



Socioeconomic distribution of GP visits following patient choice reform and differences in reimbursement models: Evidence from Sweden

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ABSTRACT

Objective: This study aims to analyse changes in the socioeconomic distribution of GP visits following primary care patient choice reform, and to compare their magnitude and direction in pure capitation, versus capitation/activity-based mixed, provider reimbursement settings.

Methods: We compute absolute and relative concentration indices using total population registry data from three Swedish counties (N~3.6 million) two years pre, to two years post, reform. We decompose the indices by the contribution of first, non-recurrent and recurrent visits, and compare their changes in the different provider reimbursement settings.

Results: In all three counties, the number of visits increased for all population groups. Increases were larger, and distributional changes more pro-poor, in the county with mixed reimbursement. Visit increases were mostly driven by recurrent and, especially, non-recurrent, visits, which were increasingly pro-poor in all counties in absolute, but not in relative, terms. First visits either became decreasingly pro-poor, or did not change significantly. Exclusion of high users removed the pro-poor patterns in the two counties with pure capitation.

Conclusions: The reform led to increased access to GP visits, but implied small changes in their socioeconomic distribution. In combination with provider reimbursement models with incentives for higher visit volumes, changes were more pro-poor over time, but it is not clear whether this was at the expense of reduced visit length or content.

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1. Introduction

In the last decades, market oriented reforms have become popular measures for policy makers to improve access and efficiency in publicly funded health care systems [1–3]. The reforms comprise several interconnected elements; increased private provision of care, competition between health care providers, changes in provider reimbursement, and patient choice [1]. Policy makers view patient choice as both an intrinsic desirability, and an instrument to increase competition, access and quality of care [1,4–6].

The impact of patient choice may be different for different socioeconomic groups [3,7]. Whilst socioeconomically weaker indi-

viduals on average have higher levels of ill health and need for care [8,9], they may be less inclined to make informed choices, have lower health literacy and fewer choice options [10]. On the other hand, choice opens up a way to exit dissatisfactory providers within the tax-funded system (i.e. without having to substitute for privately financed care), which may particularly benefit socioeconomically weaker individuals [6]. The evidence of the relative importance of these effects is scarce, and little is also known about the socioeconomic distribution of any access improvements or visit increases induced by patient choice [5,6,11].

A challenge to studying these effects is that patient choice interacts with other features of the health care system. For example, the design of provider reimbursement may dampen or amplify any visit increases induced by patient choice [12]. Overall, reimbursement through capitation creates incentives to keep visit levels low (underproduction), whilst activity-based reimbursement creates incentives to overproduce visits [13–15]. Few studies

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have addressed the effects of reimbursement models for different socioeconomic groups [16], and none has to our knowledge considered its possible combined effects with patient choice.

The interest of this study is patient choice in primary care. Primary care is seen as an important arena to level out health inequities [17] and, contrarily to specialist visits, tend to be more accessible for relatively poor individuals [18–25]. In primary care, there is also no preceding care level that filters or facilitates individual choice. The policy relevance in studying the socioeconomic effects of patient choice in primary care is clear, but to date there are few empirical studies.

This study aims to analyse changes in the socioeconomic distribution of general practitioner (GP) visits following primary care patient choice reform, and to compare the magnitude and direction of these changes in pure capitation, versus capitation/activity-based mixed, provider reimbursement settings. For that purpose, we study the development of GP visits in the three largest Swedish counties, before and after the Swedish patient choice reform.

2. Setting

2.1. Institutional background

Sweden has a tax-financed and universal coverage health care system, where a high degree of decentralisation creates regional variation in policy and organisation. Twenty-one elected county councils are responsible for financing, purchasing and (in-house or contracted) provision of care. There is a national annual co-payment ceiling of € 130, and doctors are typically salaried rather than individually contracted and - reimbursed.

Prior to patient choice reform, all counties had a community oriented primary care system of centrally planned, multi-professional centres with geographically defined uptake areas. These centres could be privately operated (and financed through public procurement), but local markets were in practice monopolies, as patients had limited opportunities to choose a provider outside their uptake area. The system put strong focus on equity but struggled with limitations in access and low utilisation levels compared to other countries [12,26]. Patient choice was motivated as an instrument to increase access, by facilitating provider entry and competition, and as a desirable goal in its own right [27]. A national law made it mandatory for all counties to offer patient choice in primary care by 2010 [28], but there was regional variation in the implementation timing, as some counties started already in 2007 [12].

2.2. Policy content

Three main policy components were shared across counties: (1) entry restrictions were removed, i.e. primary care providers who met certain basic criteria were allowed to set up practice without geographical restrictions, (2) individuals could choose to enlist to any practice, and (3) all practices received public funding on equal terms through a patient voucher system ('the money follows the patient'). Most counties chose a provider reimbursement model that resembled the pre reform fixed payments based on characteristics of the population in the uptake area - but now the basis for capitation was the number of enlisted individuals, typically adjusted for age, sex, socioeconomics and/or disease burden. Stockholm however stood out by implementing larger changes to the reimbursement design. The capitation share was lowered, and 60 per cent (unadjusted) per visit payments were introduced [12].

In sum, there was a shared but sequential implementation of patient choice across counties, and a differing design of provider reimbursement.

2.3. Policy effects

Quantitative follow-up of reform effects is scarce, but we know that the reform resulted in increases in the number of providers, primarily in densely populated areas [29]. People were generally positive to the possibility to choose, but much fewer utilized it in practice [30]. Studies from two counties show that the probability of making a first visit increased less for vulnerable groups (those with family income below the median, and those in poorer mental health and/or living in more deprived areas) [31,32]. There are no published studies on the full socioeconomic distribution of visits, or studies accounting for the differences in provider reimbursement design across counties.

3. Materials and methods

3.1. Study design

We use the inter county variation in reform timing to assess if reform implementation coincided with changes in the socioeconomic distribution of GP visits, independently of implementation date. We compare two counties where provider remuneration was only through capitation (Skåne and Västra Götaland), to one county with a capitation/activity-based mixed reimbursement model (Stockholm). We centre data around the reform date in each county (1 May 2009, 1 October 2009 and 1 January 2008 respectively [12]), and cover the period from two years before, to two years after the reform year (defined as the period \pm 6 months from the respective reform date, graphical depiction in Appendix 1 in Supplementary material). This design allows us to differentiate between shared developments across all three counties - regardless of reform timing or reimbursement - as well as diverging patterns across counties or reimbursement models. The idea is that a shared pattern more likely is attributable to patient choice, whilst a specific development in the capitation/activity-based mixed county more likely is attributable to reimbursement design.

3.2. Materials

3.2.1. Total population register data

We use individual level registry data from Statistics Sweden on all adults (25 years of age or older) residing in any of the three included counties (N~3.6 million, half of the adult Swedish population; descriptive statistics are available in Appendix 2 in Supplementary material). These counties were selected as individual level information on GP visits was available and linkable to registries of background data using personal identity numbers.

3.2.2. Socioeconomic indicator

We use equalized household disposable income per individual and year as our socioeconomic indicator, computed using Statistics Sweden's equivalence scale. Individuals with zero or negative equalized household income (~1.5 and 0.5 percent of the population) are excluded. The use of income as socioeconomic indicator allows us to differentiate across a wide socioeconomic spectrum (contrary to for example educational levels), and is the standard socioeconomic proxy in health economic studies of health care equity [19,21,23].

3.2.3. GP visits

We have compiled a unique visit level database containing the respective health care utilisation registers from each of the three included counties, and linked this to the total population data. We focus only on on-clinic GP visits, as practices regarding registration of home and nurse visits differed between registries. For GP visits

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