THE WENNBERG INTERNATIONAL COLLABORATIVE POLICY CONFERENCE

Tracking Regional Variation in Healthcare
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Abstract

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ZENTRALINSTITUT FÜR DIE KASSENÄRZTLICHE VERSORGUNG IN DEUTSCHLAND

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Nature of the paper (check boxes)

☒ report on implementation project / experience / policy perspectives

☐ scientific research a) describing work in progress ☐ b) new methods ☐ c) presenting results ☐

Title

Evaluating practice variation: can prioritisation help?

Background

The description of medical practice variations, geographic or other, usually ends with the question: who is „right“, the unit with many or that with few services? There are at least two approaches to address the problem. The first (in silver) uses aggregate data (e.g. % of elderly patients with permanent atrial fibrillation (AF) currently under effective anticoagulants) and specifies a priori a threshold or range (“normative prevalence”, e.g. 80%) below which a unit is deemed to provide substandard care. The second approach (in gold) capitalises on prespecified indication rules, uses clinically relevant data from individual patients and compares the clinical characteristics of each case with the indication criteria. The cases can then be evaluated as – more or less - over-, adequately or under-treated.

Objectives

To assess the usefulness of prioritisation to rank medical objects (here indication rules) according to a set of accepted values and criteria

Methods

Prioritisation is a complex methodology to addresses the “more or less”. It ranks medical objects such as health targets, service goals, patient populations, cases, clinical states, single methods, or indication rules, i.e. fixed combinations of defined clinical states and defined diagnostic or therapeutic methods. It is to be based explicitly on social values, medical and scientific criteria and robust procedures. According to a Swedish model (Broqvist et al 2011) prioritisation can result in national guidelines aimed at supporting clinical management and governance (“stöd för styrning och ledning”). The rank of a “condition-intervention-pair” (CIP) is expressed by means of a numeric rating scale (1 = highest, 10 = lowest priority). Compared to the Rand Corporation approach to assessing “adequacy of care” prioritisation seems to be coarse-grained, due to the often less detailed description of both the clinical state and the method of interest. It may nevertheless help to estimate the actual appropriateness of care for certain clinical states and can be based on administrative data.

Results

An example: In the most recent Swedish Prio-Guideline on Cardiac Care (January 2015), the combination of permanent AF in patients aged 75+ and one of the new oral anticoagulants received a “2”, expressing a very high priority and a strong indication - nearly a “must” given that no other and equally strong or stronger obligation exists. It seems comparatively easy to use the indication rule as a quality indicator, identify both elements of the CIP in (German) administrative data banks, and assess - on a casewise basis - the adequacy of care in a defined region or compare it between geographical or organisational units.

Conclusion/Discussion/Policy Perspective

Prioritisation following the Swedish model may help to answer the initial question.

Literature

Broqvist M, Branting Elgstrand M, Carlsson P, Eklund K, Jakobsson A: National model for transparent prioritisation in Swedish health care. Linköping (University Press) 2011

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