



Prioritization and the elusive effect on welfare – A Norwegian health care reform revisited



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ABSTRACT

The Faster Return to Work (FRW) scheme that Norwegian authorities implemented in 2007 is an example of a policy that builds on the human capital approach. The main idea behind the scheme is that long waiting times for hospital treatment lead to unnecessarily long periods of absence from work. To achieve a reduction in average sickness absence duration, the allocation of FRW funds and new treatment capacity is *exclusively* aimed at people on sick leave. Many countries have allocated funds to reduce waiting times for hospital treatment and research shows that more resources allocated to the hospital sector can reduce waiting times. Our results support this as the FRW scheme significantly reduces waiting times. However, on average *the reduction in waiting times is not transformed into an equally large reduction in the sickness absence period*. We find significant difference in the effects of FRW on length of sick leave between surgical and non-surgical patients though. The duration of sick leave for FRW patients undergoing surgical treatment is approximately 14 days shorter than for surgical patients on the regular waiting list. We find no significant effect of the scheme on length of sick leave for non-surgical patients. In sum, our welfare analysis indicates that prioritization of the kind that the FRW scheme represents is not as straightforward as one would expect. The FRW scheme costs more than it contributes in reduced productivity loss. We base our analyses on several different econometric methods using register data on approximately 13 500 individuals over the period 2007–2008.

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1. Introduction

In a health care system financed by general taxes, it is not unusual that the demands for some health services are rationed through waiting lists. In principle, prioritization of planned admissions to hospital is based on first-come-first-serve basis.

In such a health care system, it is customary that additional resources are allocated to services where waiting times are long relative to some explicit goal or to services where the time factor is crucial in terms of avoiding permanent loss of functionality or avoiding premature deaths (Siciliani and Hurst, 2005; Gravelle et al., 2003; Iversen, 1993).

However, according to the human capital approach resources should first and foremost be allocated to health services for which the indirect cost (or opportunity cost) of waiting for treatment is the largest, all else equal. For example, additional resources

specifically aimed at employed people in need of planned hospital treatment will lead to a better cost–benefit ratio compared to resources allocated to children, the unemployed and retired people. The reasoning is that waiting lists prolong productivity losses compared to a situation without rationing. Additional resources aimed at employed people will therefore contribute to reduce the productivity loss in connection with sickness absence and to decrease the level of sickness benefit transfers. The human capital approach is controversial but some argue that prioritization should be addressed, at least in part, by using the indirect cost argument (Canadian Agency for Drugs and Technologies in Health, 2006, see also discussion in Drummond et al., 2005; Olsen and Richardson, 1999).

The Faster Return to Work (FRW) scheme that Norwegian authorities implemented in 2007 is an example of a policy that builds on the human capital approach. The main idea behind the FRW scheme is that long waiting times for hospital treatment lead to unnecessarily long periods of absence from work. Around 40% of persons registered as being on sick leave receive hospital treatment (Holmås and Kjerstad, 2010) during the sick leave episode. The

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average waiting time for hospital treatment is around 70 days (Norwegian Directorate of Health, 2008). This indicates that a reduction in waiting times could lead to a reduction in length of sick leave and faster return to work. Obviously, the goal of FRW is that waiting times and thus total length of sickness absences shall decrease as a result of increased treatment capacity. To achieve this, the extra treatment capacity financed through the FRW scheme is exclusively for people on sick leave.

The National Health and Social Insurance system in Norway, as in many other countries, is under economic stress from an increasing number of disability and sickness benefit claimants (Bonato and Lusinyan, 2004; OECD, 2010). On a given working day, around 6.5% of the workforce (130 000 persons) receives sickness benefits based on a sickness certificate from a general practitioner (GP) (The Norwegian Labour and Welfare Administration (NAV), 2013). As part of an on-going effort by the Norwegian government to reduce both the incidence and the duration of absences from work, a committee comprised of representatives from central government, labour unions and employer organizations proposed a set of new measures to reduce sickness absences. The FRW scheme was one of the first measures to be implemented. The other measures were related to all people on sick leave, not only FRW patients, and gave rules and guidelines of how employers and employees on sick leave should interact during a sickness absence spell. The FRW scheme was introduced early 2007 and the Norwegian Government spent approximately NOK 500 million (around EUR 70 million) yearly in the period 2007–2009 on additional treatment capacity aimed only at people participating in the labour force. The scheme was not large enough to supply services to all on sick leave in need of treatment. At any point of time there will be more people on sick leave in the ordinary waiting list than on the FRW waiting list.

The interesting research question is whether the FRW contributes to enhance welfare. We level the playing field and ask: Does prioritization through the FRW scheme lead to a welfare enhancing reduction in productivity losses caused by waiting lists?

We use a dataset on individuals where hospital data is merged with social security data including socio-economic characteristics. A treatment group and a comparison group are created based on a quasi-natural experiment design. We estimate ordinary least squares (OLS) regressions and different binary treatment effect models with and without heterogeneous average treatment effects taking into account unobserved selection into treatment. We use the *distance* to the nearest FRW hospital minus the distance to the nearest hospital of any type (FRW or regular hospital) for each patient as the exclusion restriction for identifying causal effect of the FRW scheme in the empirical analysis. The distance variable should affect the decision to enter the FRW scheme, but should not directly affect our outcome variables length of sick leave and return to work.

We conclude that the type of prioritization that the FRW scheme represents do not give the welfare effects policymakers envisaged. We find that the *waiting times*, calculated from the commencement of the sick leave period, for patients who received treatment through the FRW scheme in 2007 and 2008 was 13.8–15.5 days shorter compared to people on sick-leave enlisted on the regular waiting list depending on the estimator. These latter patients are not prioritised ahead of other patients in the queue, as is the case under the FRW scheme. However, the reduction in waiting times is only partially transformed into a reduction in *total length of sick leave*. On average, the reduction in total length of sick leave is around 8.5 days and 9.3 days. The welfare analysis shows that effect on the duration of sick leave is *not strong enough* to outweigh the costs of the FRW scheme.

We do find a significant difference between surgical and non-

surgical patients though. Patients undergoing *surgical treatment benefit the most*, both in terms of shorter length of sick leave and shorter waiting times. Patients undergoing surgical treatment through the FRW scheme have episodes of sick leave that are, again depending on the estimator, 13.7–22.5 days shorter, on average, compared to surgical patients on the regular waiting list. We find no significant effect of the FRW scheme on length of sick leave for non-surgical patients.

The paper continues in Section 2 with a description of the institutional settings. Data and descriptive statistics are presented in Section 3. Presentation of the empirical methods follows in Section 4. Main results are presented in section 5. The results are discussed in Section 6.

2. Institutional setting

The Norwegian sickness benefit scheme is organized under the public National Insurance Scheme (NIS). All workers are entitled to sickness benefits if: (1) their occupational activity has lasted for at least 14 days with the same employer, (2) they have an annual income of at least half the basic income, and (3) they are incapable of working because of sickness. Employees may self-certify illnesses a maximum of four times a year for periods of no more than three days each time. Otherwise, a physician, in most cases a GP, assesses all absence caused by sickness. For employees, statutory sickness benefits are 100% of pensionable income and are paid from the first day of sickness for a maximum period of 260 working-days (52 weeks). The employer pays the sickness benefits for the first 16 days and the NIS pays the remainder.

Some firms, called IA firms, have a slightly more generous sickness benefit scheme compared with non-IA firms. The IA agreement is a letter of intent regarding a more inclusive working life, and was agreed between the Government and the labour organizations in 2001. One important goal of the agreement is to reduce the number of people on sickness benefits.

The health care system is tax-based, provides universal access and is predominantly public. Provision of primary health care, including services from GPs, is the responsibility of local authorities, whereas provision of hospital services is the responsibility of state-owned hospitals. The hospital sector is organized into four Regional Health Enterprises (RHEs). Each RHE governs one or more Health Enterprises (HEs) and several hospitals may be grouped into one HE. As in most countries with universal access to health care, waiting times are relatively long. In 2008, the average waiting time for specialist health care was around 70 days (Norwegian Directorate of Health, 2008).

Central government allocated the FRW funds through the Regional Health Authorities (RHA). The RHAs made the decision of which FRW application to support and fund. The applications came from local health enterprises/hospitals. The directions for use of funds was that it should not lead to lower capacity for existing treatment but that the FRW scheme should add capacity. There were not given any explicit goals regarding staffing, waiting times etc. Of course, the main aim was to reduce the duration of sickness absence periods through lower waiting times but this was not translated into specific targets for the individual FRW facility.

Whereas the FRW scheme is provided by hospitals, referral to the scheme is normally the responsibility of GPs. GPs have the so-called gate-keeper function and, in general, an individual patient cannot obtain inpatient or outpatient care without a referral from a GP, with the exception of emergency cases. An employee absent from work because of sickness must obtain a sick leave certificate from a GP, and the same GP can help the employee to obtain specialist care by providing a referral to a hospital offering the FRW scheme, or to a hospital that is not under the FRW scheme but

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