

Comment

Reflecting on ‘Choice policies in Northern European health systems’

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The topic of patient choice plays a sentinel role in health policy, providing what the Swedes call a ‘red thread’ that links together a variety of seemingly separate policy issues across time as well as across differently configured health systems. Choice of what, by who, where and when reveals a great deal about current roles, responsibilities and authority in the complex organizational maze that modern health care has become. The issue of choice also can highlight the capacity of a health system to innovate and reform itself, in that changes in provider choice, when linked to provider payment, often challenge long-defined organizational patterns, regional planning assumptions and professional as well as union work rules. Viewed at its broadest, choice can help demarcate the boundaries between different types of European health systems. Those that were traditionally funded predominantly through social health insurance arrangements – where patient choice was typically built into institutional arrangements and thus normal and non-controversial – differ fundamentally on this issue from systems traditionally (and still) funded predominantly by publicly levied taxes – where patient choice has historically been tightly constrained, and remains contested and controversial.

In the tax-funded health systems of Northern Europe, the question of patient choice of provider has been a contentious topic for 30 years. The first privately operated but publicly paid walk-in primary care clinic in Sweden, Citi-akuten, opened its doors in downtown Stockholm in 1983, the same year when the concept of patient choice among public providers was first raised in Sweden for health sector discussion (Saltman, 1983). Like other ‘permanent’ health policy questions that never go away – one thinks of the public–private mix (Saltman, 2003), also centralization vs decentralization of public sector health system administration (Saltman, 2008) – the topic of choice in the Nordic Region has a history of extensive debate, uneven implementation and – not infrequently – political backsliding. In the case of choice of provider, the central policy questions range from whether experts or citizens should determine where care is provided, when

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an individual becomes a patient, and who chooses the doctor or medical team, as well as the impact of individual patient decisions on collective population planning and service payment mechanisms, and the availability and role of quality and safety reporting about clinical outcomes.

One undeniable element of the development of choice in tax-funded Northern European health systems, however, has been its trajectory. That trajectory has been inexorably toward more and increased choice for patients. The decidedly mild forms of patient choice that were introduced in the late 1980s and early 1990s – and were initially pilloried by labor and social democratic parties and other public system stalwarts as neo-liberal assaults on the core values of the welfare state (e.g. see Dahlgren, 1994) – have slowly but surely been augmented by increasingly wider options and alternatives, especially in primary care and home care services. Norway, in 2001, moved the majority of primary care doctors out of publicly run centers into private GP practices (Ringard *et al.*, 2013). Sweden, in 2005, began a process in which regional and county governments facilitated and paid for privately as well as publicly funded primary care providers – resulting in a rapid shift of >50% of all primary care visits from the public centers to the new private providers (Anell, 2011). England, in its hospital sector, began in 2006 to require that patients referred for elective procedures be given the name of at least one private as well as public hospitals to choose from (Boyle, 2011).

This trajectory toward increasing choice reflects a number of converging forces: growing economic wealth and the expectation to have more control over their own lives on the part of the middle classes; increasing information via internet about choice options in other European health systems, especially social health insurance systems on the continent; the rise of consumerism in other sectors of social services such as schools and also public transportation; and the growing influence of European Union policies that emphasize the need for publicly operated systems to either provide timely elective interventions or to fund patients to travel in or especially outside their country to receive care. All of these forces are beyond the control of the health planners and the elected politicians who have traditionally made decisions about how much choice will be acceptable and allowed. As a consequence, one could expect that, while the speed of movement may vary owing to national differences in organizational and institutional structures, the general direction of movement overall will be similar in direction and, eventually, result.

This continuing expansion of patient choice of provider is part of a broader health sector policy process that incorporates a substantially wider range of choice-related topics summarized in the broad concept of patient centeredness. The additional choice-related issues moving into the center of policy decision making in European systems include patient rights (privacy, right to review one's medical record), waiting time guarantees (one month in Denmark, six months in Sweden), citizen involvement in health system decision making, participation of patient advocacy and consumer organizations in policy making, patient involvement in clinical decision making, patient education and public reporting of outcomes data.

The Vrangbaek *et al.* (2012) article adds welcome understanding to this evolving policy process. It recognizes in its first sentence that patient (as against primary care physician) choice of hospital – which the article focusses on – was hardly present in tax-funded systems in the early 1980s, and that this form of choice has grown dramatically over the ensuing years. The article then postulates a conceptual framework to examine that expansion – a four-part logic developed by Christopher Pollitt (2002) – and then compares the development of hospital choice in the four countries the article has chosen to examine.

It is at this point, however, that the authors find themselves confronting a common difficulty in comparative research of any kind, and especially of health care systems in Europe. In a desire to broaden their reach, and thus strengthen the validity of their conclusions, the authors decided to include not only three tax-funded health systems in Northern Europe – Denmark, Sweden and England – but also the increasingly complex, market-oriented structure that has now evolved out from its traditional social health insurance system in the Netherlands. As a result, the article finds itself required to make exceptions for Dutch findings on choice-related issues, in effect muddying the results from its analysis.

It is also interesting that the authors restrict their analysis to only patient choice of the provider institution. One of the continuing oddities of the entire choice debate across tax-funded health systems for 30 years is its lack of focus on choice of attending physician inside the hospital, particularly for surgical or other higher-risk procedures. In the Nordic context, local politicians and citizens alike fall back on the belief that ‘all our physicians are (medically) qualified’, implying that there are no skill differences – or outcome differences – between junior and senior doctors, or between urban specialists who see hundreds of one type of case a year as against a rural specialist who might treat only a handful of those cases. This lack of focus on physician as well as provider institution is curious in that researchers in countries like Finland and Sweden have been for some time compiling data that demonstrates considerable inequalities of treatment and outcome dependent on where one lives, and in England concern about ‘post-code’ differences has long been part of the policy debate. Moreover, research has clearly demonstrated that higher-volume inpatient teams produce better clinical outcomes (Birkmeyer *et al.*, 2002) and the Ministry of Health in Sweden has for some years been seeking to consolidate certain specialized procedures in fewer hospitals so as to achieve those better clinical outcomes (Magnussen *et al.*, 2009). Further, in the less-intensive area of primary care, patient choice in all four studied countries now typically can include selection of the specific primary care physician.

A similar issue concerns patient participation in treatment decisions, especially where effective clinical options exist, for example, in type of surgery performed for either breast or prostate cancer. Although the rise of patient centeredness discussions suggests that this issue of patient involvement in clinical decision making will become more important in the future, its absence in the paper serves to make its research results more initial than conclusive in scope and in its implications for future policy making.

A further interesting point raised but not fully explored by the Vrangbaek paper is that patient choice of hospital appeared to encounter no political opposition (Vrangbaek *et al.*, 2012: 53, bottom). The authors noted that this was surprising, given that left of center political actors typically opposed the introduction of competition and market forces in the three studied tax-funded countries (again here the Netherlands is an obvious outlier among the four studied health systems). The authors argued, however, that ‘values like freedom, patient empowerment, etc.’ were common across the political spectrum in Denmark, Sweden and England.

One recent instance that tests this hypothesis, however, has been the actions of the Social Democratic-led minority government in Sweden that was elected in mid-September 2014. On taking office, the Social Democrats signed a written agreement with the former Swedish Communist Party (now called Vanster, or Left, party), committing the new government to ending all forms of competition, contracting and especially profit making in the entire health care sector. The Social Democratic regime also began the process of reversing the 2010 Vardval (care choice) legislation that mandated all 21 regions and county councils to fund private as well as public primary care providers.

Although the current Social Democratic-led coalition in Denmark has not sought to reduce existing patient choice options, nor has the British Labour Party adopted any clear position on rolling back existing choice options in England (many of those options, of course, put in place previously by the Blair-led Labour government), the Swedish experience suggests that the perceived broad acceptance of patient choice options in tax-funded health sectors may be as much about tactical politics as about firm philosophical commitment. The continual debate in England between those who favor additional structural reforms in NHS organization and management, as against those who appear to be committed to returning to not just bedrock principles of the 1948 Bevanite NHS, but to its structures and management practices as well, implies that political commitment on the left to choice in the English context may not be much stronger than it has now been shown to be in the newly hardline Swedish context.

These several concerns about the research presented in the Vrangbaek article are, however, not so much failings of that paper as indicative of the future work that still needs to be done on choice-related issues. The need for future research only adds weight to the argument in the introductory paragraph of this commentary that patient choice is a ‘red thread’ that ties together a wide range of health policy issues, and that will be part of the ongoing health sector debate – especially in a prolonged austerity policy world – for the foreseeable future.

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