



Short report

The impact of different prioritisation policies on waiting times: Case studies of Norway and Scotland



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ARTICLE INFO

Article history:

Available online 25 July 2013

Keywords:

Waiting times
Prioritisation
Norway
Scotland

ABSTRACT

We investigate the distributional consequences of two different waiting times initiatives, one in Norway, and one in Scotland. The primary focus of Scotland's recent waiting time reforms, introduced in 2003, and modified in 2005 and 2007, has been on reducing maximum waiting times through the imposition of high profile national targets accompanied by increases in resources. In Norway, the focus of the reform introduced in September 2004, has been on assigning patients referred to hospital a maximum waiting time based on disease severity, the expected benefit and the cost-effectiveness of the treatment. We use large, national administrative datasets from before and after each of these reforms and assign priority groups based on the maximum waiting times stipulated in medical guidelines. The analysis shows that the lowest priority patients benefited most from both reforms. This was at the cost of longer waiting times for patients that should have been given higher priority in Norway, while Scotland's high priority patients remained unaffected.

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Introduction

In recent years there has been a trend for policy makers to set priorities on a more explicit basis. The most common policy is *blanket waiting-time target setting* (introduced in e.g. Australia, Denmark, England, Italy, Scotland, Spain, and Sweden). Under blanket waiting time targets all patients have equal priority regardless of their clinical condition and the treatment they are waiting to receive. This unconditional guarantee may be effective in reducing long waiting times (Siciliani & Hurst, 2005), but the reduction of waiting times does not necessarily benefit all patients because hospitals may choose to treat less needy ones. Other countries have introduced *vertical waiting time prioritisation* (e.g. New Zealand and Norway). With this type of prioritisation, explicit guidelines are given on how patients should be prioritised. It is believed that vertical waiting time targets will lead to improved prioritisation and reduced waiting time for patients in most need.

We examine the consequences of two different prioritisation policies, blanket and vertical prioritisation, for inpatient treatments. For that purpose we use data from Norway and Scotland as different prioritisation policies have been introduced in the two countries over the same period.

The empirical literature on prioritisation practices is limited, and differs in the kind of data that are used. Arnesen, Erikssen, and Stavem (2002) and Löfvendahl et al. (2005) investigate patients' medical records. A problem with this approach is the limited sample that can be used, and the potentially very high cost of providing data of sufficient generality. As an alternative, other researchers have used register based data. Dimakou, David, Devlin, and Appleby (2009) analyse how the probability of admission of any given patient varies during the time she waits. They find that hazard rates vary over time and that a high probability of admission coincides with the targets; the peaks in hazard rates change when targets change, indicating shorter waiting times when more aggressive targets are implemented. Askildsen, Holmås, and Kaarboe (2010) evaluated whether prioritisation-practices changed following a Norwegian hospital reform, which changed ownership structures and catchment areas of the hospitals. They find that the reduction in waiting times after the reform favoured lower priority patients. Propper, Sutton, Whitnall, and Windmeijer

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(2008, 2010) analyse whether a planned reduction in waiting times, backed up by strong managerial sanctions and stringent monitoring, reduced waiting times. By comparing changes over time in England to those in Scotland (which adopted a similar policy later), they found that the policy met the goal to reduce long waiting times without apparently diverting effort from less well-monitored aspects of health care. Their analysis of re-prioritisation, however, was inconclusive as the pre-intervention trends differed between the two countries.

The impacts of introducing blanket maximum waiting times targets in Scotland and individual maximums in Norway have not been evaluated in previous research. Since no condition-specific maximum targets exist for Scotland, we apply the Norwegian medical guidelines to the Scottish data. The aim is to evaluate whether more severely ill patients are prioritised better in a country where vertical prioritisation is emphasised by the introduction of differential maximum waiting times. Furthermore, we investigate if the common concern of too low priority given to the most severely ill patients is dampened when introduction of blanket waiting time targets are accompanied by increases in resources.

The analysis shows that the patients with the lowest priority benefited most from the reforms in both countries. In Norway, where we should expect the vertical prioritisation to benefit the higher priority patients, the effect actually appears to have been at the expense of this group. In Scotland waiting times for the high priority patients were unaffected.

Institutional settings

Norway

The Norwegian specialised health care sector is predominantly publicly owned and organised as state owned enterprises within five regional health authorities (RHAs). The RHAs have the responsibility for providing specialist health care to all patients within the region. Provision of health care is organised through health enterprises owned and governed by the RHAs. The RHAs can also contract with private suppliers for providing treatment. However, this outsourcing is quite small compared to overall treatment activity, and confined to a few diagnoses. Patients' access to specialised health care is either through a referral system (elective care) or by acute (emergency) care.

Prioritisation of the patients is regulated through the Act on Patients Rights and administrative regulation of prioritisation (Ministry of Health and Social Services, 1999, 2003). For elective patients, it establishes that, upon referral, the assessment of a patient's condition must consider: a) how serious is the condition, b) whether a suitable treatment exists that may improve the patient's condition, and c) the cost-effectiveness of this treatment. From September 2004 patients who are referred to the specialist health care sector have the right, within 30 days from referral, to an evaluation of whether or not their medical condition is such that it gives a legal right to treatment within an individual maximum waiting time.

The allocation of prioritisation status to elective patients is formally managed in the following way. Within 30 days of the receipt of a referral, the hospital has to consider whether the patient should be given a legal right to treatment or not. This decision is based only on the description of the medical condition given by the primary care physician. Each patient is to be considered according to criteria a–c above. If the patient is considered as fulfilling the criteria, (s)he is given an individual maximum waiting time until start of treatment. If this waiting time is exceeded, the patient has the right to file a complaint. The hospital is then given a short time frame for providing treatment (typically 14 days). If

treatment is still not given, the patient can choose treatment at another hospital, privately, publicly or abroad, at the cost of the initial health enterprise. This cost is proportional to the expected cost of treatment.

Scotland

The Scottish specialised health care sector is predominantly publicly owned. It is organised into 14 regional health boards, responsible for primary, community and secondary (hospital) health care services to the populations resident within their geographical boundaries. Until 2004, responsibility for providing hospital services was held by NHS Acute Trusts who negotiated annual contracts with local health boards. From 2004, health boards took over direct responsibility for delivering these services. Contracts with private suppliers represent a very small proportion of NHS-financed hospital care and privately-financed (either directly or through insurance) hospital care is also a very small proportion of total hospital care expenditure.

The first aspiration to reduce waiting times was announced in 2000 (Scottish Executive, 2000). For inpatient waits, the maximum waiting time was to be nine months by December 2003. A more ambitious target of six months was announced for 2005 in a 2002 press release (Audit Scotland, 2006). In 2004, a further White Paper pledged to reduce waiting times to 18 weeks by 2007 (Scottish Executive, 2004). The maximum waiting time guarantees only covered patients without an Availability Status Code (ASC). An ASC was assigned to patients who were 'unavailable' or 'medically unsuitable' for treatment.

Although Scotland did not implement a waiting times policy until later than England, a similar "targets and terror" regime was adopted once the policy began in earnest. The compliance of the regional health boards with the targets was monitored on a monthly basis and Chief Executives faced a real threat of dismissal for breaches of the target. To facilitate compliance, health boards could divert patients at risk of breaching the targets to a national waiting times centre; a dedicated hospital that the NHS had bought from the private sector. It has been estimated that about £116 million was spent on tackling waiting times in 2004/05. Approximately 40% (£45.7 million) of this was spent on the national waiting time centre (Audit Scotland, 2006). This additional expenditure on reducing waiting times was made at a time of substantial growth in the general resources spent on the hospital sector in Scotland.

Empirical method

In order to investigate how prioritisation practice has evolved over time, we use the method suggested by Askildsen, Holmås, and Kaarboe (2011) which derives maximum waiting times from Norwegian medical guidelines. The medical guidelines cover 21 medical specialities. Based on a description of a medical condition, they assign a recommended maximum waiting time (between 4 and 52 weeks), or no priority.

The data in both countries are taken from the administrative patient registers for elective inpatient hospital treatment in the period 2003–2006. Approval to use the Norwegian data is given by the Norwegian Data Protection Authority and the Regional Committee West for Medical and Health Research Ethics. The authority providing access to Scottish data was the "Information Services Division of NHS National Services Scotland". The main interest in our analysis is the policy change and we therefore restrict the period of the analysis to two year periods: patients added to waiting lists between 1st of August 2003 and 31st of July 2004 are included in the pre-reform year, while patients added between the 1st of August 2005 and 31st of July 2006 constitute the sample for

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