DO WE HAVE THE SPARK?
ALI LAHKO ZANETIMO ISKRICO PREBOJA?

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ABSTRACT

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Upgrading any system is challenging. Neglecting continuous monitoring and evaluation might impose solutions that worsen the situation. Primary orientation toward increasing productivity is the main reason for the tremendous decline in the accessibility of outpatient services in Slovenia since 2015, in addition to additional funds from the state budget. In the actual 'fee-for-service', providers are incentivised to deliver more expensive services, not first visits. Although the stakeholders are not to blame, it is high time for an orientation towards patients’ needs: a breakaway from inefficient technical solutions, an acceptance of patients as active participants in decision-making, measurement of their treatment outcomes, and the adoption of already proven advanced payment models, such as population-based payments. The journey towards value-based healthcare must start!

IZVLEČEK

Ključne besede:
dostopnost, vzpodbude, plačilni modeli, na vrednosti temelječa zdravstvena oskrba

Nadgradnja vsakega sistema predstavlja poseben izziv, opustitev stalnega spremljanja in vrednotenja pa lahko vse vgrajene vzpodbude pripelje do neželenega rezultata, celo poslabšanja razmer. Ob glavni usmeritvi k stalnemu povečevanju produktivnosti je prav to eden glavnih vzrokov za izjemno poslabšanje dostopnosti specialističnih ambulantnih storitev v Sloveniji po letu 2015 navkljub visokim dodatnim sredstvom iz državnega proračuna. Z veljavnim sistemom plačevanja po storitvi so bili izvajalci vzpodbujeni k zagotavljanju dragih storitev, kar seveda niso prvi pregledi. Nobenemu deležniku v sistemu ne gre očitati, je pa napočil skrajni čas, da se končno usmerimo k potrebam bolnikov: da se od neučinkovitih rešitev premaknemo k sprejemu pacientov kot aktivnih odločevalcev, merjenju rezultatov zdravljenja in sprejetju dokazana delujočih naprednih plačilnih modelov, kot so plačila, usmerjena na prebivalstvo. Začnimo potovanje k zdravstvenemu sistemu, kjer zdravstvena obravnava temelji na vrednosti!

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Between 2015 and 2020, the number of patients waiting for the first visit naturally decreased (from 39,033 to 30,339 in neurology, and from 98,723 to 93,753 in orthopaedics) (4).

3 CHANGE OF INCENTIVES

This purpose of this editorial is not to apportion blame. Indeed, is there anyone to blame? Can we blame the providers? Indeed no, as their reaction to the incentive was the only logical one. Can we blame the ZZZS? Surely no, as their intention to pay for more services was positive. Of course, the Ministry of Health is not to blame as it merely provided the additional funds.

So, where does all this leave us? We should realise that it is time to stop, take a moment and analyse the impact of the incentives implemented in the last five years before we organise yet another national tender to pump additional funds into a bottomless hole.

The first obvious step to start optimising accessibility is to define the services that need to be performed by providers for the points paid. In other words, the ZZZS should act as an active strategic purchaser of services to fulfil patients’ needs. The differences among the providers in terms of the ratio of the number of control visits per first visit and the number of points per service are huge and can be improved. Proper incentivising for the provision of more first visits, alongside more points, is the obvious first step. At the same time, the formula for defining the plan of first visits needs to be revised. When the ZZZS establishes the plan of first visits, they divide the fixed plan of points by the average provided number of points per first visit. If the provider provides fewer first visits or more points per visit (the denominator in the formula would be higher), this will result in a lower plan of visits or more points per service (the numerator in the formula would be lower), both of which the providers will try to avoid. The incentives implemented in the last five years before we organise yet another national tender to pump additional funds.

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4 VALUE-BASED HEALTHCARE

While this solution might shorten waiting lists by increasing the number of first visits provided without additional funds, the fee-for-service system would still give the wrong incentives, as highlighted by the current pandemic. While the world was rushing to reorganise and build temporary facilities to accommodate COVID-19 patients, the traditional fee-for-service revenues, resulting from provided services, dried up. Healthcare providers faced financial issues and required state help or well-paid COVID cases to keep
them afloat. People were either scared to visit the doctor for fear of becoming infected, or delayed visits due to hospitals being overwhelmed with COVID-19 patients. The Health Care Payment Learning and Action Network (HCP-LAN) published a framework (5) with the explanation of payment models and their (dis)advantages. Prospective, population-based payments encourage providers to deliver coordinated, high-quality and person-centred care, which is easier to maintain in pandemics as the payment does not depend on each single service produced. Such value-based healthcare (VBHC) holds particular promise for providers and patients who are then willing and able to participate in it. Actively engaged patients feel more responsible and motivated to cope with their disease, which results in the better treatment outcomes that are regularly measured in VBHC systems (6).

5 CONCLUSION

We have been talking about patient involvement, patient-centred care and patient decision-making, and their adherence and cooperation, for the last two decades. Theoretically, of course. The pandemic taught us to live, work and adapt in ways we never even imagined. Hopefully, the pandemic was enough to give us this tiny spark needed to tip us towards change: to break away from inefficient technical solutions, accept patients as active participants in decision-making, measure their treatment outcomes and try to adopt already proven advanced payment models, such as population-based payments.

CONFLICT OF INTEREST

The author declares no conflicts of interest.

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ETHICAL APPROVAL

Ethical approval is not required for this editorial.