

Norwegian Patients in EU Hospitals The Medical Treatment Abroad Project

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AN INTRODUCTION TO NORWAY

Norway has a population of nearly 4.5 million inhabitants, living in a total land area of 386 958 km². This gives an average of about 12 persons per km² and makes Norway one of the most sparsely populated countries in Europe. Norway share common borders with Sweden, Finland and Russia.

Norway is a constitutional monarchy and is governed by a three-tiered parliamentary system. Each tier governed by a popularly-elected body: the national parliament (Stortinget), the county councils (fylkestinget) and the municipal councils (kommunestyret). The representatives of each council are elected by proportional representation for a four year period. For the time being Norway has 19 counties and 435 municipalities.

The division of duties and responsibilities among the abovementioned tiers of government, can be described as follows. The counties are responsible for hospitals, specialized outpatient care, pharmacies, cultural matters, secondary education, energy delivery and communication. The municipalities have the responsibility for health promotion, primary health care, care of the elderly, care of the handicapped and mentally handicapped, kindergarten and primary school education, social work (child protection and social protection), water, local cultur, local planning and local infrastructure. The central government has the responsibility for a few very specialized hospitals, for university and college education and research, for health and other registries, and for institutions like The National Insurance Administration, The National Institute of Public Health, The Norwegian Board of Health and of course for the various ministries.

AN INTRODUCTION TO THE NORWEGIAN HEALTH CARE SYSTEM

In the years following the Second World War Norway has developed what might be called a decentralized model of provision of welfare goods and services. There has been an ongoing process of devolution of central powers to local government, specially the municipalities. But as mentioned before have the hospitals been a responsibility for the counties. This will change from the 1. of January 2002, when the hospitals become a responsibility of the central government. There is 85 hospitals in Norway. These are widely spread across the country and they vary a lot when it comes to size and numbers of patients. The organizational structure of the Norwegian health care system is built on the principle of universality. This means that all inhabitants shall have the same access to services, independent of social status, location and income. The most important feature of the Norwegian health care system is the predominance of tax-financed public provision. The whole resident population of Norway is covered for needs and the financial burden for using health care services. As there is no premium- based financing, there is only a small connection (limited to out- of- pocket payments) between individual health risks and costs. Because of this system of financing, voluntary health insurance has not, until recently, been a relevant alternative. There has recently been som attempts to provide complementary health insurance, specially targeting the patients who would like to avoid waiting for hospital treatment. These attempts have at least so far not been very successful. But there has been an increasing tendency for the establishment of private health care centres in the urban centres of Norway, with membership applications which can be considered a type of health insurance. Medical technology has increased possibilities for treating diseases in outpatient care and, as a result, some private health care suppliers benefit from both waiting-lists and the increasing demand for general and specialized services. The most urgent problem facing the health care system in the past decade has been the insufficient ability of both general and psychiatric hospitals to absorb patient inflows. Long waiting-lists for non-emergency treatment are considered unacceptable both by patients, politicians and health authorities. A number of reforms and means to handle this problem have been and are being implemented,

both legislation, changes in the financial system, and now by the purchase of medical treatment abroad.

THE MEDICAL TREATMENT ABROAD PROJECT

Background

The Norwegian Parliament granted on the 14. of November 2000 one billion Norwegian kroner for the purchase of medical treatment abroad. The decision was a compromise based on a original proposal of changes to the national budget from the right-wing Progressive Party. Amongst these changes was a proposal of granting 3 billions norske kroner for purchasing medical treatment abroad and creating a new central office to administrate the arrangement. The final decision ended with the granting of one billion kroner and the responsibility for organizing and administrating the arrangement where given to the National Insurance Administration (NIA). NIA chose to organize this as a project: The Medical Treatment Abroad Project (MTAP). From the 15. of January 2001 MTAP has had the responsibility for implementing this new arrangement.

Organization

The patients treated abroad are selected by the hospital where the patient is waiting for treatment. This arrangement of treatment abroad gives the hospitals means to handle their waiting-lists and an alternative to building up waiting-lists for treatment. The local Norwegian hospitals are responsible for the selection of patients and for asking whether the patients are willing to travel abroad. The hospitals are also responsible for sending the medical documetation regarding the patients to be treated abroad to the MTAP. MTAP communicate with the foreign hospitals and organise the travel for the patients.

It is important to emphasize that this arrangement don't represent a judicial right for Norwegian patients to be treated abroad or a free choice of hospitals abroad. This might be a perspective for the future, but it is not the current situation.

It is fair to say that this project and this means of handling the waiting-lists created some debate in Norwegian hospitals and amongst various physicians. Some physicians argued that considerable larger number of patients could have been treated in Norwegian hospitals if they where given the grant. To this it can be noted that the grants for Norwegian hospitals have been increased year by year. When the Parliament granted this billion it was under the condition that the money only could be spent abroad. The reason for this was that the majority of the Parliament did not want to worsen the balance of the national budget, and maybe create an increase in prices and wages and then again worsen Norways competitive situation. The grant then actually both had an macro-economic background and a medical one.

From physicians there where also argued that the treatment of Norwegian patients abroad would lead to an increase in the import of antibiotica-resistant bacterias, and then again lead to an increase in the need for isolation-capacity for patients in Norwegian hospitals. According to Norwegian legislation every person admitted to a Norwegian hospital within tree months after he/she has been hospitalized in a country outside Scandinavia should be kept isolated until the patient has been tested for antibiotica-resistant bacterias. To avoid the need for building up new isolation-capacity in Norwegian hospitals, MTAP set up a special surveillance and research program, aimed to test patients treated outside Scandinavia, before they leave, and after they come back from abroad. In this way we will know right away if a patient is infected and need to be isolated. This program has been important to maintain legitimacy for the MTAP amongst physicians.

After the news about this decision started spreading throughout the world both the The Ministry of Social and Health Affairs, and the National Insurance Administration started to receive offers from all over Europe to treat Norwegian patients. There were even offers from the United States and from Asia. Relatively short time after the decision in the Parliament, the Ministry of Social and Health Affairs made a temporarily agreement with a the german consortium of hospitals called Germedic GmbH. This to get started with treating patients while NIA made the MTAP operational. The responsibility for negotiating with foreign hospitals lies today formally at the NIA and the MTAP.

According to the EEA (and EU) regulations NIA did not need to invite for a tender for the purchase of these services. NIA made a restricted enquiry which out-lined our demands both regarding services offered and quality criterias. This enquiry was sent to about 20 of the hospitals/consortiums of hospitals that had made their interest known, also including a few hospitals recommended by Norwegian physicians.

Based on this enquiry MTAP received about 20 possible offers to treat Norwegian patients, mainly from Scandinavia and Northern-Germany. A panel of medical advisers went through all the medical documentation in the offers, including medical quality criteria and infection- and complication-rates, and on the basis of this recommended hospitals for a contract. Internal expertise in MTAP considered the prices and judicial sides of the individual offers. After an over-all consideration, negotiations were started. These ended with a visit/inspection in each hospital, before a contract where reached. In mid- November 2001 NIA and MTAP have contracts with about 15 hospitals in Sweden, Denmark, Germany and France. The Norwegian hospitals main concern, regarding the choice of foreign hospitals, were of course first and foremost the medical quality, but also that the countries and hospitals chosen should not have a tradition of treatment to unlike the Norwegian. This obviously would give an advantage to our neighbour-countries in Scandinavia, which of course already have an advantage when it comes to language.

MTAP had by mid- November received about 4000 patients for treatment abroad. This within a broad range of diagnosis. Hopefully we'll be able to offer treatment abroad to about 5500 patients this year.

Experiences

This project was decided on very quickly without any foregoing analysis regarding possible reasons for the long waiting-lists, and without any discussion in the health care system. The attitude and willingness in Norwegian hospitals to use this project were very limited in the beginning, and the project has been working continuously this year to try to motivate the Norwegian hospitals to use this opportunity. There has obviously been a reluctance amongst the physicians in the Norwegian hospitals against using this project. The reasons for this have been many. It was argued, as mentioned before, that a larger number of patients could have been treated in Norway, if the grant was spent in Norway. There have also been several discussions regarding the waiting-lists and whether the length of them represent a problem. It has been argued that the waiting-lists is a tool for the hospitals and physicians to plan the activity in the future.

This project represent a new challenge for the Norwegian hospitals and their owners. Strategic management has to be used to implement this project properly. It has been a lack in both the willingness and the capability to use the necessary strategic management in the hospitals and amongst the owners to implement this project properly. The problems in implementing this arrangement also symbolize the complexity concerned with leadership in hospitals. The organizational characteristics of hospitals as large and fragmented organizations dominated by various professions make them difficult to lead. The project have

been missing a greater capability specially amongst the hospitalowners to use this project strategically to reduce their waiting-lists.

The patients treated abroad have so far been very satisfied with the received treatment. It is of course a special situation for many to travel abroad to receive treatment, and some feel a bit uncertain. The patients main concern in this regard have been the travel arrangements and possible language problems. Nobody has questioned the quality of the medical treatment in the countries chosen for this project.

FUTURE STEPS

We consider this first year of The Medical Treatment Abroad Project as a learning period. For the next year and the future in general we must initiate a debate of priorities. What kind of diseases/diagnosis should have the first priority for treatment abroad?

So far MTAP has coordinated the contact between the domestic hospitals and the hospitals abroad. For the future we will try to initiate more direct relations between the domestic hospitals and the hospitals abroad. A stronger direct relation between the hospitals responsible for treating a patient will ensure a better medical outcome for the patients. In addition will this represent an opportunity for physicians in different countries to cooperate and exchange knowledge.

The project will be evaluated and documented by Norwegian scientific institutions. The results from this evaluation will be available in the summer of 2002. But already now can secondary effects from the project be noticed. The project creates a kind of pseudo-competition for the Norwegian hospitals which stimulates to greater effectiveness. This project also creates a opportunity for the hospitals to investigate their waiting-lists, and make sure that the patients on them are relevant for treatment.

REFERENCES

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