On crutches across the ice – why free choice is no solution to the healthcare queues

In reality, how efficient is free choice of provider in bringing down waiting times in Norwegian hospitals?

The Minister of Health has promoted free choice of provider as a key intervention to reduce healthcare waiting lists (1). I recently had the opportunity to test this assumption through personal experience and with reference to 20 years in Scotland, where health policy revolves around performance-managed integration rather than a healthcare market and competitive tendering. Free choice of provider is therefore less relevant.

A speedy, efficient, high-quality service

In autumn 2015 I went to my GP to obtain a referral for a bunion operation. The response to the referral from the orthopaedic department at my nearest public hospital came in a long letter with many references to legislation: as I was not considered «a priority under the Patient Rights Act, my anticipated waiting time for an assessment was a minimum of 5 years,» in other words forever. I changed my GP.

My new doctor referred me to a private provider with a contract with the Health Trust, and an appointment followed quickly, possibly because the referral was made under the «Faster Return to Work (FRW) scheme». Events followed ensued at the same welcome speed. A month later I walked into the operating theatre at 11.30 a.m. At 3 p.m. the same day I was sitting on my sofa at home eating chocolate cake.

A system based on personal resources

The next two months on crutches, living in a block of flats without a lift and with icy pavements outside, taught me this about free choice of providers: the service might be efficient for me personally, but it is not necessarily efficient at a societal level because not everybody has the resources to benefit from it.

I had to make sure somebody was with me the first night after the operation. «What if I were on my own?» I asked the pleasant nurse who fed me coffee and biscuits to help me come round from the anaesthetic. «They would not have been able to offer you a service» was the reply. Safely home, I wondered who was responsible for me if something went wrong in a Norway closed over the Christmas holidays? The private provider was closed. My surgeon was on holiday and even though I had a phone number, I had no information regarding what she could do in case of an emergency. My GP operated Christmas holiday opening times. A precautionary Google search reported an absence of any appointment system and four-hour waiting times at the accident and emergency department, that they have no access to patient records from other services, and that it is recommended I bring the relevant papers myself. It was thus an advantage to be fit and to have good support at home.

> «The service is least accessible to those who need it most»

The system of which my brilliant service was a part suddenly seemed less than user-friendly. I missed Scotland. There my GP would have been responsible for my follow-up even during holiday periods. In the event of an acute crisis, a member of an extended primary care team would have helped with advice and information, and if necessary arranged a hospital admission and ambulance. Outside surgery opening hours (8 a.m. to 6 p.m.) the emergency service is coordinated with the GP. A telephone call puts the patient in touch with somebody who can find the patient records electronically. Admission to hospital can be arranged without the patient having to attend for a consultation.

The time came for a two-month check-up. I needed X-rays from a private provider – an extra trip , in and out of a taxi, across icy pavements. I had to pay for the X-rays and take them along to the appointment myself. In Scotland an appointment with a specialist is coordinated with the X-ray department at the same hospital, under the same roof and on the same day. The X-rays are transferred electronically to the specialist immediately.

Free choice of provider and «the inverse care law»

«But just think of the short waiting times! You can't expect everything to be done for you!» my Norwegian friends say when I praise the brilliant service I received, but go on about the personal effort involved.

But is my service the answer to long waiting times, or is the need for private providers a sign that free choice as a solution has failed? Free choice follows competitive tendering, and from what I can see, services here are fragmented into small units governed by contracts and agreements that separately may very well deliver high quality, but as a whole appear inefficient and time-consuming. The result is the «inverse care law» (2): the service is least accessible to those who need it most.

So long as I am able I will manage with as little extra help as possible. But my resources now are used on myself alone and to increase the profit margin of a private provider, not to contribute to a whole package that releases options for those who are less fortunate. And one day I will be one of them – old, disabled, non-profitable – one of the many challenges that vulnerable groups with complex problems represent.

In Scotland, years of performance-managed collaboration across professional and organisational boundaries have produced an 18-week waiting time guarantee for a referral to a specialist hospital service (3). The services are provided by a small number of public and quality-assured services who work actively with GPs to ensure all referrals are relevant and that the pressure on the hospital sector is reduced. Integrated services provide follow-up for vulnerable patients outside of specialist care. Health resources remain in one public pot. The system is far from perfect and is now creaking under the recession. But if Scotland can (4), why can't Norway?

Postscript – another round?

The two-month check-up revealed that a small operation was needed to remove a pin. «Takes ten minutes,» said the surgeon and made an appointment there and then. But then a letter arrived telling me that the provider had lost the Faster Return to Work contract in the new year, and that the health trust does not cover pin removal for public health service patients. However, I was referred to another department which did have a contract, in the same provider chain. This department sent me a letter, again containing many references to legis-

lation: «This diagnosis unfortunately does not fall within our agreement regarding public cover for assessment/treatment. We recommend that you contact your GP.»

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