

Quality and priorities in the health services

The provision of equal health services of high quality to all Norwegian citizens is a key political goal on which a broad political consensus has prevailed. Setting the right priorities is a tool to achieve this goal. In relation to this, the Norwegian Council for Quality Improvement and Priority Setting in Health Care was established in 2007.

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The ambitious goal to achieve equal health services for all has remained virtually unchanged since the establishment of public services started after World War II (1).

In 2009, health expenditure amounted to NOK 228 billion (2), a figure which places Norway among the countries that spend most on health per citizen (3). The recognition of this fact has given rise to political acceptance of – and a framework for – setting of priorities in the area of health services. One can also see a wider acceptance of priorities as a means to ensure allocation of resources to those areas where they are most needed. The two public reports *Lønning I* (4) and *Lønning II* (5) constitute key documents in this process, in which the principles for the setting of priorities were elaborated. These principles have also been incorporated into the Patients' Rights Act (6). Internationally as well, priority setting is being regarded as one of the key tools available for ensuring the political goal of equal health services (7).

Quality and priorities were given broad attention in the National Health Plan for the period 2007–2010 (8). In the plan, the incumbent government emphasised that these two topics should be regarded more in conjunction at the national level. A key way to achieve this would be to establish clear positions of responsibility and arenas for interaction in the health services. At the same time, it was acknowledged that few organisational meeting-places were available for those who hold responsibility for the health services. In addition, several of the agencies consulted had referred to the need for a new top-level agency to address issues related to quality and priorities.

Against this background, the Ministry of Health and Care Services decided to

establish a national council for quality and priorities. The council held its first meeting in April 2007. In this article we will describe the council and its work during its first mandate period (2007–2010), as well as some of the major challenges it has encountered.

The national council

The Norwegian Council for Quality Improvement and Priority Setting in Health Care can be regarded as a continuation of the previous Priorities Council, which existed in the period 2000–2006. In establishing the National Council, the Ministry of Health and Care Services set out a mandate (9). The mandate says, for example,

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that the council should be composed of leaders from enterprises responsible for the provision of health services, public administration and organisations for patients and users, as well as universities and university colleges.

The purpose of the establishment of the council was to highlight the roles and responsibilities of the various actors involved, improve interaction between the levels and promote openness. The council should have an advisory function in issues pertaining to quality and priorities in the health services, and it was pointed out that the council would be barred from issuing

instructions on how to follow up any recommendations.

At the same time, political authorities have repeatedly emphasised their expectation that the actors in the health services should follow up the decisions. We have previously described the council's form of work (10, 11). In association with the council, a separate secretariat was established in the Norwegian Knowledge Centre for the Health Services.

Cases processed

In the period 2007–2010 the council has consisted of 25 members. Bjørn-Inge Larsen, Director General of Health, has served and still serves as Chair of the council. The council members are appointed by the Ministry of Health and Care Services, with no deputies.

A total of 4–5 full-day meetings have been held annually (totalling 18 during the mandate period). Each year, the council has processed 9–13 major agenda items that have led to specific measures being taken, in the health administration or in the health services (11). In addition, the council has addressed a number of information items, the purpose of which has been to provide the council members with better insight into the manifold challenges encountered by the health services.

Figure 1 shows how the agenda items have been distributed among the two main topics, as well as items that could not immediately be categorised under these topics, for example cases concerning the council's internal procedures.

During the first years, the majority of cases were related to priorities, such as access to costly drugs, treatment of colorectal cancer and neonatal screening. In 2010, cases related to quality accounted for one-third of the total, such as how to achieve a good and equal treatment of patients suffering from rare diseases. It remains to be seen whether the tendency towards a better balance between the topics will continue.

During the first mandate period only the council members and the secretariat were entitled to submit cases for discussion. A recurring feature during the first years

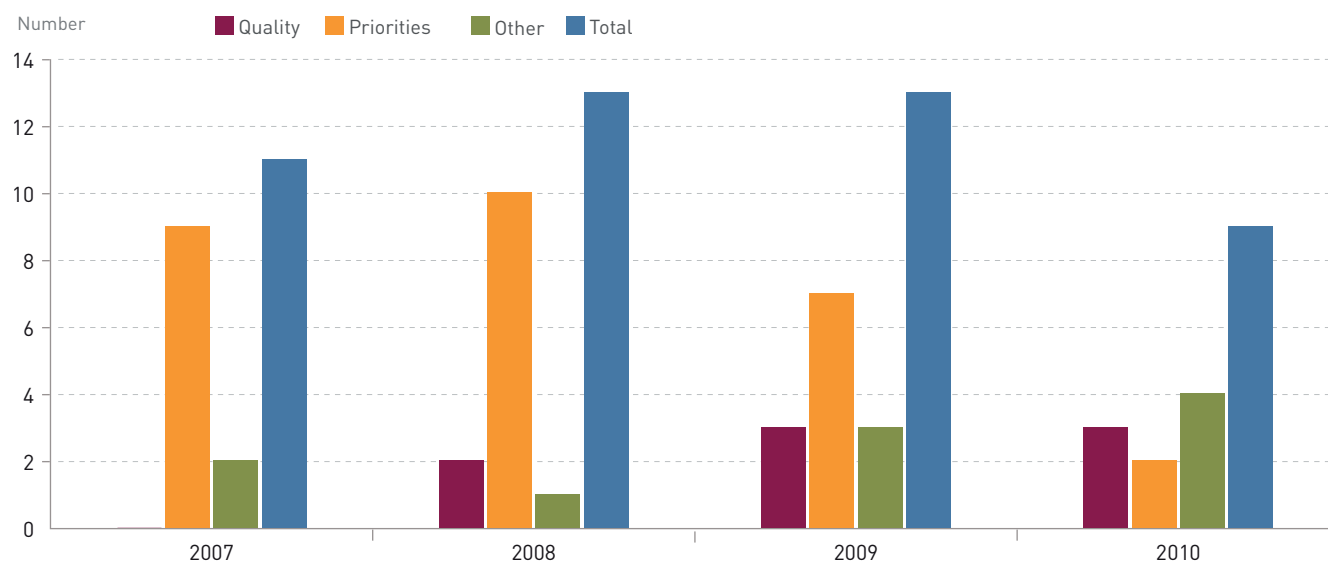


Figure 1: The number of cases debated by the Norwegian Council for Quality Improvement and Priority Setting in Health Care, by topics. During the first years the large majority of cases related to priorities, while in 2010 the distribution among the various topics had evened out.

was that proposals for cases were mainly submitted by the representatives of the central health administration and the regional health enterprises, in addition to the secretariat. This produced a preponderance of, and thereby also a focus of attention on, matters pertaining to the specialist health services. Towards the end of the period this was counterbalanced by several proposals from the service providers and the representatives of the user groups.

Looking at the cases that have attracted most attention during the first mandate period, we can emphasise the case concerning the inclusion of a vaccine against the human papillomavirus (HPV) in the national programme for vaccination of children. The council deliberated the matter in 2007–2008. The case is interesting in itself, while it also illustrates how the council works. Having elaborated a number of documents and held comprehensive discussions, the council issued a recommendation to introduce the vaccine. The Ministry of Health and Care Services followed the recommendation by allocating funds to the vaccine in the state budget for 2009. Vaccination commenced from the start of the school year 2009–2010. This case has been noticed as a good illustration of how “difficult” cases can result in good and legitimate decisions by basing the discussions on high-quality knowledge about all aspects of the problem, including ethics and organisational consequences for the health services (11).

Discussion

An evaluation of the council was undertaken in the spring of 2010. The purpose of the evaluation was to summarise the experience gained from the council’s activities, and compare this experience to the intentions behind its establishment (12).

The evaluation pointed out several challenges to the council’s activities, such as the biased distribution of the case volume among the various sectors of the health services. The council has processed relatively few cases from the municipal and primary healthcare services. We can see various reasons for this. One reason could be found in the weaker line of governance between the national health authorities and the various practitioners in the municipal health services. A concomitant weaker sense of organisational linkage than in the specialist health services may render it more difficult to submit cases from the municipal sector. In this context it has also emerged that for parts of the services, such as the GPs, there is only a limited national professional level. These challenges are not insurmountable, but ought to be kept in mind during the next mandate period.

During its first period, the council has made several decisions implying that costly forms of treatment have not been introduced – in spite of the fact that many patients could have benefited from them. Such decisions represent a particular challenge for those of the council’s members who represent the patients’ and users’ organisations. This notwithstanding, they have participated in the discussions on how the resources of the health services should be prioritised on an equal footing with the other council members, even in situations where a group of patients for whom they are responsible on a daily basis will not gain access to a given form of treatment. In many cases they have been able to give the other council members valuable insight into the patients’ viewpoint. Thus the user representatives have helped ensure unanimous and clear decisions in difficult cases.

In this context we also need to emphasise the health politicians, who are the recipients

of the council’s recommendations. So far, they have without exception chosen to listen to and support the implementation of the recommendations. This support has been totally decisive in ensuring that the work of the council could enjoy the necessary legitimacy in the health and care services, and will also continue to do so in coming periods.

Figure 1 shows that issues pertaining to service quality have not received sufficient attention among the cases discussed by the council. This could be because these issues can be addressed by the services themselves to a greater extent than matters related to priorities. However, the council should devote attention to national *systems* for quality management in all parts of the health services. To date, information on quality indicators, health registries and the correlation between treatment volumes and quality has been submitted for discussion in the council. The debate on these and related general challenges ought to continue during the coming period. Following up all the expectations presented in the National Health Plan (8) has represented another challenge, since the council has at all times depended on the nature of the cases submitted and their suitability for the council’s procedures (10).

During the period a number of parallel studies were initiated, without any direct involvement of the council, in areas where the council according to its mandate is assumed to have a role, for example with regard to topics such as national functions and highly specialised services. In the aftermath of these processes the council has been awarded a more pronounced role in following up such issues.

A new mandate

At the end of 2010, the Ministry of Health and Care Services decided to continue the

National Council, although with some amendments to its mandate. One important amendment is that the opportunity to submit cases for processing is no longer restricted to the members and the secretariat. This opportunity is now in principle available to everybody.

Whether the case will in turn be made subject to a discussion will still be decided by the members of the council.

The council's mandate has also been expanded (2011–2015) to include the care sector, which is reflected in the new name – The Norwegian Council for Quality Improvement and Priority Setting in Health and Care Services. With regard to cases pertaining to the introduction of new technologies, the council no longer needs to restrict its discussion to matters related to hospitals, but can address such issues within the entire field of responsibility for the health and care services.

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Conflicts of interest: None declared.

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is Director General of Health. He is trained as a medical doctor and has an MA in Business Administration and an MA in Public Health. He has been Head of the Directorate of Health since 2002, and has been Chair of the Norwegian Council for Quality Improvement and Priority Setting in Health Care since its establishment in 2007.

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