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The 2015 hospital treatment choice reform in Norway: Continuity or change?

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ABSTRACT

In several European countries, including Norway, polices to increase patient choice of hospital provider have remained high on the political agenda. The main reason behind the interest in hospital choice reforms in Norway has been the belief that increasing choice can remedy the persistent problem of long waiting times for elective hospital care. Prior to the 2013 General Election, the Conservative Party campaigned in favour of a new choice reform: "the treatment choice reform". This article describes the background and process leading up to introduction of the reform in the autumn of 2015. It also provides a description of the content and discusses possible implications of the reform for patients, providers and government bodies. In sum, the reform contains elements of both continuity and change. The main novelty of the reform lies in the increased role of private for-profit healthcare providers.

1. Institutional setting and reform background

As in most European countries, statutory coverage in Norway is obligatory and opting out is not permitted. There is no choice of the statutory benefits package but patients are allowed to choose their healthcare provider. Healthcare provision is organized at two main levels, municipalities and state. The municipalities are responsible for primary care and enjoy a great deal of freedom in organizing health services. Patients are in general free to choose their general practitioner (GP). GPs act as gatekeepers responsible for referring patients to specialist care, i.e., a privately practicing specialist or a hospital. The referral process normally comprises the following stages: (1) the GP examines the patient and, if specialist care is needed, writes a letter of referral; (2) the referral is assessed by a public hospital; (3) the hospital determines if care is needed and if the decision is affirmative the hospital grants the patient the right to treatment within a specified period of time (waiting time guarantee); (4) if the guaranteed waiting time is exceeded by the hospital, the patient is allowed to select an alternative provider (either another public hospital or a private hospital under contract with the Regional Health Authority (RHA)) [1]. The responsibility for specialist care lies with the state—the owner of the four RHAs, which in turn own hospital trusts. The Ministry of Health influences the activity of the RHAs (e.g., what their budget allocation should be spent on) through its annual "letters of instruction". These letters are supplemented by annual circular letters from the Directorate of Health focusing on issues such as quality of care, e-health, etc. The Directorate is an agency subordinate to the Ministry and is involved in implementation of healthcare policies.

Waiting times for elective hospital care have been seen as a major shortcoming of the healthcare system since mid-1980s and have been the motivation behind a number of

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waiting-time guarantees and choice reforms [1,2]. Since 2001, somatic patients have had the right to choose any public hospital in the country (but the level of hospital, secondary or tertiary, could not be chosen) [3]. Subsequently, patient choice was expanded to include private hospitals contracted by the RHAs (patients who received care at private hospitals not contracted by the RHAs had to pay for it out of their pocket). However, this expansion did not necessarily mean a major change for the patients in terms of increasing their choice as almost all hospitals in Norway (approximately 99%) are publicly owned and funded through public budgets [4]. Not-for-profit private hospitals, often organized as foundations owned by ideological organizations such as the church, are publicly funded and seen as part of the public healthcare services. Private for-profit (PFP) providers play a small role in the provision of specialist care, as less than 1% of hospital beds are in private for-profit hospitals [1]. The largest proportion of private provision of somatic hospital care is found for elective day surgery (about 10%) [5]. Other patient and user groups, such as psychiatric patients and patients in need of treatment for alcohol and substance use have also been granted the right to choose a hospital/institution (in 2004 and 2005, respectively). In recent years, the RHAs have also started offering patients the option to receive rehabilitation care in a different region.

Although patient choice can contribute to reducing hospital-waiting times for individual patients [6,7], an overall effect on waiting times in Norway has yet to be demonstrated. The waiting times problem has persisted and not left the policy debate. According to a 2010 OECD survey, 21% of Norwegian respondents had to wait four months or more for elective surgery (third highest score after Canada (25%) and Sweden (22%)) [8,9]. Between 2011 and 2014, the average waiting times were the highest for somatic treatment (70 and 80 days), with patient waiting for orthopaedic and medically essential plastic surgery facing the longest waiting times. For alcohol and drug treatment a reduction in waiting times was observed, from about 75 days in 2011 to about 60 days in 2014. For psychiatric care, the average waiting times remained stable at about 55 days [10].

The article aims to describe the background and process leading up to introduction of the new treatment choice reform in late 2015. It provides a description of its content and discusses possible implications of the reform for the patients, providers and other stakeholders.

2. Policy goals and policy process

2.1. Policy development

In mid-June 2014, the government launched what they named the "reform of free treatment choice in specialist care" [11]. The issue appeared on the political agenda prior to the General Election in September 2013, with the Conservative Party campaigning in favour of extending patients' choice of hospital. The Conservative Party won the 2013 elections and went on to form a governmental coalition with the Progress Party. The two parties are supported by the centrist Christian Democratic Party and the Liberal Party in Parliament. With respect to healthcare, the coalition parties agreed that "The Government will (...) carry out a major reform of the health service. Patients' rights will be strengthened and individuals will be given the right to choose their healthcare provider. This will ensure that patients will not have to wait in queues when private and non-profit healthcare providers have available capacity" [12]. Thus, the primary focus of the reform was on strengthening patients' rights by increasing their choice of healthcare provider, with shorter waiting times for elective care being the more immediate goal. Private providers without a tender agreement with the RHAs were to be included in this extended choice, increasing the pool of providers that patients can choose from.

Immediately after the General Elections in September 2013 the Ministry of Health and Care Services began drafting a proposal for the announced reform. The Prime Minister officially presented the draft proposal in June 2014, emphasizing once again that the reform was intended to extend the existing choice scheme and reduce waiting times for elective hospital care. The proposed reform would entail amending several existing policy tools, including payment mechanisms and ICT-systems. The proposal also called for new regulations in the following areas: a system of granting approvals for private hospitals to be included in the treatment choice scheme would be established (but it was not detailed in the proposal) and a new system for quality assurance would be set up, giving the RHAs the responsibility for assuring quality among private hospitals included in the scheme [11].

2.2. The public consultation process and key stakeholder positions

After the proposal was presented, the Ministry opened the customary public consultation process to provide an opportunity for affected stakeholders to state their opinions. The consultation process lasted three months and elicited about 100 responses [13]. Fig. 1 summarizes the position of key stakeholders.

Several of the largest patient organizations (e.g., the Federation of Organizations of Disabled People, the Cancer Society and the Patient Organization for Circulatory Diseases) expressed concerns about the proposal. The key reasons were: complexity of the reform and its administrative costs and the opportunity for private hospitals to prioritize to patients with more "easy-to-treat" conditions. Another issue was the implications for workforce planning in the public part of the system, given that more private providers would compete for the same experts. Patient representatives from the public hospital boards were also worried that private hospitals would prioritize "easy-to-treat" patients and suggested, in a common statement, that no private hospitals should be granted the right to assess GP referrals and to grant individual patients the right to specialist care. The Union for senior citizens expressed a general concern about the ongoing centralization of specialist care, and feared that the choice available to older could be restricted patients due to longer travel distances to hospitals. However, their position and the position of other patient groups were more nuanced and some aspects of the