Sweden’s 0-7-90-90 care guarantee - where simplicity meets pragmatism?

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The traditional Swedish “model”

- A public system
- “Private” elements integrated in the public financing
- Local political base in county councils
- Power balance between center and periphery
- Regional planning regarding highly specialized care
- Population and public health perspective in planning
- Intersectorial co-operation for public health
- Equity and solidarity emphasis
- Salaried physicians since 1970
Structural changes from 1995 and onwards:

- Mergers between hospitals
- Structural changes within hospitals and between the levels in the system ("chains" of care, "seamless" care etc)
- Co-operation over county council borders (selective parts of the health services spectrum)
- Forming of bigger regions (in West Sweden and in the south, "Skåne")
Members of the Federation

The Federation has 21 members:

- 18 County Councils
- Skåne Region
- Västra Götaland Region
- The Municipality of Gotland

The Taming of the Queue
Johan Calltorp 2007-04-04
Western Health Services Region
1.5 million inhabitants, 17 hospitals, 60 health centres, dental care
Ques and access problems

• Common in systems that try to combine population coverage, innovation, equity and cost control
• The phenomenon of ques is linked to specific system characteristics and steering mechanisms
• Also linked to wider cultural and social aspects of health services
Why long queues and wait-lines?

- "Bad" tradition – lack of focus on access
- Actors have been rewarded to have wait-lines
- Capacity and resources varies
- Indications for treatment varies considerably
- Oldfashioned routines for management of wait-times, referrals, patient-flow.
Ques in Sweden

• Acute services are working fairly well
• Access problems to elective services
• Ques and waiting lists are part of the tradition and social environment
• Discontent over this “tradition” and a threat to system stability
Waiting time Guarantee in Swedish health care – the first policy initiative

• 1992-1997
Maximum waiting time guarantee for 12 different procedures. (Unconditional for 8 procedures, conditional for 4 procedures)

“A patient covered by the guarantee shall be offered treatment within 3 months from the day that the decision was made to treat. Patients who can not be treated within 3 months shall be offered care at another hospital in the health services district, in another county council or through private providers”
Conclusions in the evaluation of the first Guarantee:

• Waiting lists are a complicated interplay between demand and supply. More resources are not the only answer to a more efficient way of managing waiting lists.

• Too much attention is given to the supply side when there is a need for better knowledge and discussion about the indications and priorities that are applied at the clinical level.

• Concentration on one “step” in the care process can create longer waits between other steps in the process, i.e. imposing limits on the waiting-time for treatment can give longer waits for outpatient visits.

• Patients’ influence and freedom of choice have increased, but few patients use the opportunity to change provider.

• There is a lack of common terms and rules for the management of waiting lists and waiting times in Swedish health care.

   The Taming of the Queue
   Johan Calltorp 2007-04-04

Marianne Hanning
2006-06-22
Maximum waiting times in Swedish health care

0 - 7- 90 – 90 (days)
The Swedish Maximum Waiting time Guarantee

Primary care

- Same day
- Visit to a GP within 7 days

Secondary care

- Investigation, tests, x-rays, etc.
- Decision to refer
- 90 days
- Investigation, internal referral, tests
- Decision to treat
- 90 days
- Treatment starts
- Control/reviews for chronic disease

First visit
- 90 days
- Control/reviews for chronic disease
An extended care guarantee from November 1, 2005

• The stated maximum waiting times for access are maintained.
• All medically indicated and decided treatments should be given within a maximum 3 months period.
• If not fulfilled – the patient may choose another provider (public or private), county council pays
A national preparation project

• Started during the autumn 2004
• In full effect during 2005 and 2006
• A regional organization of experts facilitating change.
• Each county council takes its own step and have full responsibility.
• Government provides extra funds.
• Building on earlier experiences and sharing best praxis.
• A focus on action and implementation
Vårdgaranti 05
We know where we are going ....
"A system without waitlines"
...and we have the tools to take us there
Many forces and competences in cooperation.....

.....can move a mountain
Definition of medical indications (appropriateness)

- Observation of variation in medical practice is one starting point.
- The tendency to widen indications is another.
- The need to define “limits” is a third (prioritisation).
- Medical speciality groups are given the task to define criteria for a selected number of interventions
National Care Guarantee 2005

Medical specialities covered

Obstetrics & Gynecology
Ophthalmology
Orthopaedics
Surgery
Rheumatology
Urology

20 different medical procedures

The Taming of the Queue
Johan Calltorp 2007-04-04
National Care Guarantee 2005

Medical indications (appropriateness)

based on

"best available scientific knowledge"

Knowledge sources for the work:

- National medical quality registries
- National Board of Health and Welfare
  - Swedish Society of Medicine
  - International studies
Demographic change – orthopedics
The "age quake"
Analyses show extensive medical practices variations (1)

Source: Swedish National Board of Health and Welfare - Swedish Hospital Discharge Register

Knee arthroplasties incl. fractures per 10 000 inhabitants 2002. Per county and in total.
Indications for orthopaedic surgery

A study from the Swedish National Competence Centre for Musculoskeletal Disorders

Commissioned by the government through

The National Board of Health and Welfare
and
The Swedish Association of Local Authorities and Regions
Reviewed therapy areas

- Hip- and knee arthrosis (March 2005)
- Disc hernia, spinal stenosis and disc generative pain (March 2005)
- Meniscus and ACL tears (March 2005)
- Foot- and ankle surgery – ten different diagnoses (February 2006)
- Shoulder surgery – subacromial pain syndromes, instability and glenohumeral arthrosis/arthritis (February 2006)

The reports can be downloaded from www.nko.se
Observations in cataract surgery:

Number of operation and percentage of patients that have a waiting time of three months (90 days) or less.
Indications for cataract surgery

Priority groups in the 1992-year MWG

Group I: Best corrected visual acuity in the better eye of 0.2 or less.

Group II: Best corrected visual acuity in the better eye of 0.3 to 0.5.

Group III: Best corrected visual acuity in the better eye better than 0.5.

Group I and II were covered by the Guarantee as well as patients in group III with “special medical and social reasons”
National indications (appropriateness criteria) for cataract surgery

- Priquest – a questionnaire for the patient

- NIKE – a national indication instrument

Available on paper and digital
Group of medical indication in the national quality registry covering all cataract operations – public and private
NIKE – a new instrument for cataract surgery

NIKE: a new clinical tool for establishing levels of indications for cataract surgery

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2Department of Ophthalmology, Lund University Hospital, Lund, Sweden
3Department of Ophthalmology, Sunderby Hospital, Umeå, Sweden
4Department of Ophthalmology, Malmö University Hospital, Malmö, Sweden
5Department of Ophthalmology, County Hospital, Rykov, Jönköping, Sweden
6Department of Ophthalmology, County Hospital, Halmstad, Sweden
7Department of Ophthalmology, Helsingborg Hospital, Helsingborg, Sweden

ABSTRACT.

Purpose: The purpose of this study was to construct a new clinical tool for establishing levels of indications for cataract surgery, and to validate this tool.

Methods: Teams from nine eye clinics reached an agreement about the need to develop a clinical tool for setting levels of indications for cataract surgery and about the items that should be included in the tool. The tool was to be called NIKE (Nationell Indikationsmodell för Kataraktextraktion). The Canadian Cataract Priority Criteria Tool served as a model for the NIKE tool, which was modified for Swedish conditions. Items included in the tool were visual acuity of both eyes, patients’ perceived difficulties in day-to-day life, cataract symptoms, the ability to live independently, and medical/ophthalmic reasons for surgery. The tool was validated and tested in 343 cataract surgery patients. Validity, stability and reliability were tested and the outcome of surgery was studied in relation to the indication setting.

Results: Four indication groups (IGs) were suggested. The group with the greatest indications for surgery was named group 1 and that with the lowest, group 4. Validity was proved to be good, surgery had the greatest impact on the group with the highest indications for surgery. Test-retest reliability test and interexaminer tests of indication settings showed statistically significant intraclass correlations (intraclass correlation coefficients [ICCs] 0.526 and 0.923, respectively).

Conclusions: A new clinical tool for indication setting in cataract surgery is presented. This tool, the NIKE, takes into account both visual acuity and the patient’s perceived problems in day-to-day life because of cataract. The tool seems to be stable and reliable and neutral towards different examiners.

Published in
Acta Ophthalmologica Scandinavica
augusti, 2006.
Distribution of indication groups for nine clinical departments in a validation test
Management of waiting list

• Most waiting lists include approx. 20-35 per cent patient that for different reasons not need or want the treatment when called.
• A very concrete “hands-on” tool for better managing waiting lists has been developed.
• All county councils, and all clinics, should apply this.
• A long – term goal is to develop “booking systems” instead of waiting lists.
Productivity, efficiency and process development

- Stimulate use of techniques for better functioning of the health services.
- Many “tools” are available for this but their use differs considerably.
- Managers on different levels of the system have to demonstrate, combine and implement the instruments.
## National wait time registry: Total number of patients waiting for treatment, all county councils per March 31, 2006

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<tr>
<th>Landskap/ Region</th>
<th>Gynäkologi</th>
<th>Hjärt- och åldrandsvård</th>
<th>Kiroprakt</th>
<th>Ortopedi</th>
<th>Plastikkirurgi</th>
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<td><strong>4972</strong></td>
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| Totalt antal väntande patienter i hela Sverige | 62 976 |
| exkl hörapparater                                  | 48 918 |
| Totalt antal som väntat >90 dagar                   | 34% 21 732 |
| exkl hörapparater                                  | 15 979 |
| Hänsisade pat. utanför egna landst. (30 april)       | 3 600 |

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The Taming of the Queue
Johan Calltorp 2007-04-04
Number of patients waiting longer than 90 days for treatment, August -05 to March -06, seven specialities. A reduction by 50 percent. Seven county councils

Number of patients waited longer than 3 months for treatment, a reduction from 15 547 till 7 846, approx 50% Data from 7 county councils/regions: Dalarna, Gävle-borg, Halland, Västmanland, Västra Götaland, Örebro och Östergötland.
Information functions developed in each county council to guide patients where to go for treatment – different approaches (telephone, oral, written information etc)

Vårdgaranti05

Norrbotten: (Vårdsluss)
Västerbotten: Vårdlots
Gävleborg: Vårdvägvisare
Region Skåne: Vårdlots
Sörmland: Valfri-rättighetskansli
Västmanland: Vårdinformatör
Uppsala: Vårdgarantienhet
Stockholm: Vårdgarantikansli
Östergötland: Info-linje
Jönköping: Verksamhetsinfo
Kalmar: Verksamhetsinfo
Kronoberg: Vårdlots
Gotland: Planeringsenhet Vård
Blekinge: Linjeansvar med central info-telefon för hänvisning

Västernorrland: Info-telefon
Jämtland: Vårdgarantiuppföljning
Dalarna: Väntetidskansli
Värmland: Vårdlots
Örebro: Vårdslussen
Västmanland: Vårdinformatör
Västra Götaland: Vårdslussen
Halland: Vårdgarantiservice
Region Skåne: Vårdlots

Where?
Side effects of a care guarantee

- A risk that less visible conditions are neglected?
- Chronic long term conditions and psychiatric disorders can be set aside?
- To articulate all patient groups of need and to link the need to resource distribution is essential.
- The prioritisation models under development are helpful for this.
Western Health Services Region Model for Prioritization

Need and resource allocation
Geographical areas
Local political boards

Vertical medical prioritisation
22 medical expert groups

Horizontal prioritisation
Resource allocation between medical areas
Political regional health council
Vertical prioritization process

Each medical speciality has listed its activity according to a common framework.
Distinct groups of patients categorized according to:

Need of care
- national 4 level grouping (prio)
- a detailed 10 score list (prio)

Methods for intervention
- preferred method of intervention
- medical acceptable waiting time
- effectiveness according to common clinical understanding
- scientific proof of evidence (if accessible)
- cost/effectiveness (if accessible)
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<th>Treatment</th>
<th>Prio I - IV</th>
<th>Prio 1 - 10</th>
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<th>Acceptable waiting time</th>
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<td>with symptoms</td>
<td>Lap/open operation</td>
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It takes time to change direction ...

A continuous focus on access
The responsibility and focus of the leaders
Developmental and change activity with all tools
To stay on for a long-term result
Local, regional and national cooperation
Further information

Health Care Trends in Sweden –
A review paper on system changes and a description of the care guarantee work can be sent on request to:

johan.calltorp@comhem.se

(as well as references to appropriateness work in different speciality areas)