Prevolnik Rupel V, Marušič D. Do we have the spark?. Zdr Varst. 2022;61(2):73-75. doi: 10.2478/sjph-2022-0010.

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

**Valentina PREVOLNIK RUPEL[1,2*], Dorijan MARUŠIČ[3]**

[1]Institute for Economic Research, Kardeljeva ploščad 17, 1000 Ljubljana, Slovenia
[2]DOBA Business School, Prešernova ulica 1, 2000 Maribor, Slovenia
[3]Health Centre Celjenje, Vojke Šmuc 12, 6000 Koper

Received: Jan 28, 2022
Accepted: Jan 29, 2022

Invited editorial

**ABSTRACT**

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!

**Keywords:**
accessibility,
incentives,
payment models,
value-based healthcare

***IZVLEČEK***

*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 dokazano delujočih naprednih plačilnih modelov, kot so plačila, usmerjena na prebivalstvo. Začnimo potovanje k zdravstvenemu sistemu, kjer zdravstvena obravnava temelji na vrednosti!*

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

***Corresponding author:** Tel. + 386 1 478 68 70; E-mail: katkarupel@yahoo.com; katka.rupel@gmail.com

*'While we are making up our minds as to when we shall begin, the opportunity is lost.'*
(Quintilian)

## 1 INTRODUCTION

According to the latest published data, healthcare expenditures amounted to 8.5% of GDP or EUR 4,125 million in 2019 (1). Large systems such as healthcare are highly complex, with elements that depend on each other. Changing such systems is not easy. If you cannot identify the real problem of the system, the investments in a solution will be ineffective, expensive and might even worsen the situation that we are trying to solve. One obvious problem in the Slovenian healthcare system is access to healthcare services, as expressed in the long waiting lists. The estimated financial value of services for patients on waiting lists was EUR 120.4 million and the estimated value of those waiting longer than the maximum permissible time (2) was EUR 44.7 million in 2020 (3). This estimation was made in 2020 after considerable amounts of money were invested in providers to shorten waiting lists – an intervention that can, by definition, be called ineffective.

## 2 ACCESS TO SPECIALISTS

Defining the bottleneck that forms the waiting lists is not difficult: patients are waiting for first visits to specialists. Between 2015 and 2020, the number of patients waiting for the first visit longer than the maximum permissible time in three specialist areas (orthopaedics, neurology and cardiology) increased from 1,657 to 16,350 patients, or almost tenfold. The Health Insurance Institute of Slovenia (ZZZS) and the Ministry of Health have been very active, providing additional funds from the state budget and paying providers for all the additional services they are ready to deliver over and above the plan. Such payment, where health providers are paid for each service rendered, is called 'fee-for-service'. Economists and health policymakers have long claimed that such a system is inefficient because it incentivises the providers to provide more, primarily as a way of increasing revenue. At the same time, the model incentivises providers to deliver more of the expensive services (the ones with more points). It is also not supportive of coordinated care across providers. When specialists were faced with the higher points plan, meaning that more work and more services are to be carried out, the medical specialists reacted as homo economicus, i.e. as rational human beings trying to behave in accordance with their rational self-interest. The easiest way to achieve as many points as possible is to provide more services associated with a higher number of points. These are not first visits (which have a low value). Between 2015 and 2020, the number of points per visit increased from 19.4 to 21.8 in cardiology, from 7 to 7.5 in orthopaedics, and from 33.1 to 40.9 in neurology. As our homo economicus was busy providing as many expensive services per patient as medically rational, the number of first visits per year 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 first visits. A purely mathematical issue diminished all the effectiveness of the incentives and resulted in reduced accessibility to healthcare.

## 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.

## FUNDING

This editorial was produced without external funding.

## ETHICAL APPROVAL

Ethical approval is not required for this editorial.

## REFERENCES

1. Statistični urad RS. Zdravje in zdravstvo. Accessed January 20th, 2022 at: https://www.stat.si/StatWeb/Field/Index/10/117.
2. Pravilnik o najdaljših dopustnih čakalnih dobah za posamezne zdravstvene storitve in o načinu vodenja čakalnih seznamov. Uradni list RS. 63/2010, with amendments. Accessed January 20th, 2022 at: http://www.pisrs.si/Pis.web/pregledPredpisa?id=PRAV1029.
3. Nacionalni Inštitut za javno zdravje. Analiza stanja na dan 1.1.2020 1.6.2020 in 1.1.2021. Accessed January 20th, 2022 at: https://www.nijz.si/sl/publikacije.
4. Prevolnik Rupel V, Marušič D, Kuhar M. Decision-making in Slovenian outpatient care: can financial incentives reduce patient waiting lists?. Medical Writing. 2021;30(3):28-33. Accessed January 20th, 2022 at: https://journal.emwa.org/medical-decision-making-and-health-technology-assessment/decision-making-in-slovenian-outpatient-care-can-financial-incentives-reduce-patient-waiting-lists/.
5. The Mitre Corporation. Health care payment learning & action network: alternative payment model framework. Accessed January 20th, 2022 at: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.
6. Meuse D. Is COVID-19 the end of fee-for-service payment? State health & value strategies. Princeton University, 2020. Accessed January 20th, 2022 at: https://www.shvs.org/is-covid-19-the-end-of-fee-for-service-payment/.