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## Stakeholder views on criteria and processes for priority setting in Norway: a qualitative study



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### ABSTRACT

Since 2013, Norway has engaged in political processes to revise criteria for priority setting. These processes have yielded key efficiency and equity criteria, but excluded potentially relevant social values. This study describes the views of 27 stakeholders in Norway's health system regarding a wider set of priority-setting criteria and procedural characteristics.

Between January and February 2016, semi-structured interviews and focus groups were conducted with a purposive sample of policymakers, hospital administrators, practitioners, university students and seniors.

Improving health among low-socioeconomic-status groups was considered an important policy objective: some favored giving more priority to diseases affecting socioeconomically disadvantaged groups, and some believed inequalities in health could be more effectively addressed outside the health sector. Age was not widely accepted as an independent criterion, but deemed relevant as an indicator of capacity to benefit, cost-effectiveness and health loss. Cost-effectiveness, severity and health-loss measures were judged relevant to policymaking, but cost-effectiveness and health loss were considered less influential to clinical decision-making. Public engagement was seen as essential yet complicated by media and stakeholder pressures.

This study highlights how views on the relevance and implementation of criteria can vary significantly according to the health system level being evaluated. Further, the findings suggest that giving priority to socioeconomically disadvantaged groups and reducing inequalities in health may be relevant preferences not captured in recent policy proposals.

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### 1. Introduction

In all health systems, resources are finite and thus generally insufficient to meet populations' demand for health care. Against the backdrop of an aging population, rising health care costs and the introduction of expensive treatments, Norway recently proposed principles and criteria for priority setting and resource allocation [1].

Prioritisation among competing health interventions occurs at the policymaking, hospital administration and

clinical levels of the health system [2]. Priority setting and resource allocation should reflect health system goals, typically defined as maximisation of health and fair distribution of health benefits, i.e. a balance of efficiency and equity [3–5]. Determining the bases upon which allocation choices should be made is a significant challenge for public health systems. It is widely held that developing a framework for priority setting should engage a broad spectrum of stakeholders, including members of the public, to facilitate transparency, accountability and legitimacy of the process and associated outcomes [6].

Given the importance of stakeholder input and the plurality of criteria relevant to priority setting, numerous

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empirical studies have sought to identify the preferences of decision makers and the public. Several literature reviews and studies investigating decision makers' views tend to substantiate the relevance of health benefits, cost-effectiveness and severity of illness [7–10]. Public preference studies reveal the importance of health benefits and severity of illness, while evidence regarding the relevance of cost-effectiveness is limited [11–13]. While many other criteria have been considered in the empirical literature, studies have yielded highly variable results. These inconsistencies may relate to differences in sample type, criteria used, question framing and elicitation technique, as well as variations in country setting and priority-setting context [8,12]. Further, heterogeneity in definitions of criteria (e.g. “age” and “severity of illness”) can affect respondents' interpretations [11].

Empirical studies show public engagement is considered to have a legitimate role in priority setting, yet opinions among stakeholders differ in regard to how public preferences should be elicited and integrated [14–16]. Additionally, few studies have explored how stakeholders believe criteria should be applied at distinct levels of the health system [17].

Norway's universal health care system is primarily tax-financed, with four regional health authorities (RHAs) governing specialised health services and municipalities overseeing the provision of primary health care. Most hospitals are publicly owned and funded, and general practitioners (GPs) act as gatekeepers for specialised services. Norway has some private hospitals, but private health expenditures, including co-payments, account for only 15% of the country's total spending on health [18].

Priority setting has been part of the public discourse in Norway for over 30 years, and in 2013 the government appointed its third commission, the Norwegian Committee on Priority Setting in the Health Sector, to provide guidance on health care resource allocation. The previous national commission in 1997 had established three criteria: severity of the condition, effect of the intervention and cost-effectiveness [19,20]. The latest Committee's final report was released in November 2014 [1,21]. The Committee proposed three criteria: the health-benefit criterion (priority increases with the expected health and other relevant welfare benefits), the resource criterion (priority increases, the less resources required), and the health-loss criterion (priority increases with expected lifetime health loss, absent an intervention). Cost-effectiveness represents a combination of the resource and health-benefit criteria, while the health-loss criterion captures concern for the worse off. In its mandate, the Committee was asked to evaluate criteria related to “end-of-life care, age, lack of alternative treatment, innovation, and rare diseases.” The Committee argued that these characteristics were “relevant only to the extent [they] informed the use of the benefit, resource, or health-loss criteria” [1]. In Fall 2016, Parliament by and large approved the Committee's recommendations, while replacing the lifetime health-loss criterion with a “severity” criterion. Severity is concerned with current health quality and prospective health loss, but not past health loss [1,22]. In this paper, the author will often refer to severity and health loss together, but will

not use the terms interchangeably. While health loss is one conception of severity, severity is variously defined in the literature.

While the Committee's recommendations comprise notions of efficiency and fairness, they omit additional criteria that reflect other potentially relevant social values and distributive preferences that could inform resource allocation [23–25]. In this study the author aimed to investigate stakeholder perspectives on a larger universe of equity criteria and procedural elements.

## 2. Methods

### 2.1. Design

The author conducted a qualitative study consisting of open-ended interviews and focus group discussions (FGDs). Stakeholders were recruited from the policymaking, hospital administration, and clinical levels of the Norwegian health care system, as well as from the public.

Criteria were selected based on their relevance to public debate and to the distribution of health. In contrast to health maximisation, health distribution is concerned with the idea that all members of society should have a fair chance to live a long and healthy life [4,5,26]. The author was particularly interested in exploring stakeholders' views on equity criteria that might be considered alongside cost-effectiveness, the system levels at which they would apply, and the processes of decision-making. Questions in the interview guide therefore focused on criteria, levels of decision-making, and public engagement and processes.

As one of the of the first countries to systematise priority setting, Norway serves as a valuable setting for this study [19].

### 2.2. Sampling and settings

In this study the author employed a purposive sampling strategy, seeking variation in perspectives [27]. With the assistance of University of Bergen research colleagues and key informants in Norway, the author identified decision makers with experience in priority setting, health care policy or clinical ethics. To capture differences among perspectives, the author selected persons that belonged to various policy and medical institutions across three health regions. However, respondents were chosen without knowledge of their specific views. The author contacted the individuals to explain the study's purpose and to request their participation, emphasising the voluntary and confidential nature of participation. Additionally, to elicit the opinions of Norwegian citizens—claimants of the public health system—the author organised FGDs with a group of university students and a group of individuals from an association of seniors. Students and seniors were identified with assistance from a former course instructor and organiser at the senior association, respectively, who were informed about the study. The students had taken the same course in introductory political theory and had some basic fluency in related topics. These senior and student groups were selected because they varied across a relevant char-

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