Summary

This report examines whether it is possible to control physicians' behavior through political decisions. Specifically, this is done by studying how Swedish orthopedic doctors acted in relation to the implementation of a specific reform – the waiting-time guarantee. The reform, which was an agreement between the Swedish Association of Local Authorities and Regions, SALAR (formerly the Federation of County Councils) and the state, was introduced in the healthcare system in 2005. For specialist care, the guarantee states that a determined treatment shall be offered within 90 days and shall include all forms of planned care at the specialist level. If the patient cannot be offered treatment within the set time limits, the patient shall be offered treatment with other caregivers in their home county or in another county. Statistics on waiting times show that many counties still do not fully meet the guarantee deadlines, suggesting that the implementation of the reform has not been completely successful.

From a management perspective, the national waiting-time guarantee is particularly interesting to examine since it, in some respects, seems to stand in opposition to medical logic. The guarantee aims to put greater pressure on healthcare providers to shorten wait lists, but also questions the usual procedures that doctors use to determine when patients should be treated.

Never before has the state intervened and regulated the timeframe within which a treatment should be performed in such a conspicuous manner - this has traditionally been regarded as the medical profession's domain. The waiting-time guarantee has been criticized by individual physicians as they believe that it breaches the parliament's priority guidelines. These physicians assert, for example, that younger patients with less severe symptoms are prioritized before the elderly, the chronically ill and more severely ill patients, which is contrary to the profession's views on how

healthcare should be planned and conducted. This clearly illustrates the difficult conflicts that may result when the state chooses to legislate or regulate areas of healthcare, while at the same time trying to maintain a relatively autonomous medical profession with expertise and the ability to make independent decisions.

By studying the role of doctors in the implementation of a political reform, in this case the waiting-time guarantee, the actor in the end of the management chain is highlighted. The doctors are likely to play a key role in taking action to implement the reform, for example by informing patients about the guarantee and current waiting times for different treatments. The empirically interesting question examined in this study is how the doctors themselves view their responsibility to comply with the guarantee and what they do to enforce it.

Methods of the study

The waiting-time guarantee includes both primary care and specialist care. In our report, however, the focus is restricted to care from specialists. It is mainly this part of the guarantee that affects the individual doctors in their professional lives, and therefore the part that is most important to focus on for a study that deals with the governance of the medical profession.

There are few scientific studies that describe how individual physicians respond to political management and there are no comprehensive studies examining the role of doctors in the implementation of the current waiting-time guarantee. The central part of the report is therefore based on a survey, the purpose of which was to gather broad empirical data on physicians' behavior in terms of a specific reform, the health care guarantee. The questionnaire was distributed to 985 orthopedic doctors across the country between January and April 2010. A total of 566 of the questionnaires sent out were returned, and of these 45 had a valid non-response, such as those from doctors who have retired or who are no longer working with patient-related activities. The final response rate was thus 55.4 percent, which is currently the response rate that can be expected of questionnaires sent directly to healthcare professionals.

The questions in the survey were largely concerned with the orthopedic doctors' role in the implementation of waiting-time

guarantee, their means to meet it, its impact on the physicians' work situation and clinical autonomy, as well as the physician's knowledge about the regulations of the guarantee. The answers to the survey questions were then analyzed and described in detail in the result section of the report.

Orthopedics as a specialty was chosen for the study. This was mainly because it is a specialty for which the waiting-time guarantee is well-suited. Orthopedics is composed largely of "well-defined, planned single actions" where it is fairly easy to determine whether or not the care guarantee applies for an individual patient. In other specialties, such as internal medicine or psychiatry, patients often have multiple illnesses with multiple diagnoses that are not as easily classified in terms of the guarantee. Orthopedics is therefore, compared with many other specialty fields, an area with favorable conditions for the successful implementation of the reform. If the implementation does not work within the specialty field of orthopedics, it is likely that it works even less-effectively within other specialties with less favorable conditions. The case selection is thus a so-called "most likely case" (Esaiasson et al 2007).

The doctors' role in meeting the waiting-time guarantee

The first step towards finding out how physicians relate to political governance, in the case of waiting-time guarantee, involved studying the policy documents and what they require regarding the physicians' role in implementing the guarantee. A summary of the analysis indicates that the original national policy document does not clearly express what role doctors should play in the implementation of the reform. The document gives an indication that healthcare personnel, in general, shall be responsible for informing the patient about waiting times and the possibility of invoking the guarantee. It focuses on the role of the county council and its responsibility to meet waiting-time guarantee deadlines. However, a closer examination of several counties' local guidelines for the guarantee revealed that they did not specify exactly what role doctors should play in the implementation of the reform either. Instead, counties generally have a global policy paper which stresses that all healthcare professionals have a general responsibility to inform patients of their rights, for example those

regarding the right to use the guarantee and to choose healthcare providers.

Newer documents at the national level, including the government's bill on a statutory health care guarantee (Prop. 2009/10: 67) and SALARS's action plan for waiting-time guarantee, have proven to be more explicit about the role healthcare professionals, including doctors, will have to contribute to the actualization of the guarantee. The documents emphasize the responsibility of the healthcare staff to provide personalized information on the waiting-time guarantee when meeting with patients. If this had an impact in practice has so far been unclear, i.e. have doctors really taken on the role of advising patients about the possibility of invoking the guarantee? Some evaluations of the reform suggest that this is not the case and that doctors, for example, do not inform patients about the waiting-time guarantee as much as is desirable.

In this study, we have argued that doctors should play a key role, particularly in informing the patient of the waiting-time guarantee and supporting the patient in choosing other caregivers should their own department be unable to meet the deadline. Other professions can take on that role and currently do work as patients' "guides", but because doctors are primary responsible for a patient's treatment, it should naturally also be their duty to provide information about the guarantee. This is because knowledge of waiting times and the ability of other healthcare providers to provide a specific treatment is ultimately an integrated part of the medical profession's domain. For instance, discussing the medical consequences if a patient chooses to wait at their home clinic instead of using the guarantee is an issue that, in most cases, is best discussed with their doctor.

Prerequisites for doctors to conduct the reform – ability, understanding, desire

Implementation research indicates that three important conditions are necessary for those who act furthest out in the management chain, in this case doctors, to implement a reform and play the role which the political management requires. The first condition is that the executors must have the "ability" to implement the reform, which is based on the surrounding organizational context being

favorable with respect to for example resources and time. The second condition, "understanding", means that executors of the reform should understand the reform’s objectives and its regulatory framework in order to take the necessary measures with regards to the implementation. The third condition, "desire", means that the executors must desire to implement the reform, which to a large extent depends on their attitude towards the reform and how they perceive that it affects their work situation.

In this case the county councils’ political management and organization particularly affects physicians’ ability to implement the reform. For example, the county can prevent doctors from providing information on the waiting-time guarantee or referring patients to other health care providers/counties as this may cause additional costs. Other organizational constraints can include counties not providing enough resources, for example, financial resources, equipment, facilities or necessary working hours for physicians to increase access in healthcare and thus help patients to receive care within the time limits. One of the report’s questions is whether the doctors feel that the organizational framework of the county is good enough for physicians to help patients utilize the guarantee or provide patients with treatment within the time limits.

It is equally important that physicians understand the waiting-time guarantee deadlines and which regulations apply to the reform. If the doctors do not know enough about this, it is likely that it affects their willingness to inform patients about the treatment guarantee and to otherwise promote its implementation. The county council may have conveyed information to healthcare personnel concerning the reform’s regulations; however, this cannot be taken as evidence that the doctors actually acquired the knowledge needed. Thus, they may still be unable to enable patient usage of the guarantee. At a first glance, the reform’s framework is considered to be clear and relatively easy to follow and communicate. However, a closer look at the current design reveals a number of exceptions from time limits. Among other things, there is a lack of information about examination methods such as laboratory tests and X-rays, which can lead to a lack of clarity regarding the regulatory framework for the doctors. A second important question of this report is whether doctors have sufficient knowledge to be able to convey information and help the patient to use the guarantee.

In this context, it is also central that intentions of the reform and the methods for achieving these goals are consistent with the physicians' professional opinion on how the operation should be run. Otherwise, there is an imminent risk that they will neither desire to implement the reform, nor work towards it in practice. Waiting-time guarantee can involve a number of concrete changes in how the medical community must conduct its efforts for the reform to be carried out. First, the health care guarantee means that doctors are no longer free to determine when a patient should be treated, unless there are specific medical reasons. The doctors' clinical autonomy, i.e. the right to plan a patient's treatment plan, can therefore be perceived, by the doctors, as being at risk since the guarantee exactly stipulates the time limit within which the patient shall be treated and hence restricts the opportunity to prioritize patients according to standard methods. Second, doctors' possibilities to mainly determine their own working conditions can be affected. The demands for increased accessibility may lead to more scheduling of working hours and less freedom for doctors in planning their own schedules. Furthermore, it is likely that the new demands placed on the physician as a result of the reform may mean more time-consuming tasks for doctors, for example because of the greater need to inform and be even more service-oriented towards the patient. Given this reasoning, the last question in the report is therefore the extent to which physicians perceive that the waiting-time guarantee impinges on their working conditions and clinical autonomy.

Results and conclusions

One question raised by the report was whether the orthopedic doctors believe they have a responsibility to implement the waiting-time guarantee, and also if they inform and support the patient's use of the guarantee. The results show that the orthopedic doctors have very different views concerning their responsibilities to implement the guarantee and that they also act in different ways to help patients use the guarantee. Many, but not all, are in favor of the reform, yet, a majority believes that it is not their role to implement it. The exception is a small, distinct group, which believes that their professional role includes a clear responsibility to realize the patient's guarantee, by being a patient's "guide" in the

system. A possible explanation for why the vast majority still do not believe they have a role to play in the achievement of waiting-time guarantee may be the vagueness of the political management concerning the reform. It is not obvious that individual doctors will voluntarily take on new tasks if no one in a leadership position for the operation proclaims that doctors have this responsibility.

When it comes to orthopedic doctors' actual conduct in providing individualized information to patients concerning the guarantee, results show a partially mixed picture. Some doctors almost always inform patients of the reform. Most often, however, the information is 'conditional', i.e. special circumstances must be met in order for doctors to actively inform about the guarantee when meeting with the patient. Examples of this include if the patient requests information or if the waiting time at the clinic is long. Most doctors, however, are far more active in informing patients about the queue situation at the clinic, which should have laid a foundation for doctors to also play a more active role in informing of the guarantee and how to utilize it.

The study also investigated whether orthopedic doctors feel that the organizational conditions are sufficiently favorable to have the "ability" to implement the reform. The results of the survey show that the majority of orthopedic doctors believe the lack of operating rooms and hospital beds are key barriers to meeting the waiting-time guarantee. However, they do not feel that the county councils have imposed any restrictions regarding the possibility to refer patients to other healthcare providers, suggesting that they still have the ability to channel patients through to clinics with shorter waiting times in order to meet the guarantee deadlines. The lack of information from the county council also proved to be an organizational obstacle for physicians to implement the reform. Many physicians perceive that few county, hospital and clinic managements have implemented information campaigns about the healthcare reform aimed towards the medical staff, which may have influenced their understanding of reform and the role they will play in the actual implementation.

The lack of targeted information campaigns, however, does not seem to have affected the orthopedic doctors' evaluation of their own knowledge of the waiting-time guarantee regulations. Most believe that their knowledge of the guarantee principles is good. This view is reinforced by the answers to the specific knowledge-based questions about the guarantee that are asked in the

questionnaire, which test physicians' general knowledge of the regulatory framework. However, detailed knowledge of the reform, such as what waiting times other clinics have, seems less good. The prerequisite "understand" is thus only met to a certain degree. Whether this is a genuine obstacle for the doctors in informing and helping patients use waiting-time guarantee is not clear from the responses to the questionnaire. This possibly means a more difficult discussion regarding alternative healthcare providers should a patient choose to invoke the guarantee.

A theoretical assumption in the report was that the doctors may be less "willing" to implement a reform if it restricts their working conditions and clinical autonomy, i.e. the physicians' ability to freely control their own working conditions and the treatment plan that they formulate in their meetings with patients. The results show that most orthopedic doctors agree that the waiting-time guarantee has increased the administrative work. At the same time, there are divided views on whether the reform takes time from other duties or not. The fact that many doctors still say that the guarantee has increased the administrative work, suggests that their working conditions have, to some degree, been negatively affected by the reform. The results also show that the care guarantee reform has encroached on the orthopedic doctors' clinical autonomy. Many doctors, but not all, feel that the guarantee's deadlines are too inflexible, suggesting that physicians in some cases had wanted to make other judgments on when the patient should be treated. Because the guarantee limits physicians' clinical autonomy, is also evident from many respondents' perception that the guarantee results in incorrect prioritizing of care. They say that especially younger, well-educated and less ill patients are prioritized over the elderly and chronically ill patients. This could be interpreted to mean that some doctors believe that the waiting-time guarantee forces them to depart from the essential and ethical principle of need of care, which, if this is the case, can be considered to clearly interfere with their clinical autonomy.

One possible interpretation of these results, i.e. that orthopedic doctors perceive that the waiting-time guarantee impinges on their working conditions and the clinical autonomy, could naturally in the long run mean that they are less willing to engage in reform implementation, thus taking a less active role in implementing the reform.

Practical and theoretical implications of the study

This study, has argued that doctors play a key role in ensuring that patients are able to use the waiting-time guarantee, for example by informing the patient of the right in itself and by supporting patients in their decision to possibly choose another care provider. Today the reform seems to be based on the patient himself taking an active responsibility to activate the guarantee. In several parts of the country, patients are expected to call the waiting-time guarantee registry (vårdgarantikansli) or the clinics themselves to influence their position in the queue or to be passed on to other care providers. But the question is whether this is an appropriate procedure? Should it not be a natural part of the first meeting with a doctor to raise the possibility of utilizing a possible guarantee, when the decision on treatment has been made?

The fact that a relatively large proportion of orthopedic doctors do not routinely provide information on the guarantee can possibly be traced to the state's and counties' management with regards to the implementation. The examination of key policy documents indicates that up until this point, neither the state nor counties have been very clear concerning what role doctors and other health professionals should play in the implementation of the reform. If the politicians are truly serious about the waiting-time guarantee, however, the public policy makers should make clear who is responsible for what in the various management points. This is also confirmed by the results of the study, which show that it actually does matter how the counties tried to control waiting-time guarantee work. The survey responses revealed that some doctors felt that people higher up in the management chain had clear demands in terms of accessibility work. Furthermore, they felt that the issue of short queues has become an ever-present discussion at the clinic - which in itself led to a better adherence to the reform's intentions.

What clearly emerged from the study is that many doctors believe that the medical priorities of different groups of patients were adversely affected by the waiting-time guarantee. The doctors consider it to be wrong in principle that younger, healthier and more demanding patients receive faster care at the expense of other patient groups. The fact that certain groups are pushed out is, according to doctors, not compatible with the needs principle which is the cornerstone of Swedish healthcare. A question one

might then ask is why doctors accept these circumstances and why so many ignore their own role in helping the weaker groups of patients to use the guarantee?

Finally, both researchers and policy makers have argued that, unlike for many other professions such as teachers and social workers, it is difficult or nearly impossible to control physicians' behavior through policy directives. An interesting question is whether this study has confirmed the assumption, or if it, on the contrary, suggests that the medical profession actually is responsive to political directions?

This study shows that some of the surveyed doctors are working in line with the healthcare reform's intentions, although, in many respects, it challenges the medical profession's traditional autonomy. For example, a small but distinct group of orthopedic surgeons routinely inform patients about how they should proceed to use the guarantee and about the current waiting times. There is, however, also a large group of orthopedic doctors who do not regularly take on this role and who do not understand that they have an important part to play in the implementation of the guarantee. Together, these results show that the view of the reform is very heterogeneous within the orthopedic group, which means that the management will have to think carefully about what type of action should be taken if they wish - and think it is important - that doctors participate in the implementation of the waiting-time guarantee. It is likely that the implementation process needs to be structured in a completely different way than what has previously been done. The key to a successful reform implementation includes communication with healthcare professionals to discuss and question the reform's purpose and contents, and to clarify each staff group's role in implementing the reform. Politicians must also continue discussing the design of the reform and whether or not it truly meets its objectives. This discussion is especially important since a key finding in this study is that many orthopedic doctors consider the waiting-time guarantee to be very problematic because they feel it contributes to prioritizing the wrong patient groups.