Hur påverkar systemskiftet tillgången till vård och resultaten av vårdens insatser?

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Utmaningar och reformer

Utmaningar

- Ökad andel äldre i befolkningen
  - fler med multisjuklighet
  - behov av integrerad vård
- Ökad ojämlikhet i hälsa
  - geografiska skillnader
  - socioekonomiska skillnader
- Levnadsvanors betydelse för hälsa – behov av hälsofrämjande och förebyggande arbete
- Brist på vissa yrkesgrupper i vården

Reformer, utveckling

- Ökad marknadsorientering och konkurrens i vården
- Valfrihetsreformer
  - primärvård
  - specialistsjukvård
  - äldreomsorg
- Ökat antal privata utförare
- Privata sjukförsäkringar ökar
- Betoning på öppenvård
- Färre vårdplatser
- Färre särskilda boenden för äldre
- Inget områdesansvar för befolkningens hälsa i primärvården
- Ersättningssystemens effekter (?)
  - kapitering (ev. viktning)
  - besöksersättning

Vad innebär vård på lika villkor?

- Samma vård för alla? Mer vård åt vissa?
- Horisontell och vertikal aspekt
  - likar ska behandlas lika
  - graden av behov ska styra prioritering
  - större behov framför mindre behov

- Vad är ”behov”?
- Hur mäter vi ”behov”?

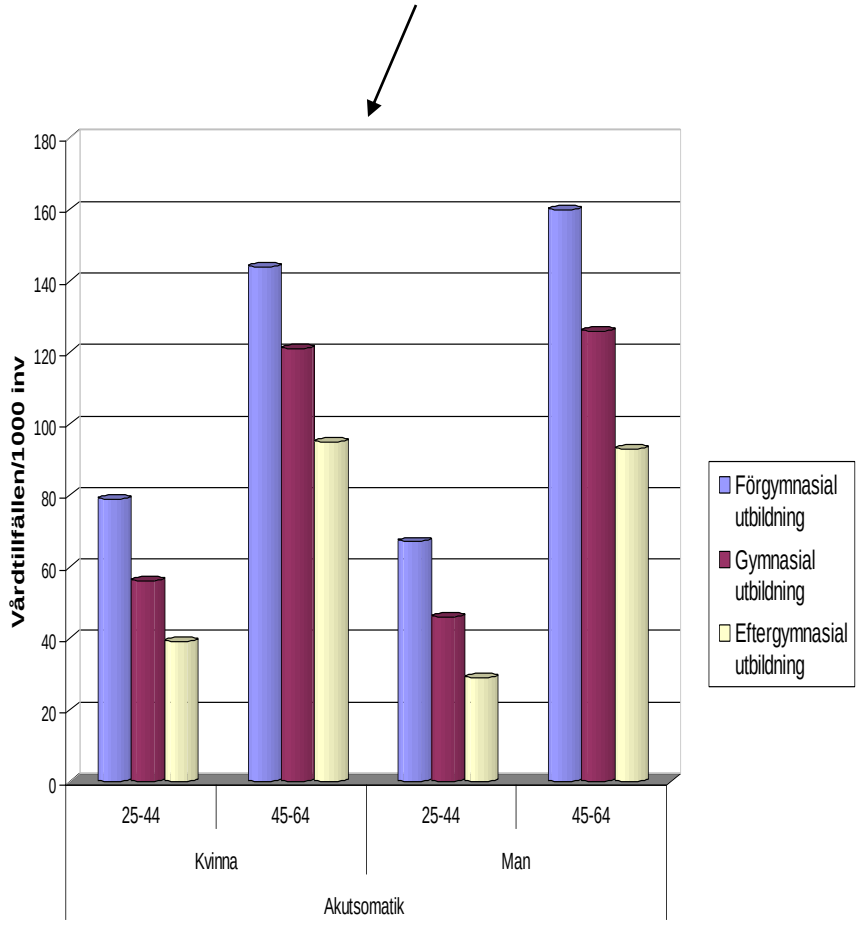
Indikatorer på behov

- Sjuklighet
  - registrerade diagnoser
  - multisjuklighet
- Hälsotillstånd
  - självskattad hälsa
  - EQ-5D index
- Sammansatta index (baserade på vissa registrerade diagnoser)

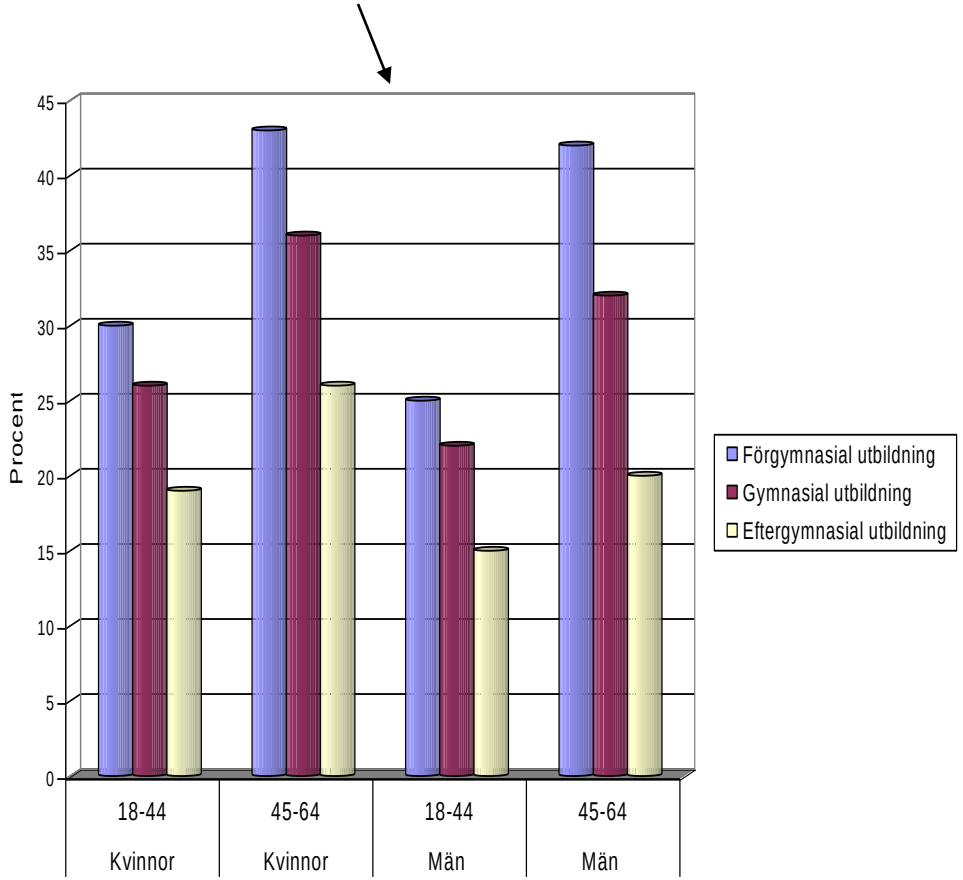
- Viktigt att ta hänsyn till behov vid analyser av vårdkonsumtion!

(Förväntade gradienter efter ålder, kön, socioekonomisk grupp)

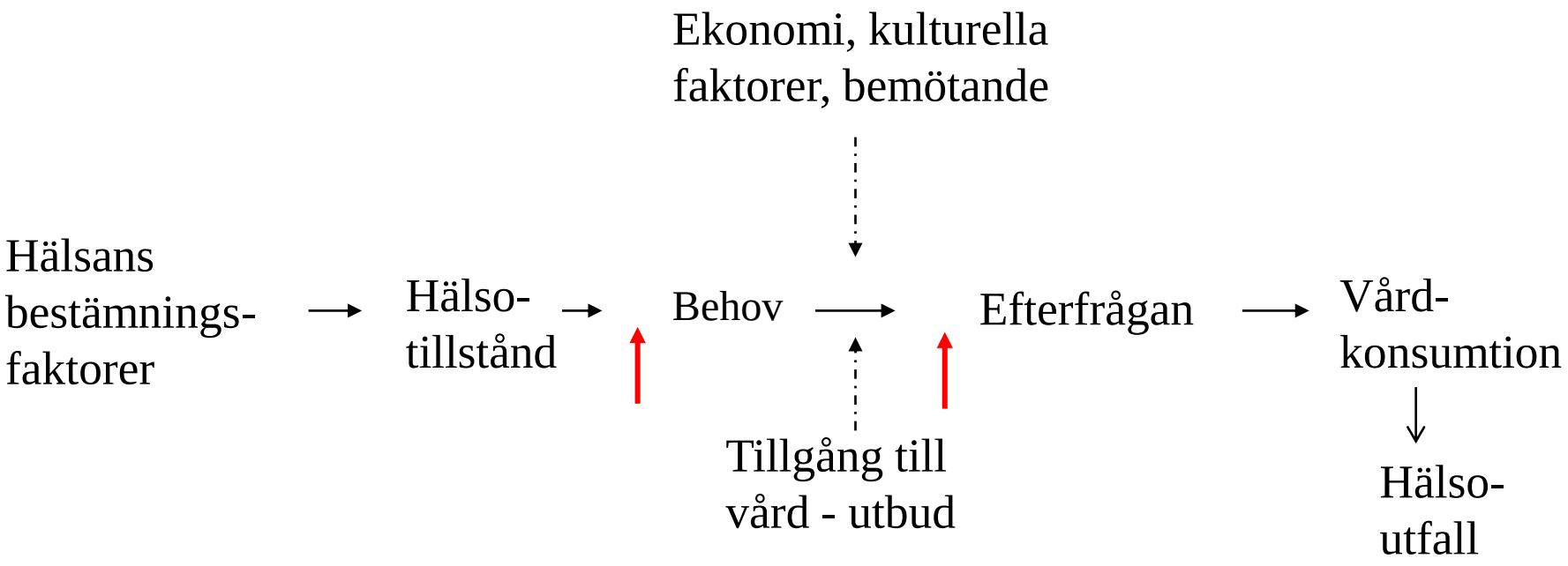
Vårdutnyttjande



Ohälsa



Sjukvårdens uppgift och ”vård på lika villkor”



Burström, 2009

Skillnader i hälsa och behov av vård mellan geografiska områden

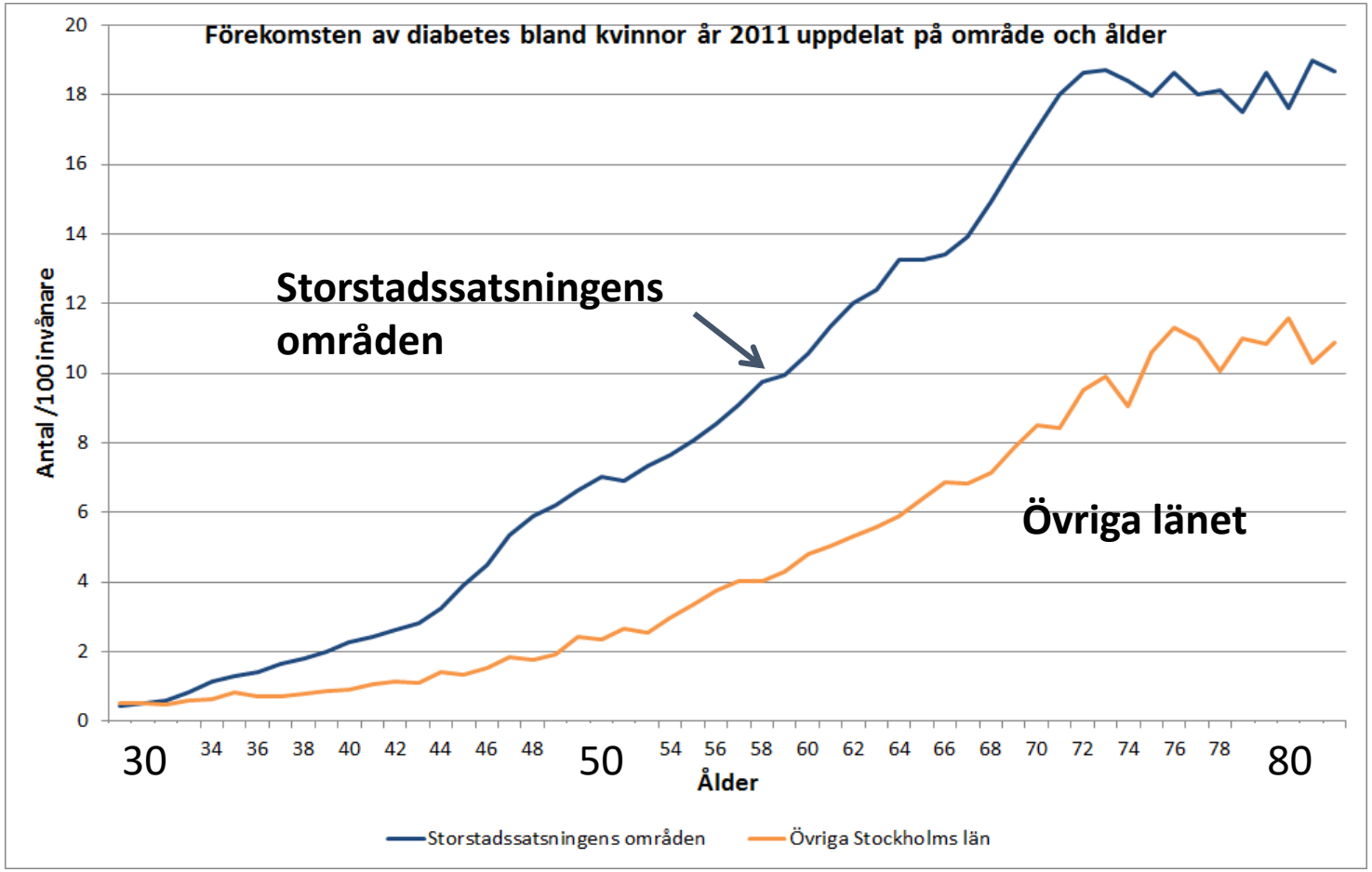
- Beror framför allt på skillnader i befolknings-sammansättning avseende socioekonomiska faktorer (utbildningsnivå, sysselsättning, inkomst)

- Områdets karaktär (fysisk och social miljö) kan också bidra, t.ex
  - Trygghet
  - Tillgång till grönområden, mötesplatser
  - Service, kommunikationer

Sämre hälsa i utsatta områden (Storstadssatsningen)

- Sämre förutsättningar
  - livsvillkor (arbetslöshet, ekonomi)
  - levnadsvanor (rökning, stillasittande)
- Sämre självrapporterad hälsa, mer sjuklighet
- Högre sjuklighet i folksjukdomar
  - tidigare ålder för insjuknande
  - större sjukdomsbörda
- Större behov av hälso- och sjukvård

Diabetesförekomst efter ålder, kvinnor 2011. Storstadssatsningens områden och övriga Stockholms län



Olika mått på behov av vård vid resursfördelning

- Besöksersättning
- Kapitering (listningsersättning)

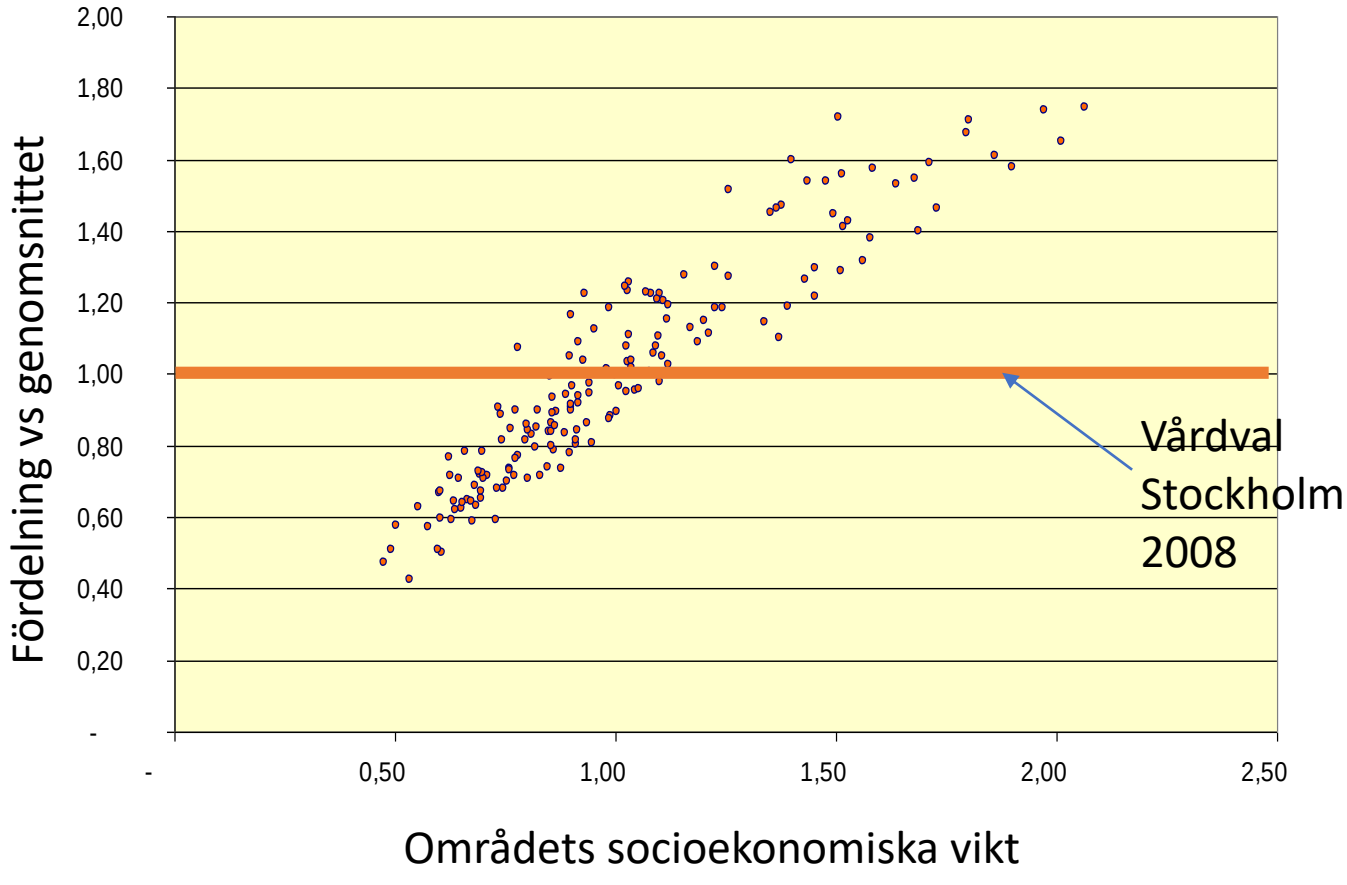
  - viktad efter socioekonomi och demografiska faktorer (Care Need Index, CNI)

  - viktad efter sjuklighet (Adjusted Clinical Groups, ACG)

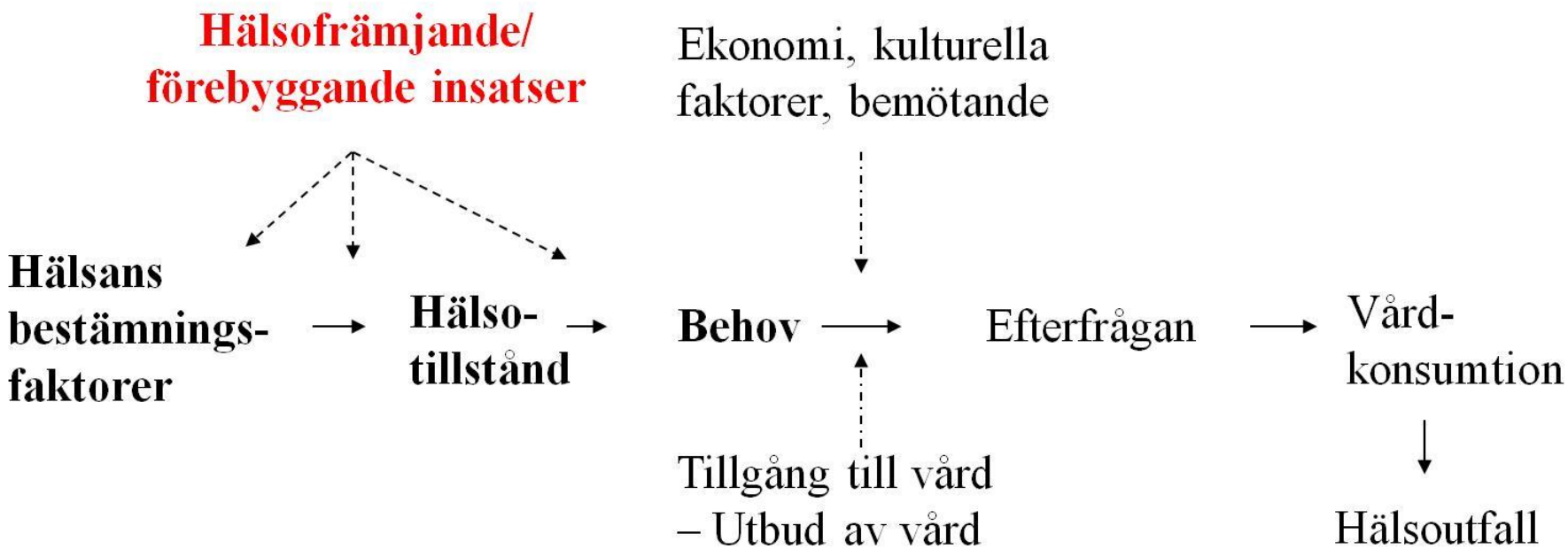
- Hur hanteras ”unmet needs” – att ha behövt men inte sökt vård?

Behovsbaserad resursfördelning – sammanvägning av ålder och områdets socioekonomiska vikt

- Före Vårdval Stockholm: behovsbaserad spridning i resurser mellan mottagningar, enligt områdets socioekonomiska vikt.
- Vårdval Stockholm 2008: ingen socioekonomisk viktning, ”lika villkor för vårdgivare”. Ingen skillnad mellan områden. Besöksersättning.
- Sedan 2016 ökning och viss viktning av kapiteringsersättning enligt CNI och ACG, men inte i paritet med skillnader i behov.



Hälsofrämjande/förebyggande insatser



Exempel på studier av effekter av Vårdvalsreformen

Vårdval Stockholm – effekter på besök (2015)

- Ökning av antal besök
- Mindre ökning bland de med kronisk sjukdom och sämre hälsa
- Mindre ökning i utsatta områden
- Mindre ökning bland de med större behov

Agerholm *et al. BMC Health Services Research* (2015) 15:420
DOI 10.1186/s12913-015-1105-8

BMC Health Services Research

RESEARCH ARTICLE Open Access

Equity impact of a choice reform and change in reimbursement system in primary care in Stockholm County Council

Janne Agerholm[1,2*], Daniel Bruce[1,2], Antonio Ponce de Leon[1,2,3] and Bo Burström[1,2]

Abstract

Background: In 2008 reforms were introduced in primary care in Stockholm County Council to increase patient choice. These reforms included changes to the reimbursement system from one that was primarily based on need-weighted capitation system (75 %) to a system largely based on fee-for-service (60 %) and freedom of establishment of primary care clinics. The new reimbursement system created incentives for producing many visits and additional primary care clinics were established, particularly in areas that were already well served. This study analyses if and how the choice reform and change of reimbursement system has affected equity in primary care consumption by investigating whether the increase in visits reflects levels of need and to what extent the reform have affected equity in health care between areas.

Methods: Cross-sectional data from the public health survey in Stockholm County 2006 ($n = 34,707$) and 2010 ($n = 30,767$) were linked to individual register data on socio-demographic characteristics and health care utilization in 2007 and 2011. Information on self-reported health status and disability pension was used as indicators of need of health care. Negative binomial regression was used to analyse the differences in GP visits between the two years.

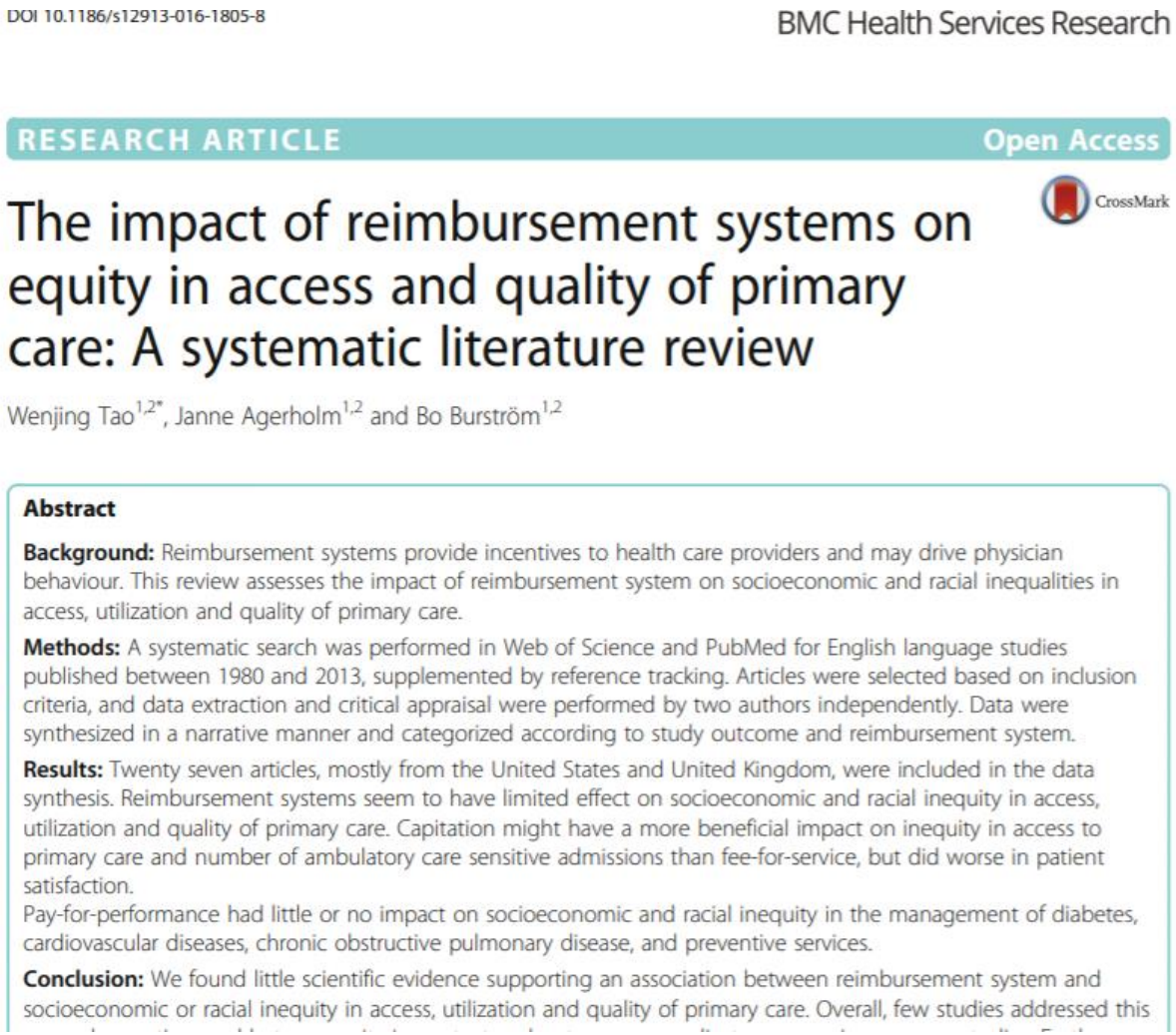
Results: The total number of visits to GPs increased by 46 % from 2007 to 2011 and the proportion visiting a GP increased by 17 %. Both men and women reporting poor mental health and women with limiting longstanding illness and poor self-rated health had significantly smaller increase in number of visits than healthy women and men. Men with poor health status living in disadvantaged areas had a smaller increase than men with poor health status living in other areas of Stockholm County.

Conclusions: The reform did not particularly benefit those with greater health care needs, and there are indications of a negative impact on equity in primary care after the introduction of the reform. There were signs of a lesser increase in total number of visits to GPs among those with poor mental health, among women with poor self-rated health and limiting longstanding illness, and among men living in disadvantaged areas.

Keywords: Primary health care, Equity, Health care utilization, Health care reform, Area differences

Ersättningssystem och vård på lika villkor (2016)

- Liten vetenskaplig evidens om hur ersättningssystem påverkar jämlikhet i vårdutnyttjande och kvalitet
- Kapitering kan öka tillgänglighet och minska undvikbara inläggningar
- Svårt att jämföra ersättningssystem som tillämpas i olika hälso- och sjukvårdssystem
- Behovsbaserad resursfördelning kan minska åtgärdbar dödlighet



DOI 10.1186/s12913-016-1805-8

BMC Health Services Research

RESEARCH ARTICLE Open Access

The impact of reimbursement systems on equity in access and quality of primary care: A systematic literature review

Wenjing Tao[1,2*], Janne Agerholm[1,2] and Bo Burström[1,2]

Abstract

Background: Reimbursement systems provide incentives to health care providers and may drive physician behaviour. This review assesses the impact of reimbursement system on socioeconomic and racial inequalities in access, utilization and quality of primary care.

Methods: A systematic search was performed in Web of Science and PubMed for English language studies published between 1980 and 2013, supplemented by reference tracking. Articles were selected based on inclusion criteria, and data extraction and critical appraisal were performed by two authors independently. Data were synthesized in a narrative manner and categorized according to study outcome and reimbursement system.

Results: Twenty seven articles, mostly from the United States and United Kingdom, were included in the data synthesis. Reimbursement systems seem to have limited effect on socioeconomic and racial inequity in access, utilization and quality of primary care. Capitation might have a more beneficial impact on inequity in access to primary care and number of ambulatory care sensitive admissions than fee-for-service, but did worse in patient satisfaction.
Pay-for-performance had little or no impact on socioeconomic and racial inequity in the management of diabetes, cardiovascular diseases, chronic obstructive pulmonary disease, and preventive services.

Conclusion: We found little scientific evidence supporting an association between reimbursement system and socioeconomic or racial inequity in access, utilization and quality of primary care. Overall, few studies addressed this

Vårdvalsreformen – jämlikhetsaspekter (2017)

- Ökning av antal besök – mer bland de med högre inkomst
- Mer etableringar i städer, mer välbärgade områden
- Försvårat integrerad vård för de med större behov
- Resursfördelning mindre kopplat till behov, mer till lokalisering, patienters val och efterfrågan på vård

Burström et al. International Journal for Equity in Health (2017) 16:29
DOI 10.1186/s12939-017-0524-z

International Journal for Equity in Health

RESEARCH Open Access

Equity aspects of the Primary Health Care Choice Reform in Sweden – a scoping review

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Abstract

Background: Good health and equal health care are the cornerstones of the Swedish Health and Medical Service Act. Recent studies show that the average level of health, measured as longevity, improves in Sweden, however, social inequalities in health remain a major issue. An important issue is how health care services can contribute to reducing inequalities in health, and the impact of a recent Primary Health Care (PHC) Choice Reform in this respect. This paper presents the findings of a review of the existing evidence on impacts of these reforms.

Methods: We reviewed the published accounts (reports and scientific articles) which reported on the impact of the Swedish PHC Choice Reform of 2010 and changes in reimbursement systems, using Donabedian's framework for assessing quality of care in terms of structure, process and outcomes.

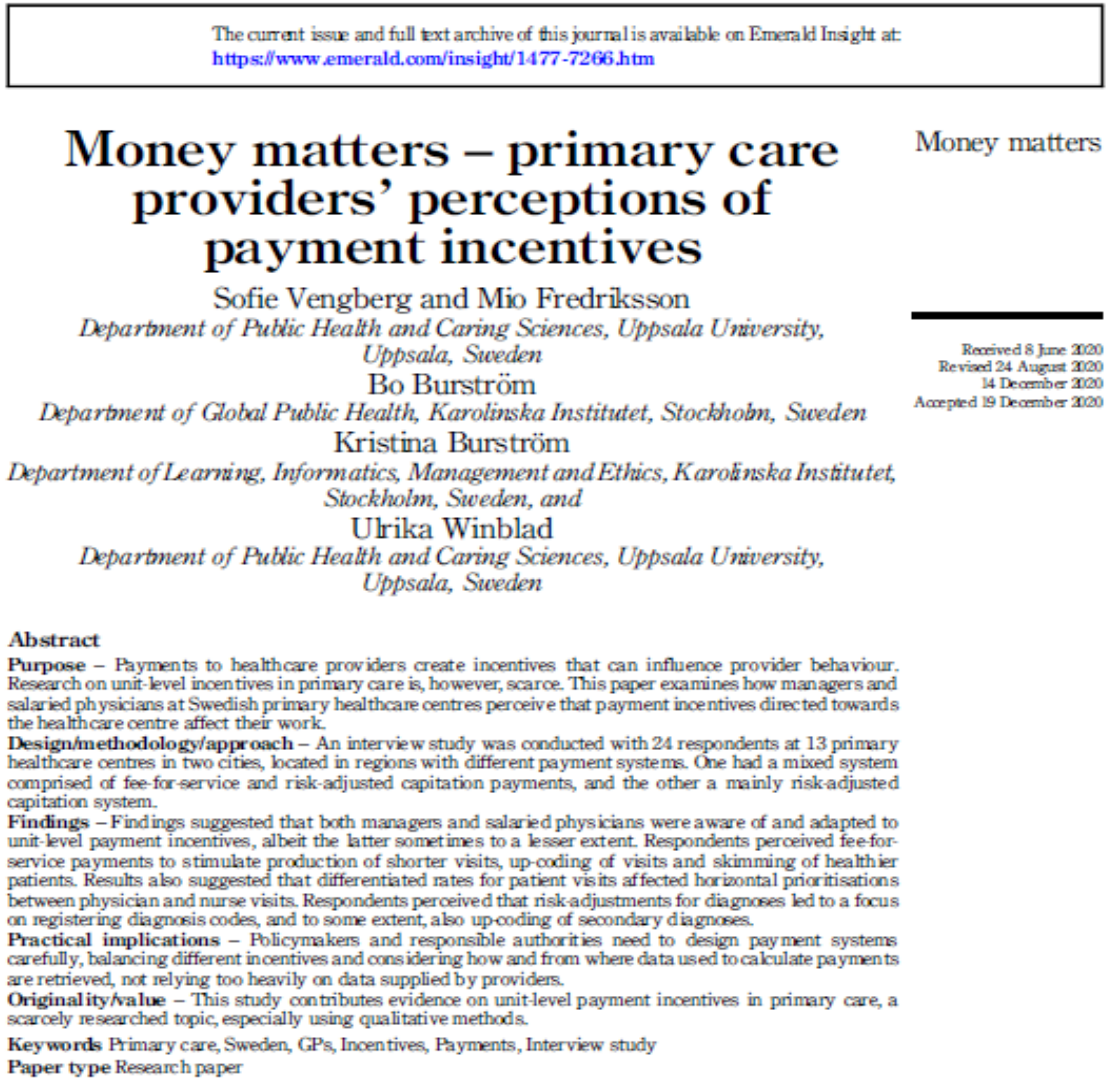
Results: Since 2010, over 270 new private PHC practices operating for profit have been established throughout the country. One study found that the new establishments had primarily located in the largest cities and urban areas, in socioeconomically more advantaged populations. Another study, adjusting for socioeconomic composition found minor differences. The number of visits to PHC doctors has increased, more so among those with lesser needs of health care. The reform has had a negative impact on the provision of services for persons with complex needs. Opinions of doctors and staff in PHC are mixed, many state that persons with lesser needs are prioritized. Patient satisfaction is largely unchanged. The impact of PHC on population health may be reduced.

Conclusions: The PHC Choice Reform increased the average number of visits, but particularly among those in more affluent groups and with lower health care needs, and has made integrated care for those with complex needs more difficult. Resource allocation to PHC has become more dependent on provider location, patient choice and demand, and less on need of care. On the available evidence, the PHC Choice Reform may have damaged equity of primary health care provision, contrary to the tenets of the Swedish Health and Medical Service Act. This situation needs to be carefully monitored.

Keywords: Equity, Inequalities, Health care need, Primary Health Care Choice Reform, Quality of care, Reimbursement

Primärvårdsläkares syn på ersättningssystem (2021)

- Läkare påverkas av ersättningssystemens utformning
- Besöksersättning => kortare besök av friskare patienter
- Ersättning som viktas med diagnoskoder (ACG) kan manipuleras



Money matters

Money matters – primary care providers' perceptions of payment incentives

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Abstract

Purpose – Payments to healthcare providers create incentives that can influence provider behaviour. Research on unit-level incentives in primary care is, however, scarce. This paper examines how managers and salaried physicians at Swedish primary healthcare centres perceive that payment incentives directed towards the healthcare centre affect their work.

Design/methodology/approach – An interview study was conducted with 24 respondents at 13 primary healthcare centres in two cities, located in regions with different payment systems. One had a mixed system comprised of fee-for-service and risk-adjusted capitation payments, and the other a mainly risk-adjusted capitation system.

Findings – Findings suggested that both managers and salaried physicians were aware of and adapted to unit-level payment incentives, albeit the latter sometimes to a lesser extent. Respondents perceived fee-for-service payments to stimulate production of shorter visits, up-coding of visits and skimming of healthier patients. Results also suggested that differentiated rates for patient visits affected horizontal prioritisations between physician and nurse visits. Respondents perceived that risk-adjustments for diagnoses led to a focus on registering diagnosis codes, and to some extent, also up-coding of secondary diagnoses.

Practical implications – Policymakers and responsible authorities need to design payment systems carefully, balancing different incentives and considering how and from where data used to calculate payments are retrieved, not relying too heavily on data supplied by providers.

Originality/value – This study contributes evidence on unit-level payment incentives in primary care, a scarcely researched topic, especially using qualitative methods.

Keywords Primary care, Sweden, GPs, Incentives, Payments, Interview study
Paper type Research paper

Hur kan man bidra till vård på lika villkor?

- Bra lokalt utbud av vård
  - lokalisering efter behov
  - närhet => ökad tillgång till vård
- Resursfördelning efter behov
  - mellan mottagningar
  - mellan patienter (ex tid till tolk)
- Mera utåtriktad/uppsökande vård
  - efterfrågan ej alltid samma som behov