

Primärvård och kostnadseffektivitet

Kan en satsning på primärvården
bidra till att lösa
landstingets ekonomiska problem?



Epidemiologi
och
global hälsa

Folkhälsa
och
klinisk medicin

Umeå
International
School
of
Public Health



Vad säger forskningen

Holmsundsprojektet

Läget nu – vad göra?

Våra sammanfattande synpunkter

Konsensus i forskningen – primärvården har stor potential att bidra till systemeffektivitet

Holmsundsprojektet – ett lyckat försök att sänka totalkostnaden genom att satsa på primärvården



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Läget nu – vad göra?

återkommer vi till



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Vad säger forskningen

1999

SoS-rapport 1999:19

Allmänmedicinens bidrag till effektiv resursanvändning i hälso- och sjukvården

En litteraturstudie över primärvårdens
kostnader och kvalitet i Sverige och andra länder

Denna undersökning syftar till att systematiskt sammanställa vetenskaplig litteratur som belyser läkarverksamhetens effektivitet i primärvården

... anser vi oss ha funnit belägg för att:

En bra primärvård har positiva effekter på folkhälsan ... och bidrar till en lägre konsumtion av både sluten och öppen vård och därmed till lägre totala sjukvårdskostnader.

En väl fungerande primärvård gör att befolkningen är nöjdare med sitt sjukvårdssystem.

Organisationen av primärvården har stor betydelse för i vilken grad man når dessa effekter.

Primärvården kan, till lägre kostnad och med ingen eller liten skillnad i kvalitet, hantera de sjukdomar som kan skötas av såväl allmänläkare som organspecialist.

2001

Is general practice effective? *A systematic literature review*

Sven Engström^{1,2}, Mats Foldevi¹ and Lars Borgquist¹

¹General Practice, Department of Medicine of Care, Faculty of Health Sciences, Linköping and ²Hyd Health Centre, Linköping, Sweden.

Scand J Prim Health Care 2001;19:131-140. ISSN 0281-3472

Objective - To find evidence of the effectiveness of physicians working in primary care.

Design - Systematic literature search in the Medline and Cochrane databases.

Material - Out of 7223 titles found in the search, 45 studies, comparing, from different aspects, primary care with specialist care, were extracted.

Main outcome measures - Health indicators, health care costs, quality of health care.

Results - Primary care contributed to improved public health, as expressed through different health parameters, and a lower utilization of medical care leading to lower costs. Physicians working in primary care, in comparison with other specialists, took care of many diseases without loss of quality and often at lower cost. The organisation of primary care was important in respect of reimbursement by capitation, more group practices, higher personal continuity, and having generalists as primary care physicians.

Conclusion - To compare the effectiveness of primary care and specialist care is a complex task and there are limitations in all studies. However, we have found evidence that increased accessibility to physicians working in primary care contributes to better health and lower total costs in the health care system. It is also clear that studies with evaluation of how to most effectively organise primary care are far too few. There is an extensive need for future research in this area, a suitable task for collaborative research between the Nordic countries.

Key words primary health care, health care costs, quality of health care, review literature.

Introduction - Primary health care, health care costs, quality of health care, review literature.

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Primary care is generally accepted as the level of care at which entry into the health care system is provided for most problems. Primary care is patient-oriented, continuous over time and deals with common and less well-defined problems. The way it is organised varies between countries. In Sweden and Finland there are health centres employing many professional categories (physicians, district nurses, physiotherapists, social workers, etc.) and the health authorities run most of the health centres. In many countries in Western Europe, on the contrary, general practitioners are free entrepreneurs working in a market setting, reimbursed by fee-for-service or capitation.

Primary care physicians in Northern Europe are specialists in general practice. In the USA, physicians working in primary care include a variety of specialties, including sub-specialists. In Denmark, Great Britain, Ireland, Italy, Spain and The Netherlands, primary care physicians act as gatekeepers, thus patients are not normally allowed to see another specialist unless referred by their primary care physician (1,2).

The World Health Organization declaration signed in Alma-Ata in 1978 states that primary health care is

the first level of contact with the national health care system and takes health care as close as possible to where people live and work (3). A principle of health systems in the world should be to make primary health care universally accessible to individuals and families. In the years that have passed since the signing of the declaration, politicians in many countries have expressed their expectations of the contribution of primary care to better public health and lower health care costs. Nevertheless, in all industrialised countries, specialist care has expanded much more than primary care.

Primary care is organised in many different ways and many countries are experimenting with reorganisation. The reimbursement system influences the mode of work in primary care (4). Medical sub-specialists have argued that generalist care means care of lower quality. The costs and quality of primary care have to be evaluated and compared with care delivered in other parts of the health care system. The above issues concerning primary care, health, health care costs, quality and the influence of primary care organisation generated the research questions below.

Material – 45 studies comparing, from different aspects, primary care with specialist care

Conclusions

We have found evidence that increased accessibility to physicians working in primary care contributes to better health and lower total costs in the health care system

2005

Contribution of Primary Care to Health Systems and Health

BARBARA STARFIELD, LEIYU SHI,
and JAMES MACINKO

Johns Hopkins University; New York University

Evidence of the health-promoting influence of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system. This evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care. The evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies. The means by which primary care improves health have been identified, thus suggesting ways to improve overall health and reduce differences in health across major population subgroups.

Key Words: Primary care, health outcomes, population health.

THE TERM *PRIMARY CARE* IS THOUGHT TO DATE BACK TO ABOUT 1920, when the Dawson Report was released in the United Kingdom. That report, an official "white paper," mentioned "primary health care centres," intended to become the hub of regionalized services in that country. Although primary care came to be the cornerstone of the health services system in the United Kingdom as well as in many other countries, no comparable focus developed in the United States. Indeed, the formation of one after another specialty board

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In addition to its relationship to better health outcomes, the supply of primary care physicians was associated with lower total costs of health services.

Areas with higher ratios of primary care physicians to population had much lower total health care costs than did other areas

2009

EDITORIAL

The Paradox of Primary Care

Kurt C. Stange, MD, PhD, Editor, Robert L. Ferrer, MD, MPH, Associate Editor

Ann Fam Med 2009;7:293-296. doi:10.1176/afm.1023.

THE PROBLEM

Despite rising costs, health care often is of poor quality.¹⁻⁴ Current solutions to improving quality may do more harm than good if they focus more on diseases than on people.^{5,6,8} Efforts to improve the parts (evidence-based care of specific diseases)^{9,10} may not necessarily improve the whole (the health of people and populations).^{11,12}

Expanding access to specialty care has been proposed as both a source^{13,22} of and a solution^{23,24} for deficiencies in quality of care. Primary care is touted as an essential building block of a high-value health care system²⁵⁻²⁸ even as it is undermined by systems attempting to improve the quality, effectiveness, and value of their health care.^{9,29,32} These contradictions plague improvement efforts in health care systems around the world, particularly the United States. This article, the third in a series to understand and improve health care, attempts to define and unravel the paradox of primary care. To make sense of this and other paradoxes affecting health care and health, it is useful to begin by considering different levels of analysis and thinking inclusively about seemingly contradictory evidence.

DIFFERENT LEVELS OF ANALYSIS YIELD DIFFERENT VIEWS

Quality of health care most commonly is measured by the application of disease-specific, evidence-based process-of-care guidelines.^{33,36} This evidence fairly consistently shows that primary care clinicians deliver poorer quality care than specialists.^{37,47}

Evidence from the Medical Outcomes Study assesses care of patients with several chronic diseases. The study finds that patients' functional health status outcomes are similar for care rendered by specialists and generalists but that generalists use fewer resources.^{48,49} Similar outcome at lower cost represents higher value.⁷⁰

A growing number of studies show that for patients with chronic somatic and/or mental illness, shared care between specialists and generalists is optimal.^{51,71,81}

In further contrast, ecological studies comparing states in the United States find that a greater supply of generalists and a lower supply of specialists is associated with greater quality of care on multiple disease-specific quality measures.^{29,82} Ecological studies comparing westernized countries show that more primary care (and perhaps its associated societal values and public health systems) is associated with better population health with lower cost and greater equity.^{83,85}

NAMING THE PARADOX

Thus, the paradox is that compared with specialty care or with systems dominated by specialty care, primary care is associated with the following: (1) apparently poorer quality care for individual diseases, yet (2) similar functional health status at lower cost for people with chronic disease, and (3) better quality, better health, greater equity, and lower cost for whole people and populations.

INTERPRETATION

Two possible explanations might explain this paradox.

Studies Are Flawed; There Is No Paradox

First, is it possible that one or all groups of these studies are fatally flawed, and there is no paradox?

Each of the bodies of work cited has inherent limitations. Studies of disease-specific quality of care typically use as outcomes evidence-based guidelines based on clinical trials that largely exclude patients with comorbid conditions.^{93,94} Thus, measures of quality may inadequately reflect population morbidity and may not be applicable to most people.⁹⁴ Unmeasured confounding and selection biases appear to explain part, but not all, of the observed differences between specialty and primary care.^{43,95} Nonetheless, the face validity of disease-specific studies is high, as it is implausible that, compared with generalists, specialists would know less about their disease of interest or would be less likely to follow guidelines based on

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- (2) similar functional health status at lower cost for people with chronic disease, and
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2010

HISTORY & BACKGROUND

By Mark W. Friedberg, Peter S. Hussey, and Eric C. Schneider

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Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care

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 of Health Policy and
 Management, Harvard School
 of Public Health in Boston,
 Massachusetts.

ABSTRACT Despite contentious debate over the new national health care reform law, there is an emerging consensus that strengthening primary care will improve health outcomes and restrain the growth of health care spending. Policy discussions imply three general definitions of primary care: a specialty of medical providers, a set of functions served by a usual source of care, and an orientation of health systems. We review the empirical evidence linking each definition of primary care to health care quality, outcomes, and costs. The available evidence most directly supports initiatives to increase providers' ability to serve primary care functions and to reorient health systems to emphasize delivery of primary care.

Policy makers, professional organizations, and purchasers of health care have reached an unusual consensus on the importance of revitalizing primary care. This consensus stems from agreement that primary care is in a deepening crisis, but that effective primary care can improve health outcomes and contain health care costs.

Some proposed solutions frame the crisis as a problem of insufficient numbers of primary care physicians. This framing rests on evidence that U.S. medical students are losing interest in primary care careers and that Medicare beneficiaries are beginning to report difficulty finding new primary care physicians.^{1,2} Large income differences between specialties may deter medical students from pursuing careers in primary care.³ This has prompted the Medicare Payment Advisory Commission (MedPAC) to recommend a budget-neutral payment increase for "primary care services provided by practitioners who focus on primary care."⁴

Other proposals frame the primary care crisis as one of insufficient capability. These proposals include efforts to not only expand the number of patients who have a primary care provider, but

also to give these providers new resources such as electronic health records and nonphysician care coordinators. The medical home and Chronic Care Model include sets of interventions intended to enhance and extend the capabilities of primary care providers.^{5,6}

A third set of proposals attempts to reorient entire health care delivery systems toward primary care. Such proposals call for rebalancing primary and specialty care in the United States—a goal that may require interventions beyond increasing the number of primary care physicians.⁷ These proposals also call for basing system-level payment and organizational design on core principles of primary care.⁸

Given the magnitude of the investment necessary to revitalize primary care, it is fair to ask what evidence supports current proposals to expand, equip, and empower primary care. In this paper we review the empirical evidence linking primary care to the quality, outcomes, and costs of health care; evaluate the strength of this evidence; and discuss the resulting policy implications.

.... consensus that strengthening primary care will improve health outcomes and restrain the growth of health care spending

The available evidence most directly supports ... to reorient health systems to emphasize delivery of primary care

2012

Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services

Informe SESPAS

Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012

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ABSTRACT

As of 2005, the literature on the benefits of primary care oriented health systems was consistent in showing greater effectiveness, greater efficiency, and greater equity. In the ensuing five years, nothing changed that conclusion, but there is now greater understanding of the mechanisms by which the benefits of primary care are achieved. We now know that, within certain bounds, neither the wealth of a country nor the total number of health personnel are related to health levels. What counts is the existence of key features of health policy (Primary Health Care): universal financial coverage under government control or regulation, attempts to distribute resources equitably, comprehensiveness of services, and low or no copayments for primary care services. All of these, in combination, produce better primary care: greater first contact access and use, more person-focused care over time, greater range of services available and provided when needed, and coordination of care. The evidence is no longer confined mainly to industrialized countries, as new studies show it to be the case in middle and lower income countries. The endorsements of the World Health Organization (in the form of the reports of the Commission on Social Determinants of Health and the World Health Report of 2008, as well as a number of other international commissions, reflect the widespread acceptance of the importance of primary health care. Primary health care can now be measured and assessed; all innovations and enhancements in it must serve its essential features in order to be useful.

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Atención primaria: una creciente e importante colaboradora en la eficacia, la equidad y la eficiencia de los servicios de salud. Informe SESPAS 2012

RESUMEN

Hasta 2005, la literatura sobre los beneficios de los sistemas de salud orientados a la atención primaria ha sido consistente en mostrar una mayor eficacia, una mayor eficiencia y una mayor equidad. En los siguientes 5 años nada ha cambiado esta conclusión, pero ahora comprendemos mejor los mecanismos por los que actúa. Sabemos que, dentro de ciertos límites, ni la riqueza de un país ni el número de profesionales de la salud se relacionan con los niveles de salud. Lo que cuenta es la existencia de las características clave de la política de salud (atención primaria de salud): la cobertura financiera universal bajo el control del gobierno o regulada, los intentos de distribuir los recursos equitativamente, la integralidad de los servicios, y bajos o nulos copagos para los servicios de atención primaria. Todos estos, combinados, producen una mejor atención primaria: un mayor acceso y uso del primer contacto, más atención centrada en la persona a lo largo del tiempo, mayor gama de servicios disponibles cuando sean necesarios, y la coordinación de la atención. La evidencia ya no se limita principalmente a los países industrializados, pues nuevos estudios también lo demuestran en países con ingresos medios y bajos. El aval de la Organización Mundial de la Salud (los informes de la Comisión sobre Determinantes Sociales de la Salud y el Informe de Salud Mundial de 2008), así como una serie de comisiones internacionales, reflejan la aceptación generalizada de la importancia de la atención primaria de salud. Ahora, la atención primaria de salud puede ser medida y evaluada; todas las innovaciones y mejoras en ella deben servir a sus características esenciales con el fin de ser útiles.

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Introduction

Evidence of the value of primary care in health systems continues to accumulate. A 2005 review of evidence on the benefits

of comprehensive primary care included international comparisons, studies within countries, and studies of the impact of the important features of primary care.¹ Since then, other research and analysis has confirmed the conclusion that strong primary care health systems are more likely to provide better population health, better distribution (more equity) in health throughout the populations, and greater economy in the use of resources. Krings and colleagues reviewed 85 studies published between 2003 and 2008 for evidence in the areas of governance, economic conditions,

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Since then [2005], other research and analysis has confirmed the conclusion that strong primary care health systems are more likely to provide

- better population health,

- better distribution (more equity) in health throughout the populations,

- and greater economy in the use of resources

2015

More Comprehensive Care Among Family Physicians is Associated with Lower Costs and Fewer Hospitalizations

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ABSTRACT

PURPOSE Comprehensive care is lauded as 1 of the 5 core virtues of primary care, but its relationship with outcomes is unclear. We measured associations between variations in comprehensiveness of practice among family physicians and healthcare utilization and costs for their Medicare beneficiaries.

METHODS We merged data from 2011 Medicare Part A and B claims files for a complex random sample of family physicians engaged in direct patient care, including 100% of their claimed care of Medicare beneficiaries, with data reported by the same physicians during their participation in Maintenance of Certification for Family Physicians (MC-FP) between the years 2007 and 2011. We created a measure of comprehensiveness from mandatory self-reported survey items as part of MC-FP examination registration. We compared this measure to another derived from Medicare's Berenson-Eggers Type of Service (BETOS) codes. We then examined the association between the 2 measures of comprehensiveness and hospitalizations, Part B payments, and combined Part A and B payments.

RESULTS Our full family physician sample consists of 3,652 physicians providing the plurality of care to 555,165 Medicare beneficiaries. Of these, 1,133 recertified between 2007 and 2011 and cared for 185,044 beneficiaries. There was a modest correlation (0.30) between the BETOS and self-reported comprehensiveness measures. After adjusting for beneficiary and physician characteristics, increasing comprehensiveness was associated with lower total Medicare Part A and B costs and Part B costs alone, but not with hospitalizations; the association with spending was stronger for the BETOS measure than for the self-reported measure; higher BETOS scores significantly reduced the likelihood of a hospitalization.

CONCLUSIONS Increasing family physician comprehensiveness of care, especially as measured by claims measures, is associated with decreasing Medicare costs and hospitalizations. Payment and practice policies that enhance primary care comprehensiveness may help "bend the cost curve."

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) of 2009 has returned attention to primary care and its role in achieving the nation's Triple Aim of improved population health and patient care with lower costs.¹ Decades of evidence support primary care's potential as an antidote to health care costs, whose growth has outpaced that of the overall economy for decades and may yet accelerate, given our aging, enlarging, and increasingly insured population.^{2,3} Among the definitional features of primary care thought to be responsible for its positive impact is comprehensiveness, or the provision of care across a broad spectrum of health problems, age ranges, and treatment modalities. The Institute of Medicine, in an often-referenced 1996 publication on primary care, defined comprehensiveness as "...the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs."⁴ The value of this function of primary care was reiterated by the World Health Organization in

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CONCLUSIONS

Increasing family physician comprehensiveness of care ... is associated with decreasing Medicare costs and hospitalizations.

Payment and practice policies that enhance primary care comprehensiveness may help “bend the cost curve.”

“Holmsundprojektet”

Vårdcentralstyrd hälso- och sjukvård

Startades 2001

Målsättning:

... på en övergripande nivå är målsättningen att den totala sjukvårdskostnaden för befolkningen i Holmsund-Obbola på sikt ska bibehållas eller minska samtidigt som kvalitén i vård och behandling ska öka eller bibehållas.

Ur slutrapporten 2006



Slutsats i slutrapporten:

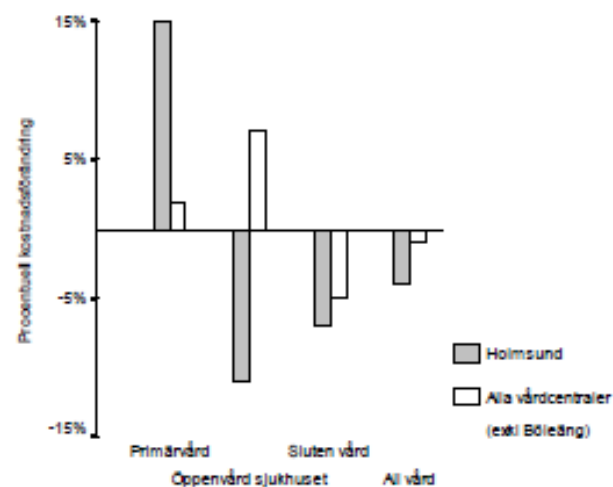
Sammanfattningsvis så är projektets målsättningar både beträffande kostnader och beträffande kvalitet uppfyllda



Ur slutrapporten 2006

Ekonomisk utvärdering av Holmsundsprojektet

Kostnaden per invånare år 2002 i jämförelse med år 2000,
fasta priser, procentuell förändring



Curt Löfgren, Inger Georgsson och Lars Lindholm

Tabell 2.1 Projektkostnader, kr., löpande priser

År	Totalt	Utveckling, administration, utvärdering	Totalt exkl. utv., adm., utvärd.	Kronor per invånare (exkl. utv., adm., utvärd.)
2000	400 000	400 000	0	0
2001	3 226 400	600 000	2 626 400	300
2002	3 127 500	600 000	2 527 500	288

Kostnaderna för Holmsundspatienterna
– över alla vårdnivåer – jämfördes med
kostnaderna för patienterna vid 13
andra vårdcentraler i dåvarande Umeå
sjukvård

Backen

Bjurholm

Ersboda

Hörnefors

Mariehem

Nordmaling

Robertsfors

Sävar

Teg

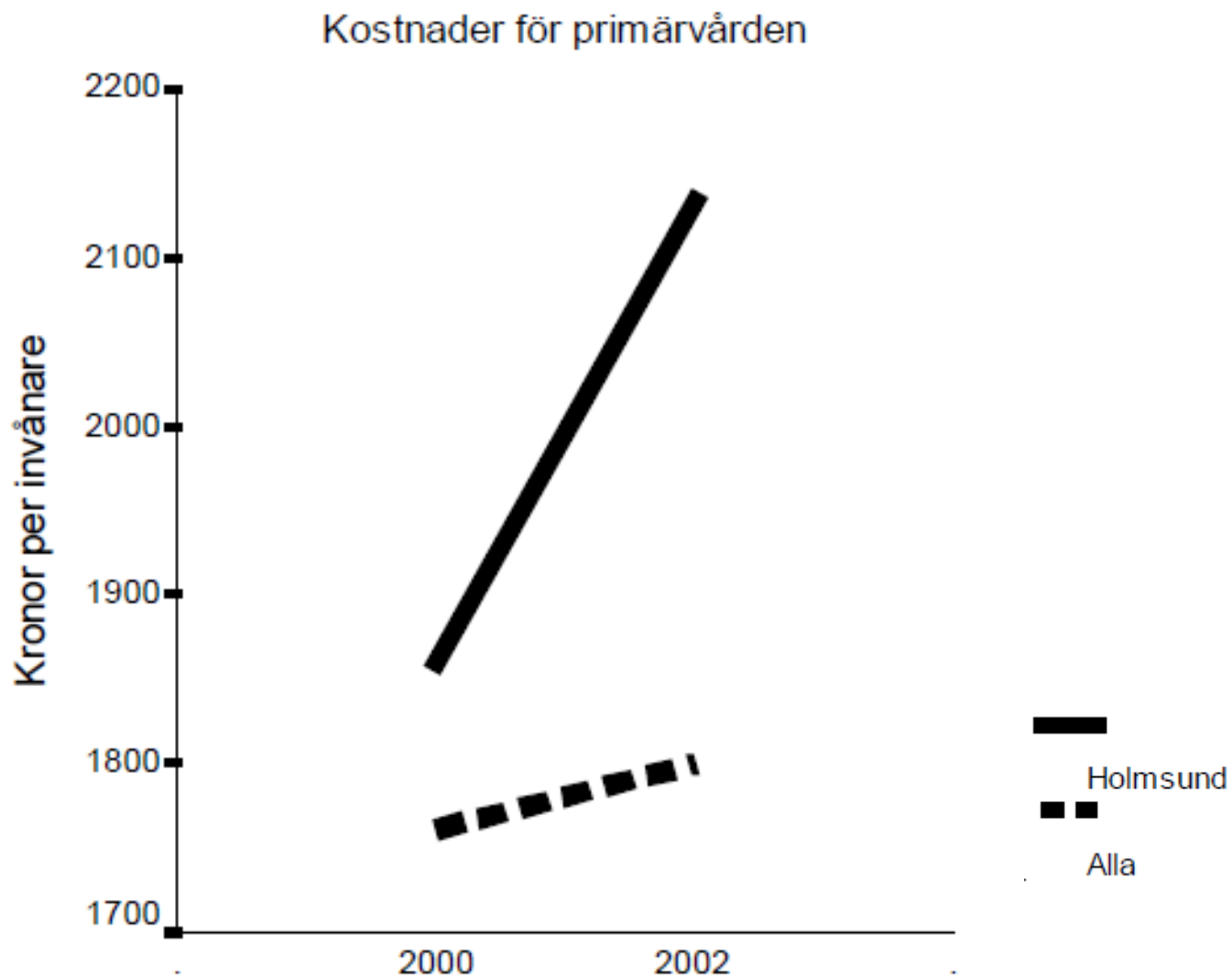
Umeå

Vindeln

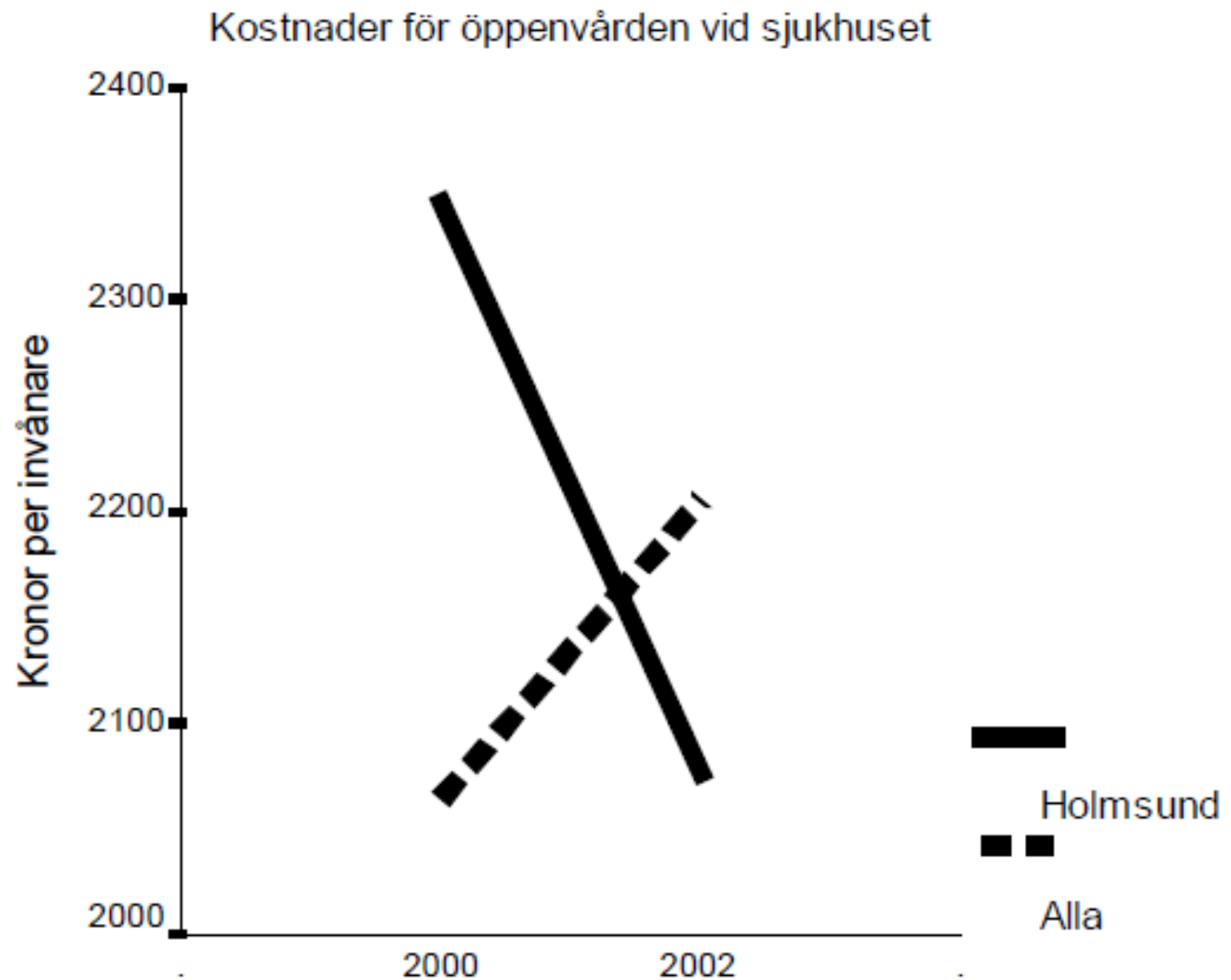
Vännäs

Ålidhem

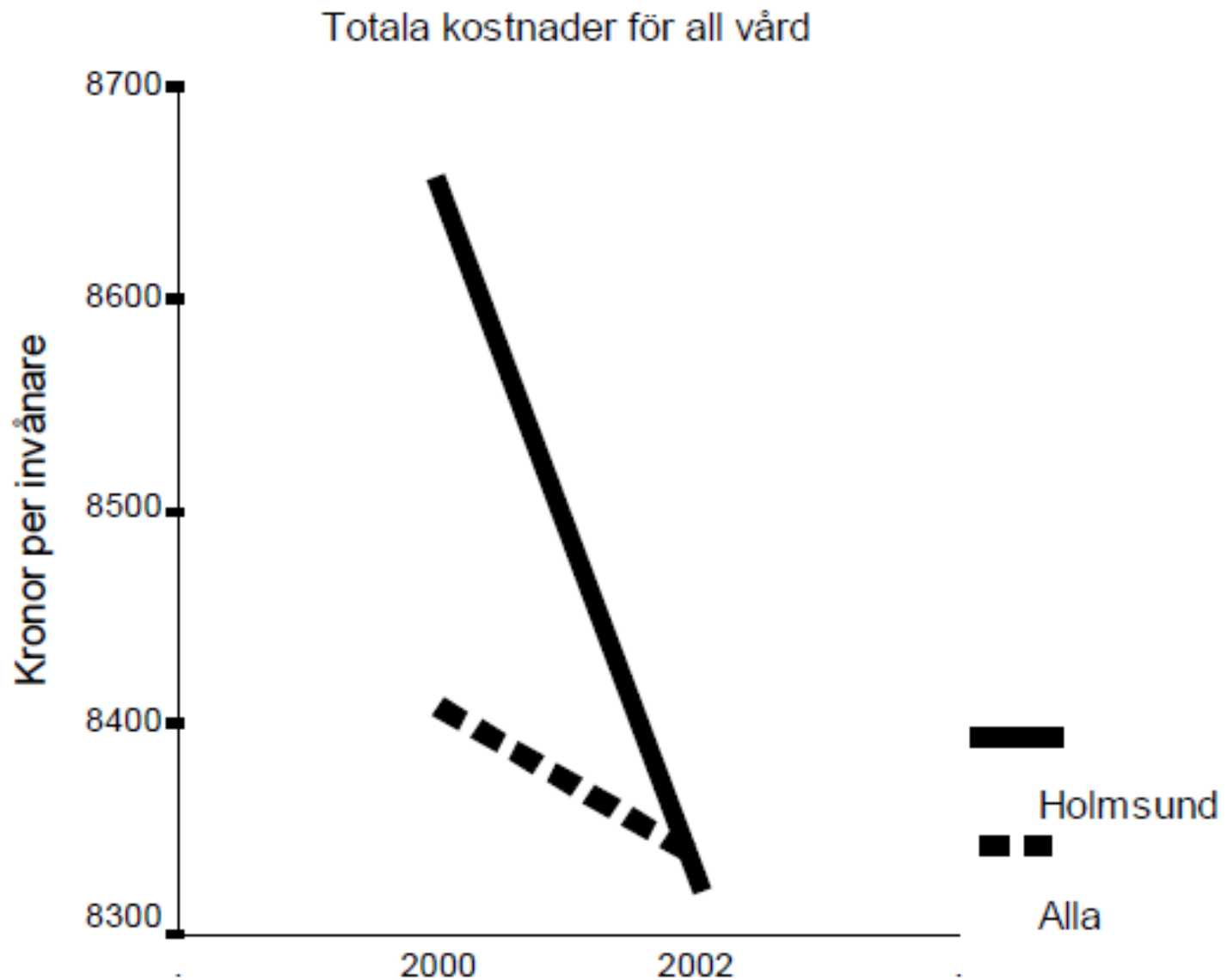
Kostnader per patient 2000 och 2002, fasta priser (referensår 2000)



Kostnader per patient 2000 och 2002, fasta priser (referensår 2000)



Kostnader per patient 2000 och 2002, fasta priser (referensår 2000)



Bemanning

Tabell 3.1. Bemanning av Holmsunds vårdcentral, antal heltidstjänster

Kategori	I budget	Tillfört i projektet	Totalt
Chef	0,5	0,5	1
Projektsekreterare		1	1
Distriksläkare	3,85	1,25	5,05
Distrikssköterska	6,5	1,25	7,75
Barnmorska	1		1
Undersköterska	2,75	0,75	3,5
Läkarsekreterare	3,5	0,5	4
Sjukgymnast	2	1	3
Arbetsterapeut	1	0,5	1,5
Kurator	0,5	0,25	0,75
Psykolog		0,5	0,5
Lokalvårdare/vaktmästare	1		1

Strategier

God kunskap om befolkningens
hälsotillstånd

Antalet patienter inom prioriterade
sjukdomsgrupper skattades.

Genom samverkan med
specialistkliniker utformades en
arbetsfördelning, dvs. hur vård skulle
kunna ges på rätt vårdnivå.

Fokus på sjukdomsgrupperna

diabetes, demens, astma/KOL
och hjärtsvikt

övriga områden:

folkhälsoarbete, familjecenter och
rehabilitering av personer med psykisk
ohälsa

Ett mål var också att upparbete bättre kontakter med sjukhuskliniker, med kommunen och med försäkringskassan

Alla medarbetare indelades i team med ansvar för olika områden.

Samverkan med sjukhuset med syftet
ömsesidig kompetensutveckling

Besök (varje halvår) av

geriatriker, 3 ggr

gynekolog, 4-5 ggr

ortoped, 3-4 ggr

internmedicinare, 2-3 ggr

psykiatriker, varannan vecka

barnhälsovårdens överläkare, 2-3 ggr

Tabell 5.2. Patienter i olika vårdformer 2002

	Andel av invånarna* som fått vård i de olika vårdformerna – för invånare tillhörande –	
	Holmsunds vårdcentral	alla vårdcentraler**
Primärvård	65%	62%
Öppen vård vid sjukhuset		
Mottagningar	45%	47%
VKR-enheter***	31%	29%
Sluten vård	9%	9%
I öppen och/eller sluten vård vid sjukhuset, <u>dock ej</u> i primärvård	10%	12%
I någon eller flera av vårdformerna	75%	74%
<u>Ej vårdats</u> i någon vårdform	25%	26%
Summa	100%	100%

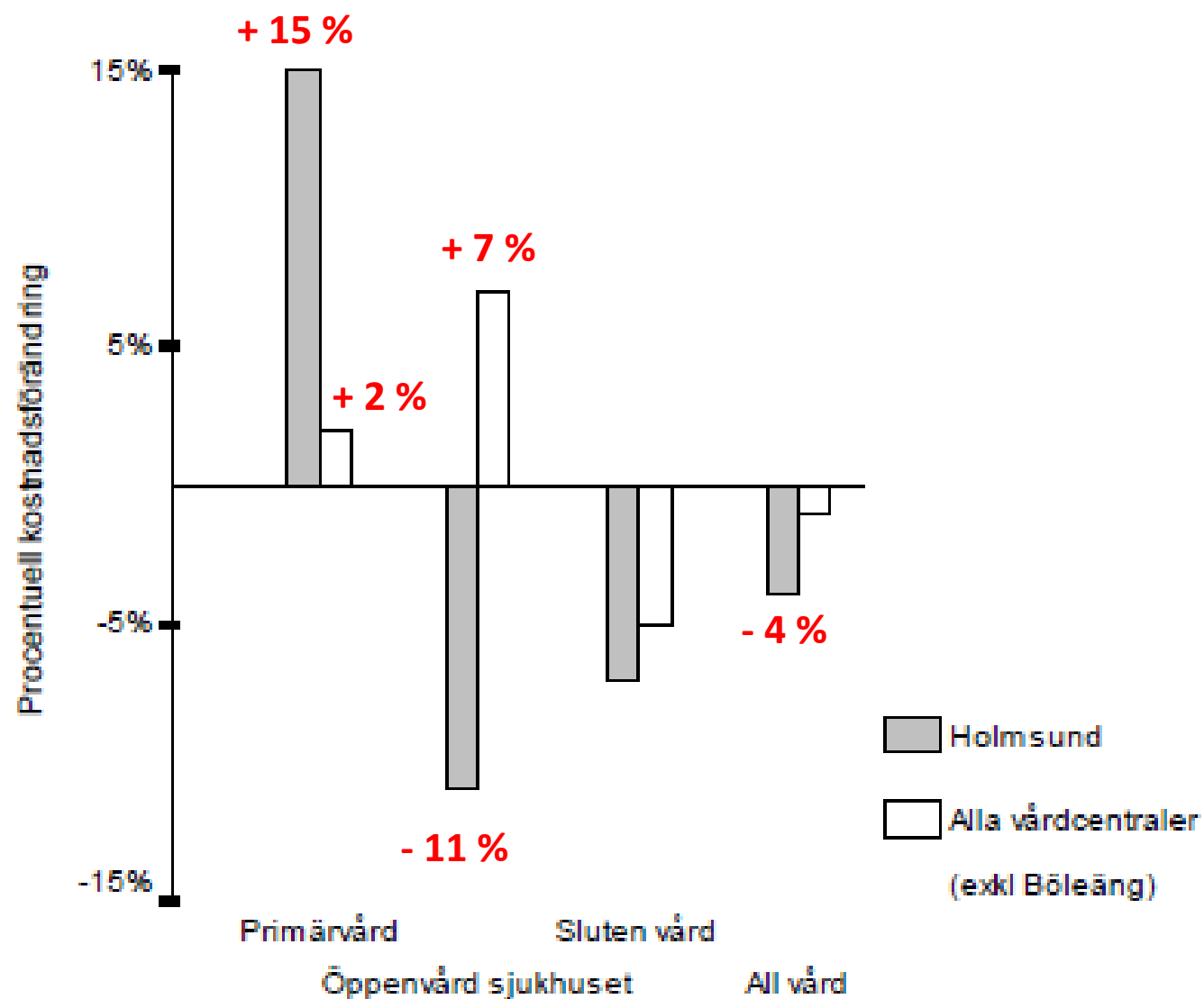
* Personer som tillhör vårdcentralsbefolkningen för någon av de 14 vårdcentralerna i studien (Böleängs vårdcentral ingår inte).

** Se tabell B4 i tabellbilagan för motsvarande uppgifter för respektive vårdcentral

*** I landstingets faktureringsystem särskiljs viss verksamhet i den öppna vården vid sjukhuset från mottagningarna. Det rör sig om ett stort antal mottagningar/enheter t.ex. den medicinska dialysmottagningen och röntgenmottagningen. Redovisningen benämns VKR (Vårdkostnadsredovisning) och de särskilda enheterna/mottagningarna har därför kallats VKR-enheter i denna studie.

Tabell 5.3. Kostnader för olika vårdformer 2002, kronor per invånare, löpande priser

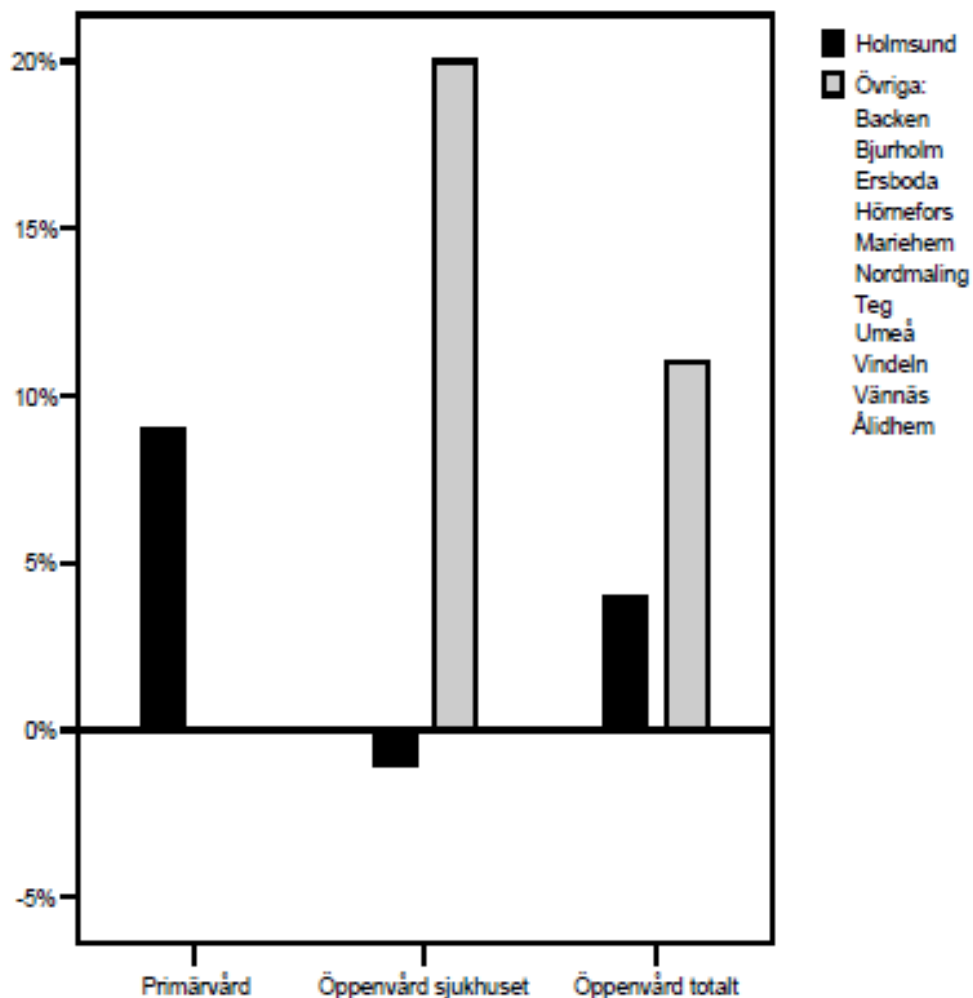
	Holmsunds vårdcentral		alla vårdcentraler*		Kostnadsskillnad	
	kr per inv	%	kr per inv	%	(1) - (2)	~ i % av (1)
	(1)		(2)			
Öppen vård						
Primärvård	2 341	26%	1 975	22%	366	16%
Öppen vård vid sjukhuset	2 277	25%	2 420	26%	-143	-6%
därav: Mottagningar	1 238	14%	1 389	15%	-151	-12%
VKR-enheter**	1 039	11%	1 031	11%	8	1%
Summa öppen vård	4 618	51%	4 395	48%	223	5%
Sluten vård	4 514	49%	4 753	52%	-239	-5%
Summa all vård	9 132	100%	9 148	100%	-16	0%



Figur 5.2. Kostnaderna (kronor per invånare) i fasta priser år 2002 i jämförelse med kostnaderna år 2000 för olika vårdformer.

Ur slutrapporten 2006:

Figur 1
Kostnaden per invånare år 2004 i jämförelse med år 2000,
fasta priser, procentuell förändring



Om primärvårdens domän och strategier

Slutrapport för Socialstyrelsens projekt:
Primärvårdens roll för hälso- och
sjukvårdens systemeffektivitet

Artikelnr 2004-123-19

Publicering www.socialstyrelsen.se, april 2004

Medverkande landsting och vårdcentraler

Nio vårdcentraler har medverkat som piloter, från sju landsting.

Landsting/ vårdcentral	Arbetsgrupp	Medicinskt sakkunniga	Projektgrupp
Dalarna/Gagnef	Anders Eriksson	Ulf Börjesson	Anders Paperin
Stockholm/Segeltorp	Nils Larsson	Kjell Andersson	Kjell Zahr
Stockholm/Vaxholm	Kerstin Hilding-Lundström	Åke Hazell	Rune Ekman
Uppsala/Bålsta	Leif Eriksson	Mikael Brandt	Ingvar Sjögren
Uppsala/Möller	Leif Eriksson	Svante Svensson	Ingvar Sjögren
Värmland/Arvika	Lars Matthiessen	Lars Matthiessen	Lars Matthiessen
Västerbotten/ Holmsund	Inger Georgsson	Sven Ekesrydh	Margareta Wiberg Christina Wennberg- Granberg
Västra Götaland/ Stenungsund	Margareta Hulthén	Lennart Nord	Yvonne Eriksson
Östergötland/Ryd	Susan Wilhelmsson	Sven Engström	Lars Borgqvist
Socialstyrelsen	Beng-Göran Emtinger Annika Gottberg		Monica Albertsson

“ ... kalkylen pekar på att man haft en gynsammare kostnadsutveckling för Holmsundsborna än för övriga Umeå och med minst bibehållen kvalitet”

“Tanken att man skall kunna skapa högre effektivitet i vårdssystemet har fått ett mer konkret uttryck i Holmsund än beträffande någon annan av piloterna”

“ Här [Holmsund] finns ett mycket medvetet sökande efter organisatoriska innovationer med bäring på systemeffektivitet”

“Trots många positiva indikationer och initiativ till stöd för systemeffektivitet är den sammantagna bilden att man har vaga eller inga direkta strategier för detta på huvudmannahåll.

Försöksverksamheten i Holmsund är det talande undantaget”

“Västerbotten/Umeå sjukvård/Holmsunds vårdcentral är ett steg före övriga i alla avseenden. Man har ett konkret projekt ... man har givit ett tydligt uppdrag ... vårdcentralen har accepterat detta uppdrag och driver försket med entusiasm ...”

“slående att ingen av pilotvårdcentralerna vid sidan av Holmsund uppfattar att de har ett uppdrag att verka för systemeffektivitet”



Epidemiologi
och
global hälsa

Folkhälsa
och
klinisk medicin

Umeå
International
School
of
Public Health



Läget nu

Vårdkostnader 2014

Hälsocentral	Antal listade	Kostnad per listad 2014			
		Hälso-centraler	Sjukhusmot tagningar	Slutenvård	Totalt
Lycksele					
Medicinkonsulten	4 435	4 050	6 271	7 260	17 581
Stenbergsska Hälsocentral	7 841	4 453	7 637	7 037	19 127
Summa/genomsnitt VBT	261 785	3 963	6 125	5 811	15 900

Hälsocentral	Antal listade	Kostnad per listad 2014			
		Hälso-centraler	Sjukhusmot tagningar	Slutenvård	Totalt
Skellefteå					
Anderstorp Hälsocentral	12 235	3 475	7 944	5 803	17 222
Erikslid Hälsocentral	9 508	3 923	9 080	6 550	19 552
Heimdalls Hälsocentral	9 264	3 796	9 206	6 688	19 690
Morö Backe Hälsocentral	15 999	3 175	6 884	5 235	15 294
Skelleftehamns Hälsocentral	7 111	3 715	8 024	5 991	17 729
Bolidens Hälsocentral	2 528	4 056	6 192	5 759	16 007
Bureå Hälsocentral	3 630	3 732	7 873	6 865	18 470
Burträsk Hälsocentral	4 028	4 567	6 025	8 050	18 641
Byske Hälsocentral	4 579	4 322	6 167	6 692	17 180
Hälsogemenskapen i Jörn	1 102	5 318	5 369	9 248	19 935
Lövånger Hälsocentral	2 212	4 029	6 464	6 220	16 713
Summa/genomsnitt VBT	261 785	3 963	6 125	5 811	15 900

Hälsocentral	Antal listade	Kostnad per listad 2014			
		Hälso-centraler	Sjukhusmot tagningar	Slutenvård	Totalt
Umeå					
Backens Hälsocentral	9 491	3 525	6 458	5 597	15 580
Citymottagningen HC	7 286	3 985	6 764	5 532	16 281
Dragonens HC	18 016	3 854	5 712	5 414	14 981
Ersboda Hälsocentral	9 147	3 327	6 481	5 930	15 738
Holmsunds Hälsocentral	6 278	5 035	5 383	5 724	16 143
Husläkarna i Umeå	3 304	3 862	5 814	6 386	16 062
Mariehems Hälsocentral	13 157	3 348	6 796	5 275	15 419
Min Hälsa HC Um	2 106	3 617	4 565	0	8 182
Norrlandsklinikens H	8 830	3 342	4 944	3 500	11 786
Sävar Hälsocentral	5 567	3 798	4 906	4 961	13 666
Tegs Hälsocentral	17 298	3 413	5 661	5 147	14 220
Ålidhems Hälsocentral	18 556	2 887	5 590	3 424	11 901
Hörnefors Hälsocentral	3 614	4 102	5 098	5 175	14 375
Summa/genomsnitt VBT	261 785	3 963	6 125	5 811	15 900

Hälsocentral	Antal listade	Kostnad per listad 2014			
		Hälso-centraler	Sjukhusmot tagningar	Slutenvård	Totalt
Längre avstånd till sjukhus					
Bjurholms Hälsocentral	2 319	5 309	5 020	7 644	17 974
Nordmalings Hälsocentral	6 302	3 846	4 887	7 265	15 999
Norsjö Hälsocentral	4 095	4 278	5 180	6 021	15 479
Robertsfors Hälsocentral	5 375	4 893	4 527	5 910	15 331
Vindelns Hälsocentral	4 783	4 275	5 012	7 187	16 474
Vännäs Hälsocentral	7 788	3 968	5 138	5 947	15 053
Sjukstugor					
Dorotea Sjukstuga	2 732	6 065	3 644	7 666	17 375
Malå Sjukstuga	3 504	6 234	3 811	7 461	17 507
Sorsele Sjukstuga	2 490	7 829	3 614	8 681	20 124
Storumans Sjukstuga	4 344	6 043	4 428	8 426	18 897
Tärnaby Sjukstuga	1 548	5 291	2 670	7 567	15 529
Vilhelmina sjukstuga	6 620	5 485	4 078	6 572	16 134
Åsele Sjukstuga	2 763	6 829	4 496	8 428	19 753
Summa/genomsnitt	261 785	3 963	6 125	5 811	15 900

	<i>Andel av total fast ersättning</i>	<i>Andel av total kostnad sjukhus- mottag- ningar</i>	<i>Andel av total öppen- vårds- kostnad</i>	<i>Andel av total sluten- vårds- kostnad</i>	<i>Andel av total kostnad</i>
Lycksele					
Medicinkonsulten	1.8%	1.7%	1.7%	2.3%	1.9%
Stenbergska Hälsocentral	3.0%	3.7%	3.6%	4.2%	3.8%

	<i>Andel av total fast ersättning</i>	<i>Andel av total kostnad sjukhus- mottag- ningar</i>	<i>Andel av total öppen- vårds- kostnad</i>	<i>Andel av total sluten- vårds- kostnad</i>	<i>Andel av total kostnad</i>
Skellefteå					
Skelleftehamns Hälsocentral	2.6%	3.6%	3.2%	2.9%	3.1%
Erikslid Hälsocentral	3.6%	5.4%	4.7%	4.4%	4.6%
Heimdalls Hälsocentral	3.7%	5.3%	4.6%	4.3%	4.5%
Anderstorp Hälsocentral	4.6%	6.1%	5.3%	4.9%	5.1%
Morö Backe Hälsocentral	5.8%	6.9%	6.1%	5.6%	5.9%
Lövånger Hälsocentral	1.0%	0.9%	0.9%	0.9%	0.9%
Bolidens Hälsocentral	1.0%	1.0%	1.0%	1.0%	1.0%
Bureå Hälsocentral	1.4%	1.8%	1.6%	1.6%	1.6%
Burträsk Hälsocentral	1.8%	1.5%	1.6%	1.9%	1.7%
Byske Hälsocentral	2.0%	1.8%	1.8%	2.1%	1.9%

Total kostnad för sjukhusmottagningar 1 603 562 097

	(1) Andel av total fast ersättning	(2) Andel av total kostnad sjukhus- mottag- ningar	(2)-(1)	Motsvarar i kronor
Skellefteå				
Skelleftehamns Hälsocentral	2.6%	3.6%	1.00 pe	16 035 621
Erikslid Hälsocentral	3.6%	5.4%	1.80 pe	28 864 118
Heimdalls Hälsocentral	3.7%	5.3%	1.60 pe	25 656 994
Anderstorp Hälsocentral	4.6%	6.1%	1.50 pe	24 053 431
Morö Backe Hälsocentral	5.8%	6.9%	1.10 pe	17 639 183

	<i>Andel av total fast ersättning</i>	<i>Andel av total kostnad sjukhus- mottag- ningar</i>	<i>Andel av total öppen- vårds- kostnad</i>	<i>Andel av total sluten- vårds- kostnad</i>	<i>Andel av total kostnad</i>
Umeå					
Husläkarna i Umeå	1.3%	1.2%	1.2%	1.1%	1.2%
Sävar Hälsocentral	2.0%	1.7%	1.8%	1.7%	1.8%
Citymottagningen HC	2.5%	3.1%	3.0%	2.6%	2.8%
Norrlandsklinikens H	2.7%	2.7%	2.8%	2.2%	2.6%
Holmsunds Hälsocentral	2.8%	2.1%	2.5%	2.2%	2.4%
Ersboda Hälsocentral	3.1%	3.7%	3.4%	3.4%	3.4%
Backens Hälsocentral	3.4%	3.8%	3.6%	3.2%	3.4%
Mariehems Hälsocentral	4.7%	5.6%	5.1%	4.5%	4.8%
Ålidhems Hälsocentral	5.6%	6.5%	6.0%	4.2%	5.3%
Tegs Hälsocentral	6.2%	6.1%	5.9%	5.6%	5.8%
Dragonens HC	6.5%	6.4%	6.5%	5.9%	6.3%
Min Hälsa HC Um		0.6%	0.7%	0.0%	0.4%
Hörnefors Hälsocentral	1.5%	1.1%	1.3%	1.2%	1.2%

	<i>Andel av total fast ersättning</i>	<i>Andel av total kostnad sjukhus- mottag- ningar</i>	<i>Andel av total öppen- vårds- kostnad</i>	<i>Andel av total sluten- vårds- kostnad</i>	<i>Andel av total kostnad</i>
<i>Längre avstånd till sjukhus</i>					
Hälsogemenskapen i Jörn	0.5%	0.4%	0.4%	0.7%	0.5%
Bjurholms Hälsocentral	1.1%	0.7%	0.9%	1.1%	1.0%
Norsjö Hälsocentral	1.9%	1.3%	1.5%	1.6%	1.5%
Vindelns Hälsocentral	2.1%	1.5%	1.7%	2.2%	1.9%
Robertsfors Hälsocentral	2.3%	1.5%	1.9%	2.0%	2.0%
Nordmalings Hälsocentral	2.7%	1.9%	2.1%	2.7%	2.3%
Vännäs Hälsocentral	3.1%	2.5%	2.7%	3.0%	2.8%
<i>Sjukstugor</i>					
Tärnaby Sjukstuga	1.0%	0.3%	0.5%	0.8%	0.6%
Sorsele Sjukstuga	1.3%	0.6%	1.1%	1.5%	1.2%
Dorotea Sjukstuga	1.4%	0.6%	1.0%	1.3%	1.1%
Åsele Sjukstuga	1.4%	0.8%	1.2%	1.6%	1.3%
Malå Sjukstuga	1.7%	0.8%	1.3%	2.0%	1.6%
Storumans Sjukstuga	2.1%	1.2%	1.7%	2.7%	2.1%
Vilhelmina sjukstuga	3.1%	1.7%	2.4%	3.0%	2.6%

***Andel av den totala kostnaden för respektive vårdnivå
i förhållande till andelen av total fast ersättning
(med rangordning inom respektive grupp efter andel total fast ersättning)***

	Vårdnivå				Andel hyrläkartid av total läkartid
	Sjukhus- mottagningar	Öppenvård totalt	Slutenvård	All vård	
<i>Lycksele</i>					
Medicinkonsulten	0.99	0.99	1.32	1.11	
Stenbergiska Hälsocentral	1.23	1.18	1.38	1.25	0.5%

**Andel av den totala kostnaden för respektive vårdnivå
i förhållande till andelen av total fast ersättning
(med rangordning inom respektive grupp efter andel total fast ersättning)**

	Vårdnivå				Andel hyrläkartid av total läkartid
	Sjukhus- mottagningar	Öppenvård totalt	Slutenvård	All vård	
Skellefteå					
Skelleftehamns Hälsocentral	1.37	1.21	1.13	1.18	8.8%
Erikslid Hälsocentral	1.50	1.31	1.22	1.27	64.7%
Heimdalls Hälsocentral	1.44	1.24	1.18	1.21	26.3%
Anderstorp Hälsocentral	1.33	1.16	1.07	1.13	27.4%
Morö Backe Hälsocentral	1.18	1.04	0.96	1.01	8.8%
Lövsånger Hälsocentral	0.91	0.90	0.96	0.92	0.0%
Bolidens Hälsocentral	0.94	0.94	0.98	0.95	97.2%
Bureå Hälsocentral	1.29	1.15	1.19	1.17	30.5%
Burträsk Hälsocentral	0.86	0.91	1.07	0.97	0.0%
Byske Hälsocentral	0.90	0.93	1.06	0.98	11.1%

**Andel av den totala kostnaden för respektive vårdnivå
i förhållande till andelen av total fast ersättning
(med rangordning inom respektive grupp efter andel total fast ersättning)**

	Vårdnivå				Andel hyrläkartid av total läkartid
	Sjukhus- mottagningar	Öppenvård totalt	Slutenvård	All vård	
Umeå					
Husläkarna i Umeå	0.90	0.91	0.83	0.88	
Sävar Hälsocentral	0.84	0.91	0.85	0.89	53.0%
Citymottagningen HC	1.25	1.21	1.06	1.15	
Norrlandsklinikens H	1.01	1.02	0.81	0.94	
Holmsunds Hälsocentral	0.75	0.88	0.79	0.84	31.3%
Ersboda Hälsocentral	1.20	1.10	1.10	1.10	0.0%
Backens Hälsocentral	1.13	1.06	0.93	1.01	1.7%
Mariehems Hälsocentral	1.20	1.09	0.96	1.04	0.0%
Ålidhems Hälsocentral	1.15	1.06	0.75	0.95	0.0%
Tegs Hälsocentral	0.98	0.96	0.90	0.93	0.0%
Dragonens HC	0.99	1.01	0.92	0.97	
Min Hälsa HC Um					
Hörnefors Hälsocentral	0.77	0.85	0.81	0.83	1.5%

**Andel av den totala kostnaden för respektive vårdnivå
i förhållande till andelen av total fast ersättning
(med rangordning inom respektive grupp efter andel total fast ersättning)**

	Vårdnivå				Andel hyrläkartid av total läkartid
	Sjukhus- mottagningar	Öppenvård totalt	Slutenvård	All vård	
Längre avstånd till sjukhus					
Hälsogemenskapen i Jörn	0.73	0.88	1.36	1.06	
Bjurholms Hälsocentral	0.67	0.83	1.02	0.90	4.3%
Norsjö Hälsocentral	0.70	0.77	0.86	0.81	33.1%
Vindelns Hälsocentral	0.71	0.80	1.03	0.89	7.0%
Robertsfors Hälsocentral	0.66	0.83	0.88	0.85	26.7%
Nordmalings Hälsocentral	0.70	0.76	0.99	0.85	23.5%
Vännäs Hälsocentral	0.81	0.87	0.96	0.90	6.7%
Sjukstugor					
Tärnaby Sjukstuga	0.26	0.48	0.85	0.62	2.7%
Sorsele Sjukstuga	0.44	0.84	1.15	0.95	58.3%
Dorotea Sjukstuga	0.46	0.74	0.98	0.83	42.1%
Åsele Sjukstuga	0.56	0.85	1.13	0.96	4.8%
Malå Sjukstuga	0.50	0.81	1.19	0.95	62.9%
Storumans Sjukstuga	0.57	0.81	1.26	0.98	5.6%
Vilhelmina sjukstuga	0.55	0.78	0.97	0.85	69.7%

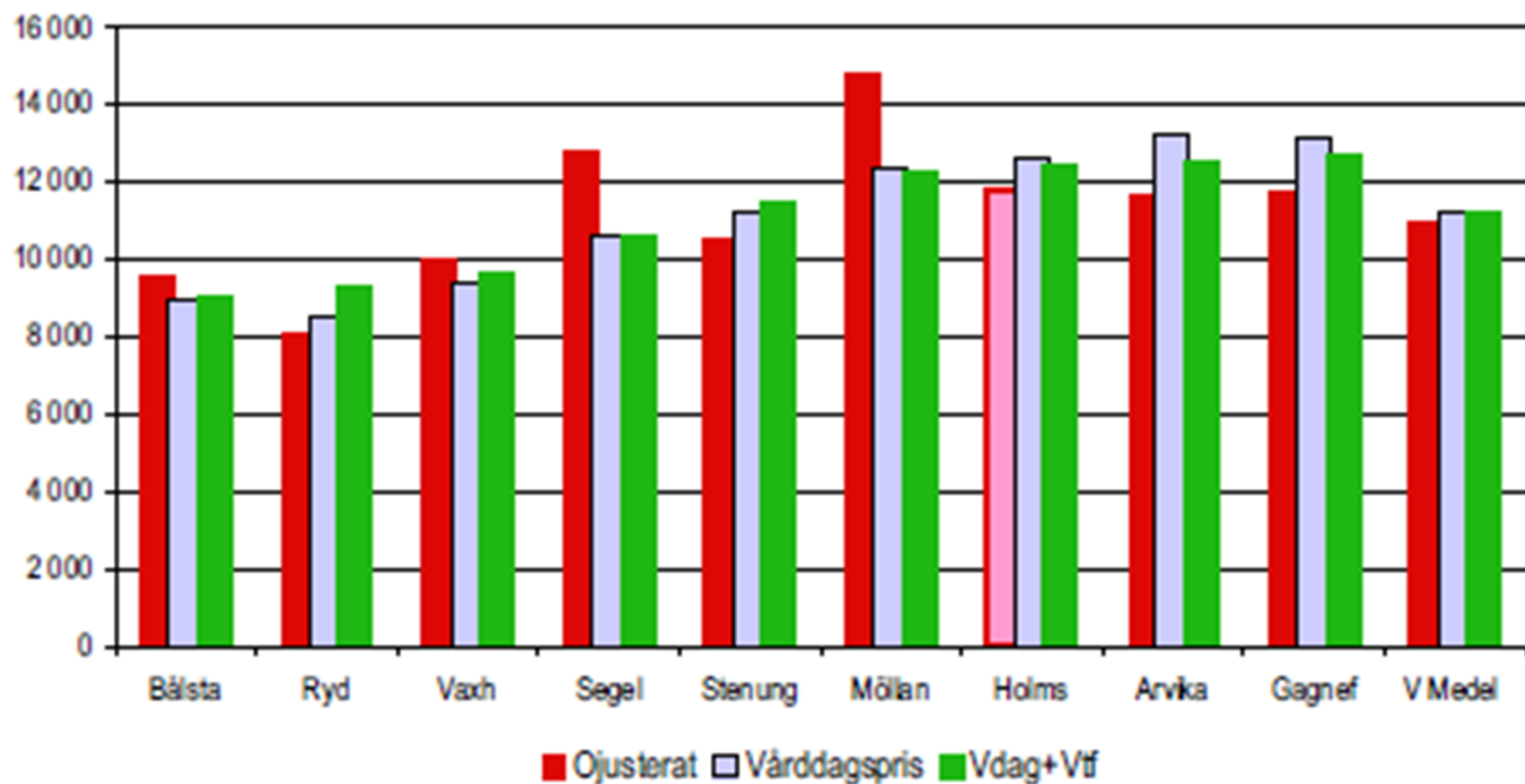
Om primärvårdens domän och strategier

Slutrapport för Socialstyrelsens projekt:
Primärvårdens roll för hälso- och
sjukvårdens systemeffektivitet

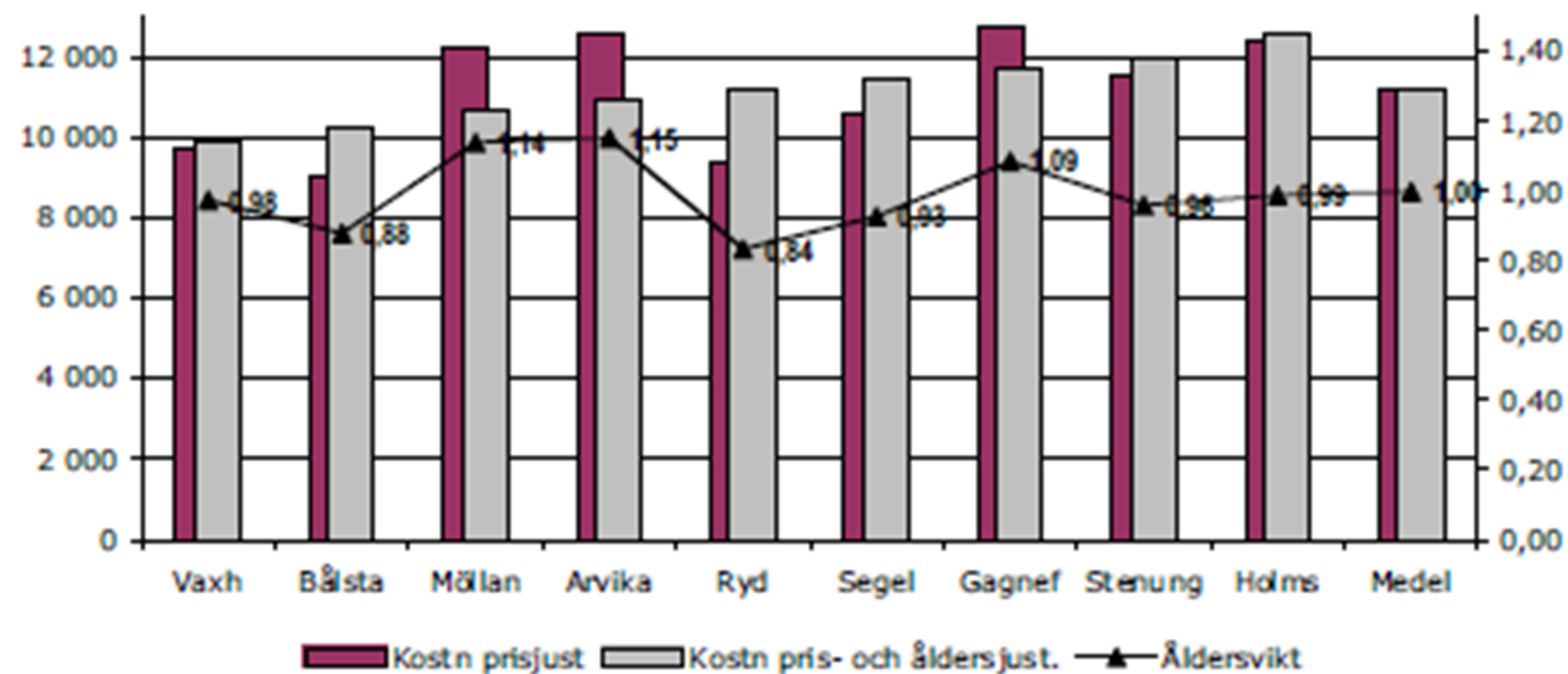
Artikelnr 2004-123-19

Publicering www.socialstyrelsen.se, april 2004

Kostnad för HoS per invånare - utan och med justering för prisskillnader



Sjukvårdskostnad per invånare - justerad för pris och ålder



Sammantaget är den bild man får när man delar upp kostnaden per invånare på detta sätt, mycket spretig.

Även om man tränger djupare och undersöker inom vilka specialiteter vårdutnyttjandet sker kan vi inte urskilja några mönster

Trots den relativt djupa detaljeringsnivån i våra data får vi dock ingen säker vägledning om vad skillnaderna beror på.

Vi kan inte utesluta att det beror på sådana skillnader i sjuklighet som vi inte kunnat dokumentera

Skillnaderna kan ha tre orsaker:

- Olika sjukvårdsbehov och sjukvårdsbörda.
- Vård- och servicestandard kan variera och därmed kostnadsnivån
- Olika effektivitet i systemet, så att man får ut olika mycket sjukvård ur samma mängd resurser.

Sammanfattning i Sos rapporten:

Vi har sett mycket stora skillnader i sjukvårdskostnad per invånare ...

Vår detaljerade analys ... skapar snarare fler frågtecken än färre

En viktig "upptäckt" är att sjukvårdens kostnader är mycket ojämnt fördelade mellan individer i befolkningen.

Ett fåtal individer står för mycket stora och krävande vårdbehov vad avser såväl resurser som planering, samordning och organisation ...

Ytterfallsparadoxen

Studier av vårdutnyttjandet i Skåne visar exempelvis att tre och en halv procent (3,5 %) av invånarna drar så mycket som 50 procent av kostnaderna

Genom att hålla reda på tre och en halv procent av alla i populationen kan man få grepp om halva totalkostnaden ...

... De är omkring 300-400 individer i genomsnitt för en vårdcentral med ansvar för 10.000 invånare

... det kan vara mycket meningsfullt både ur kvalitets- och effektivitetssynpunkt att följa upp hur samordning och vård för dessa patienter fungerar

Våra sammanfattande synpunkter

Konsensus i forskningen – primärvården har stor potential att bidra till systemeffektivitet

Holmsundsprojektet – ett lyckat försök att sänka totalkostnaden genom att satsa på primärvården



Epidemiologi
och
global hälsa

Folkhälsa
och
klinisk medicin

Umeå
International
School
of
Public Health

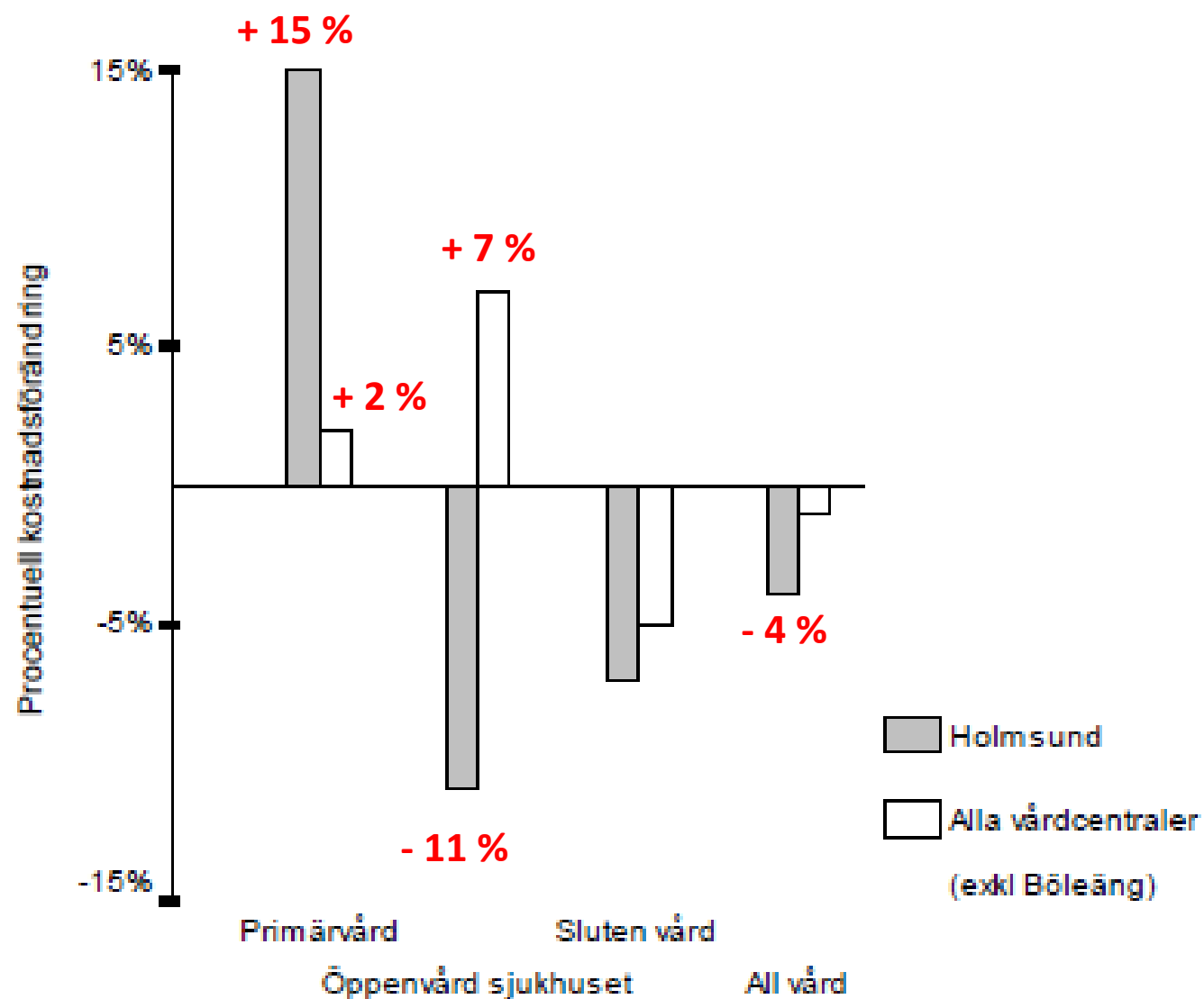


Läget nu – vad göra?

När man vill studera systemeffektivitet:

Viktigt följa patienternas kostnader över alla vårdnivåer

Men det räcker inte med en ögonblicksbild – studera kostnadsutvecklingen över tiden



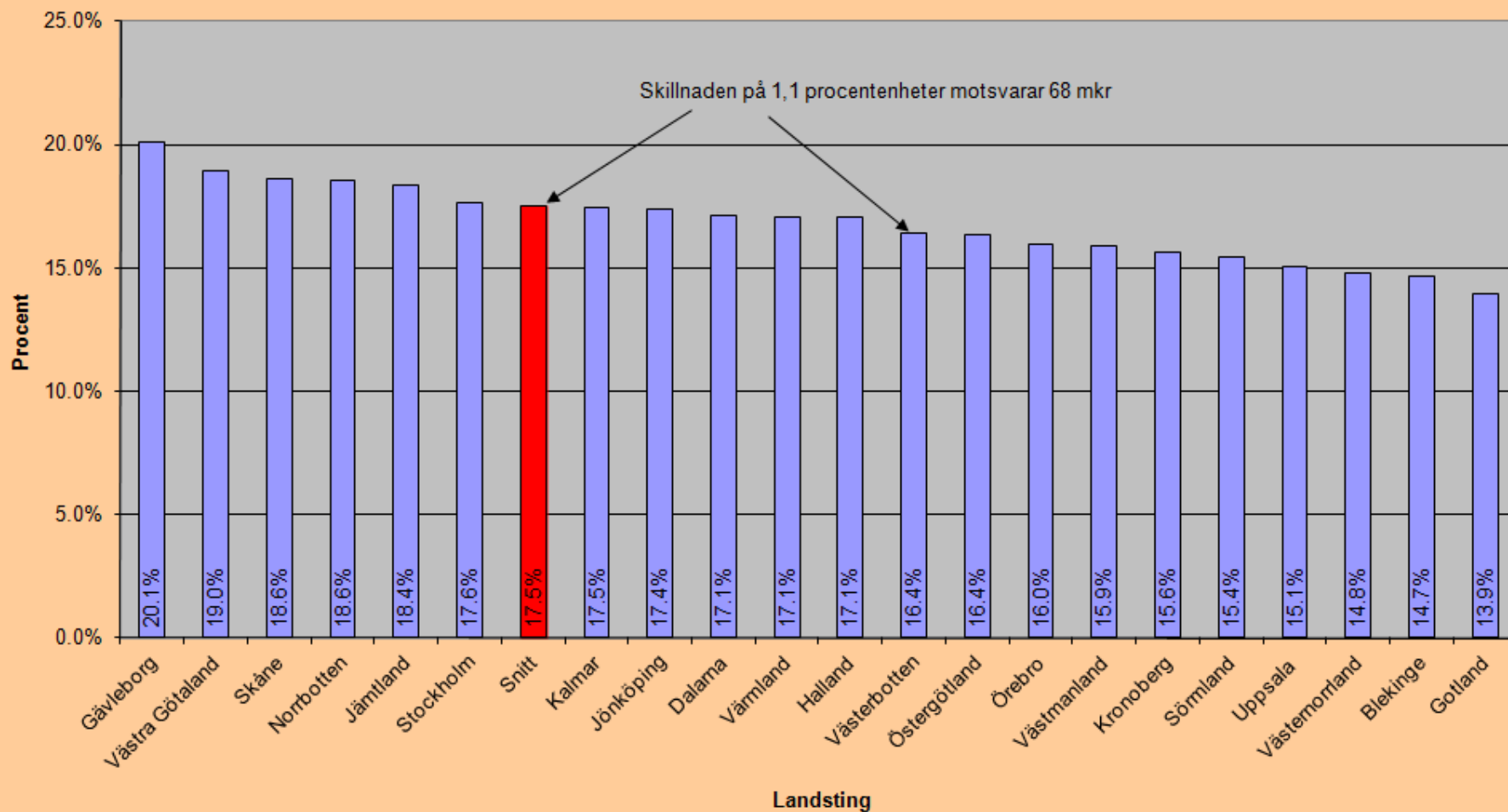
Figur 5.2. Kostnaderna (kronor per invånare) i fasta priser år 2002 i jämförelse med kostnaderna år 2000 för olika vårdformer.

I landstingets datasystem finns ett bra underlag för att regelbundet följa kostnadsutvecklingen

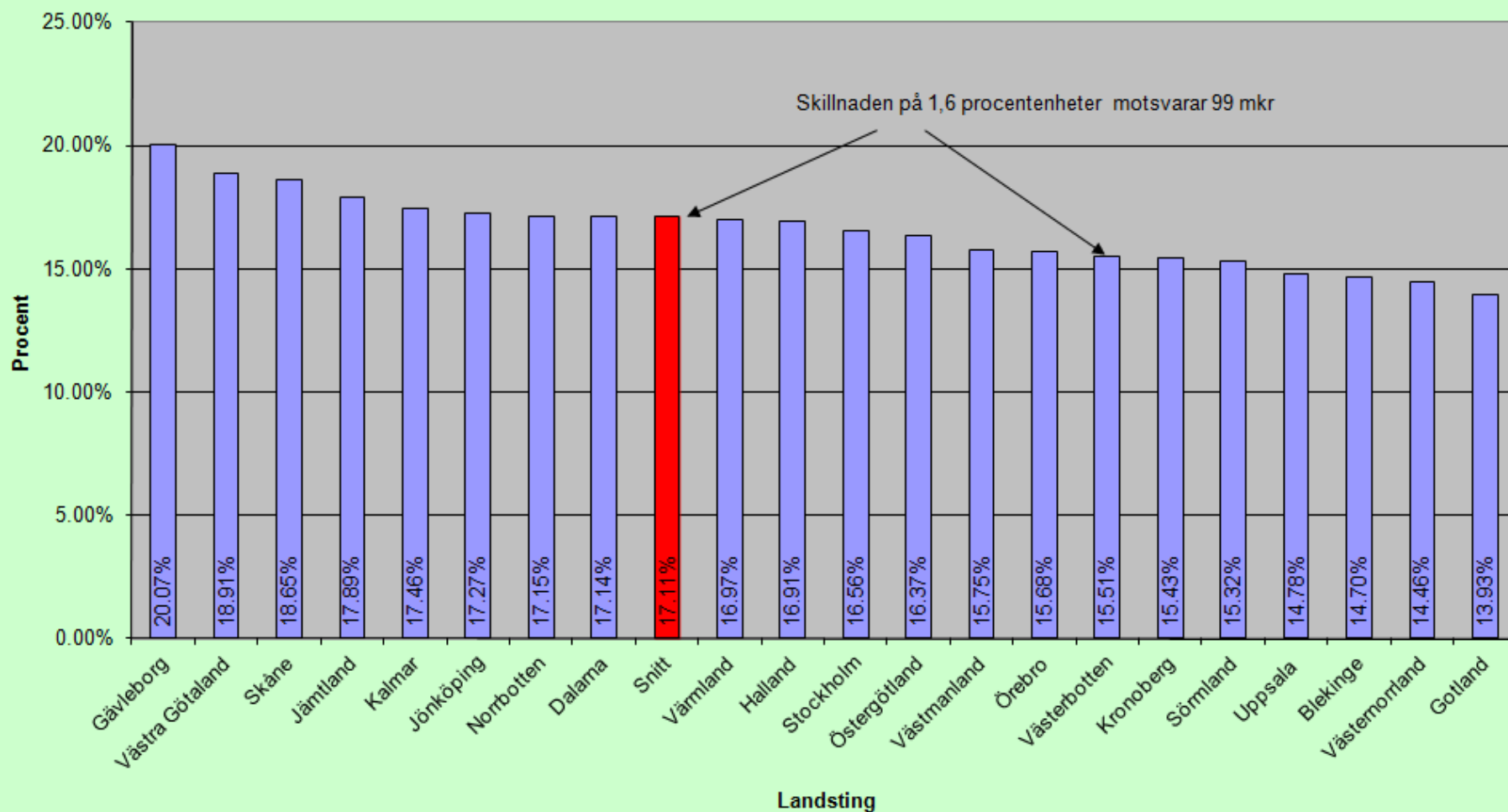
"Efter en del programmering skulle hela sammanställningen kunna göras på två sekunder"

Årlig rapport (motsvarande öppna jämförelser)?

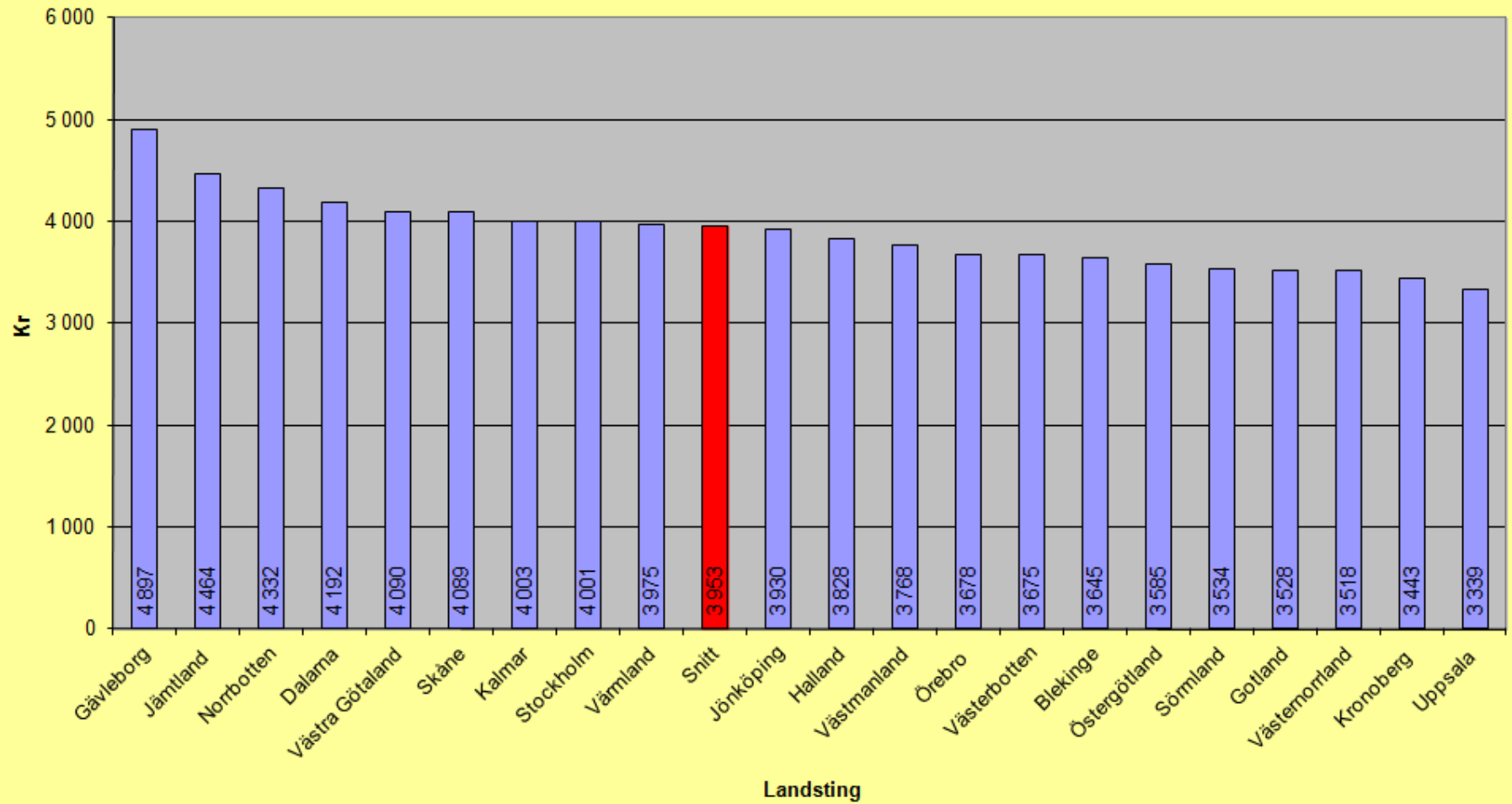
Primärvårdens andel av den totala hälso- & sjukvårdskostnaden 2014 inkl PVHS & PV slutenvård



Primärvårdens andel av den totala hälso- & sjukvårdskostnaden 2014 exkl PVHS & PV slutenvård



Nettokostnad Primärvård 2014 exkl PVHS & Slutenvård



En utveckling mot en förfinad analys:

- från länsnivå till hälsocentralnivå
- uppdelning på patientgrupper
- koppling till patientnytta, t.ex. nationella kvalitetsregister
- väcker frågor och blir grund för utvärderingar