agenda in the 2000s, when it was often stated that services should be client or patient oriented. For instance, this was emphasised in the national development plans for social and healthcare services (Ministry of Social Affairs and Health 2008 & 2012), which define the general aims of healthcare policy and the measures that will be taken to achieve these aims. The emergence of patient participation can also be observed by reviewing government programmes. It was not until 2015 when the patient's role was emphasised throughout the government programme (Prime Minister's Office 2015). The current

healthcare reform largely focuses on promoting consumerist ways of participation (Tynkkynen et al., 2016).

In the national development plans for social and healthcare services (KASTE), the programmes fund the development work in municipalities. One subproject of the KASTE programme for 2008–2011 was the 'functioning health centre' initiated by the Minister of Health and Social Services Paula Risikko in 2008. It aimed at strengthening primary care services and gained strong support from all the main trade unions, national research organisations and local governments. Among the measures to improve the services was the introduction of a Chronic Care Model (CCM, see Wagner et al., 1999) at the national level. It primarily aimed to improve the efficacy of the services and to concentrate on the large group of chronically ill patients who comprise the majority of the clientele in the Finnish health centres.

If we consider the national-level programmes' effects on the actual work in the municipalities, we can observe that many municipalities have embarked on projects and practices that are based on active patient participation promoted at the national level. While choice has not been a top development priority in the municipalities (Tynkkynen et al., 2016), they have put a lot of effort in improving the care of chronically ill patients. There are also 'experts-by-experience' who work with patients and educate the professionals. These local initiatives also employ different e-health and m-health applications (Sinervo et al., 2016). Despite many efficient and even innovative initiatives to enhance patients' abilities to influence their own care at the local level, it seems that the deep-rooted, old organisational structures and professional practices often impede effective patient empowerment and involvement in co-production (Tuurnas et al., 2015).

## Discussion and conclusions

In this paper, we have described UI in healthcare in the context of two Nordic countries – Finland and Norway. The answer to our first research question (Which types of UI can be found in the healthcare systems of Finland and Norway?) is that the types are multiple and somewhat similar in both countries. Finland and Norway have both introduced patient legislation, which gives patients the right to express their voices at the individual level. Both countries have also introduced choice policies, which offer patients the possibility to choose where they want to be treated. The present conservative, right-wing coalition government in Norway implemented the so-called extended choice in 2013, that is, the right to select a private secondary healthcare provider if a service is unavailable or the waiting-time guarantee is exceeded in public hospitals.<sup>7</sup> However, in terms of the actual use of choice, the majority of patients in both countries do not seem to utilise the exit options built into their respective reform programmes. The Norwegian survey data in 2011 indicated that almost 50% of the user respondents (N = 3200) did not receive information from their GPs about the right to choose, highlighting the importance of information in this regard (Office of the Auditor General of Norway, 2011–2012). Furthermore, the majority of the

15% who used their free choice of hospital entitlement included respondents with higher education and/or incomes (*ibid.*). In Finland, less than 10% of the population have used their right to choose (Sinervo et al., 2016).

One clear difference between the countries can be observed at the level of collective voice channels. While in both countries, people have traditionally been able to influence decision making through deliberative processes of local and regional democracy, it seems that Norway has also shown an increasing tendency to introduce new channels for user democracy. These include the introduction of user committees and patient representatives at different levels of the system. In Finland, 'choice' – which positions service users as consumers who influence service systems by choosing among different service providers – seems to be the prevalent means in the political agenda (Tritter et al., 2010). Until recently, Norway seems to have placed more emphasis on 'voice', which depicts users as citizens who participate through representative democracy, since this form of participation is anchored in formal structural reform legislation in many respects (Andreassen & Lie, 2007). Norwegian patients also seem to be increasingly involved as co-producers and expert patients in the development of services.

Another difference between the countries can be observed when we consider our second research question (In terms of choice, voice and co-production, how has UI been developed in these two countries over the past two decades?). In Norway, several reforms have (along with structural reforms) aimed at improving patients' abilities to influence the system by introducing different means of user representation and co-production through national-level regulation as well. An example is the reform in 2002, when Norway established health enterprises, which replaced decentralised political governing bodies (the county councils) with professional boards in the hospital sector (Hagen & Vrangbæk, 2009). The entire Norwegian health enterprise reform was simultaneously sold as 'a user reform'. The previous system with indirect influence, primarily coming from politicians, has in many respects been substituted with direct patient representation through the user committees (Andreassen, 2007). User-centred health policy has also gained new momentum through the recent Coordination Reform, where user representation is mandatory (Report to the Storting No. 47, 2008–2009).

Finland has not introduced any comprehensive structural reforms in the healthcare system since the early 1990s. Incremental small-scale reforms or gradual adjustments have not changed the healthcare system in any fundamental way. Instead, minor market-type reforms have been introduced in the system during the 2000s and 2010s (Tynkkynen et al., 2016). This development culminates in the most recent reform proposed in 2016, which would introduce a radical market reform in the Finnish healthcare system and make consumerist channels of influence the main means of UI (Keskimäki & Tynkkynen, 2016). Should the proposal materialise, it would mean a fundamental change in the service provision structure of the Finnish healthcare and social services and create new market structures in the system. Thus, the second conclusion of this study is that the developments have been different in Finland and Norway. In Finland, the

policy agenda has increasingly moved towards taking consumerist means as its starting point, while Norway's large structural reforms have also strengthened the users' voices and means of participation (cf. Dent & Pahor, 2015).

Although we have uncovered an increase in choice, voice and co-production mechanisms for UI, how much actual influence has been gained by patients remains an open question. It is also possible to question whose interest is ultimately represented by the different means of influence (Hogg & Williamson, 2001). For instance, in the Norwegian hospital sector, we know that selecting user representatives is neither clear nor transparent. It is often an interaction among POs, the management and the hospital boards, where the selection of user representatives takes place, and usually, the management and the hospitals' steering boards have the last word (Torjesen et al., 2016). In Finland, the increasing emphasis on user centeredness has been used as a means to undermine the high system orientation and to improve the private actors' possibilities to participate in the delivery of publicly funded services. In other words, it is not entirely clear if in the end, patient choice serves the interests of the patients or of the private industry. Finally, although UI through co-production has gained greater attention, recognition and scope, the partnership between user representatives and experts can still be described as 'fragile' and ambiguous. This tension is mainly linked to questions about which knowledge counts most – users' experiential learning or professional medical knowledge (Strøm, 2010). The findings from a Norwegian study suggest that health professionals tend to set the boundaries for UI by deeming some of the activities within hospital departments "too professional knowledge demanding" for users to be involved in (Solbjør & Steinsbekk, 2011). Taken together, while user influence has gained prominence in the policy agenda, it would be increasingly important in future studies to start contemplating these two questions: What is the actual effect of UI on the operations of healthcare systems? What other interests can take advantage from the harnessing of UI? Different means of UI would also have positive and negative synergies (Vrangbæk, 2015), which would be important future avenues for researchers to study.

When we explore the UI phenomenon in the two Nordic countries, we must also consider international influence. Public policies in European countries are increasingly affected by the international flow of policy ideas, cross-national learning and influences from European Union (EU) legislation and court dominance over politics (Vrangbæk et al., 2012). The EU has contributed to free choice policies by establishing jurisprudence on patients' rights in cross-border care (Time & Veggeland, 2016). All Nordic countries, including the European Economic Area-member Norway, have implemented the Patients' Rights Directive, which clarifies patients' right to choose health providers outside of their home country and claim reimbursement afterwards (Time & Veggeland, 2016). Market regulation and the regulatory empowerment of the individual vis-à-vis the system are central traits of EU policymaking (Kelemen, 2011; Scharpf, 2010). In fact, health policy is a striking example, given that the EU lacks formal competence but influences healthcare systems via its regulation of input factors (pa-

tients, health services, health professionals, public procurement, etc.) (Greer, 2006).

Nonetheless, are these trends only specific to healthcare, or can we observe similar patterns in other fields? If we examine higher education – another major sector in Nordic societies – it is possible to notice that the student's role is changing as well. The citizen's role is replaced by the consumer's role (Cardoso, Carvalho & Santiago, 2011). The citizens are turned into actors in the market, which also affects the ways of influence that are provided to them. Taking these lessons into account, we can recognise that the experiences presented in this paper are also of importance to similar sectors, such as higher education.

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## Notes

<sup>1</sup> e.g., Finland: Public Engagement Innovations for Horizon 2020 (PE2020), <http://pe2020.eu>; VALINT: Customer-oriented practices in primary care – choice and care integration for Tekes. Norway: Report to the Storting (2010–2011) (white paper) National Health and Services Plan, [https://www.regjeringen.no/contentassets/f17befe0cb4c48d68c744bce3673413d/en-gb/pdfs/stm201020110016000en\\_pdfs.pdf](https://www.regjeringen.no/contentassets/f17befe0cb4c48d68c744bce3673413d/en-gb/pdfs/stm201020110016000en_pdfs.pdf) and National Health and Hospital Plan, Report to the Storting No. 11 (2015–2016), <https://www.regjeringen.no/no/dokumenter/meld.-st.-11-20152016/id2462047/>

<sup>2</sup> Nor do the health authorities have an overview. A patient can be treated in various hospitals within a region, without knowledge about whether this is the patient's own choice or a consequence of functions across hospitals. <https://www.stortinget.no/no/Saker-og-publikasjoner/.../Referater/.../8/>

<sup>3</sup> The freedom to choose between public and private providers of specialist care is temporarily limited to mental healthcare and substance abuse treatment. <https://www.regjeringen.no/no/aktuelt/okt-valgfrihet-og-styrkede-rettigheter/id2363464/>

<sup>4</sup> Patient-centred care in Norway has many affinities with previous patient-centred health policy programmes launched in the UK in 1999, named the "Expert Patient Programme". Later in 2000, this was further outlined as a vision to design health services around the patient (Shaw & Baker, 2004).

<sup>5</sup> User involvement is rooted in Norwegian laws – the Patient User Right Act (1999) and the Health Enterprise Act (2001).

<sup>6</sup> Healthcare and social services reform, <http://alueuudistus.fi/en/frontpage>

<sup>7</sup> <https://www.regjeringen.no/no/aktuelt/Gir-pasienten-fritt-behandlingsvalg/id763137/>