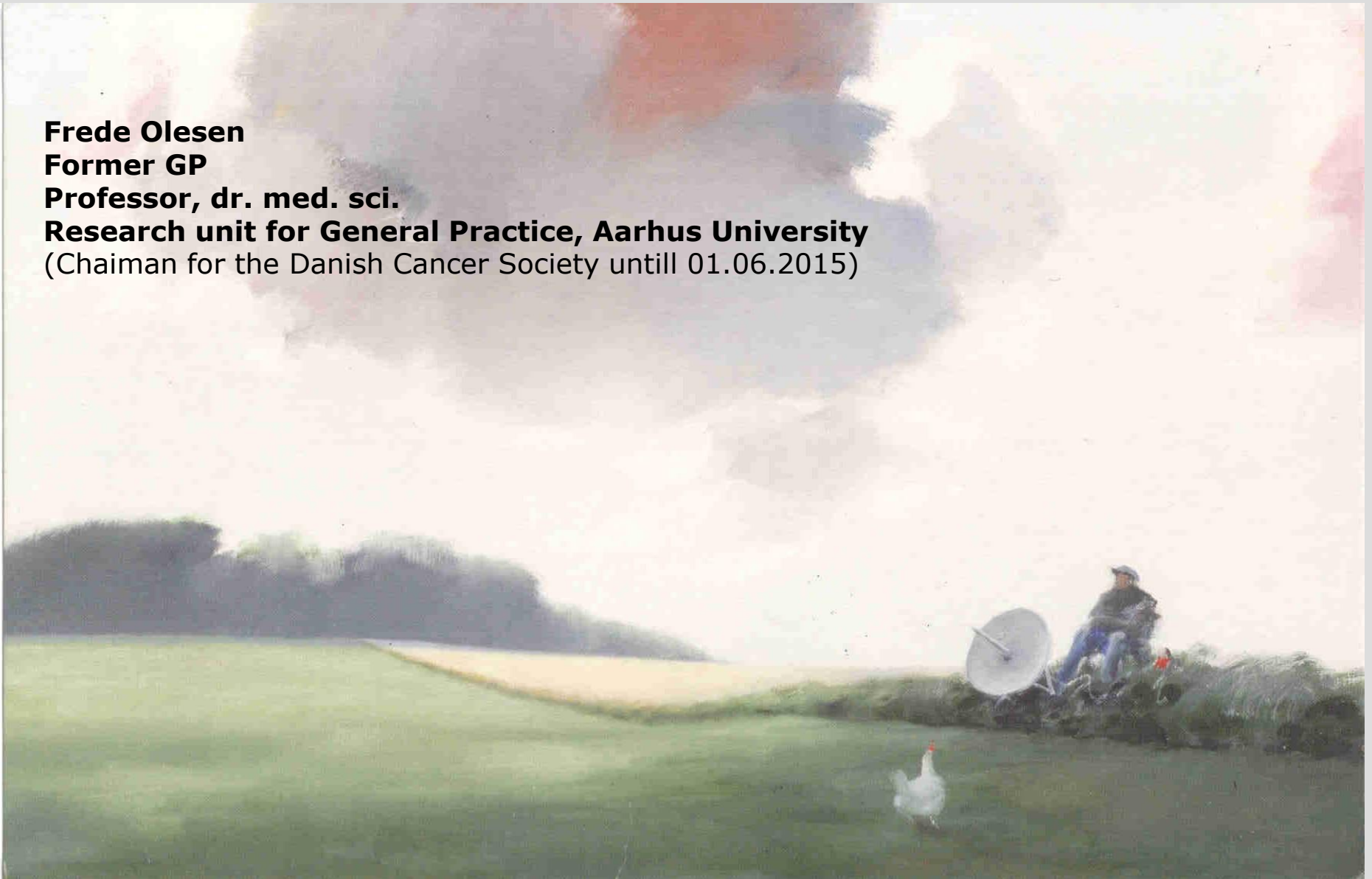


**Frede Olesen**  
**Former GP**  
**Professor, dr. med. sci.**  
**Research unit for General Practice, Aarhus University**  
(Chairman for the Danish Cancer Society untill 01.06.2015)



# Some of my first observations 1976 - 85

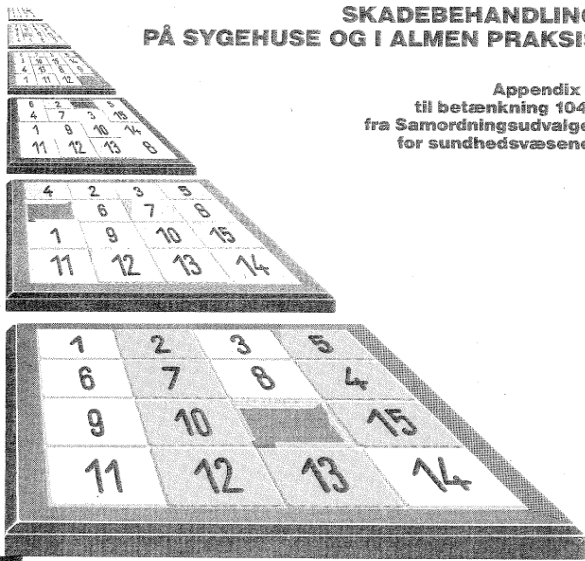
- **Variation in use of hospital based A&E service ranged between 3,5% and 35% per inhab. per year in Danish Counties**
  - Aarhus county: average 15%. A small city 15 km from center used 7%, and of these 50% might have been treated in primary care
  - (my first conversation to a very angry consultant ...)
- **Use of intermediate beds in a municipality based nursing home**
  - a substantial reduction in number of waiting days in hospital beds before discharge to a nursing home
  - (a very angry leading geriatric consultant ...)
  - A national survey showed no correlation between number of nursing home places/inhab. and number of waiting days before discharge from hospital

# The consequence of the first angry consultant ....

## Samordning i sundhedsvæsenet

### SKADEBEHANDLING PÅ SYGEHUSE OG I ALMEN PRAKSIS

Appendix B  
til betænkning 1044  
fra Samordningsudvalget  
for sundhedsvæsenet



**1983: A report from The national board of health**

**Variation from 4% to 37%  
between Danish counties with respect to  
use of A&E hospital service**

Tabel 2.2. Akutte ambulante besøg på somatiske sygehuse, 1983., i forhold til befolkningstallet, i %, fordelt på kirurgiske, medicinske og andre besøg

	Kirurgisk blok	Medicinsk blok	Andet	Akut ambulan- te i alt
Frederiksberg kommune	32,1	1,1	3,9	37,1 (1)
Københavns kommune	30,0	0,0	2,4	32,4
Roskilde amt	16,9	0,0	0,2	17,1
København amt	20,9	1,2	0,3	22,4
Frederiksborg amt	16,3	0,6	1,6	18,5
Århus amt	15,0	0,4	0,6	16,0
Vejle amt	12,8	0,9	0,3	14,0
Fyns amt	12,8	1,1	2,0	15,9
Vestsj. amt	12,8	0,6	1,5	14,9
Storstrøms amt	11,9	0,5	0,6	13,0
Ribe amt	11,9	0,4	0,1	12,4
Bornholms amt	10,2	0,0	0,0	10,2
Nordjyllands amt	9,8	0,1	1,2	11,1
Sønderjyll. amt	9,3	0,3	0,0	9,6
Viborg amt	9,1	0,1	0,0	9,2
Ringkjøbing amt	4,4	0,0	0,0	4,4
Hele landet	15,2	0,5	0,9	16,7
Hele landet	777578 (91%)	27551 (3%)	47805 (6%)	852734 (100%)

Kilde: Sundhedsstyrelsen, afd. B.

1. Sygehuskommunerne er opført efter faldende totalforbrug.

# Skadestue London Kings-College-Hosp.

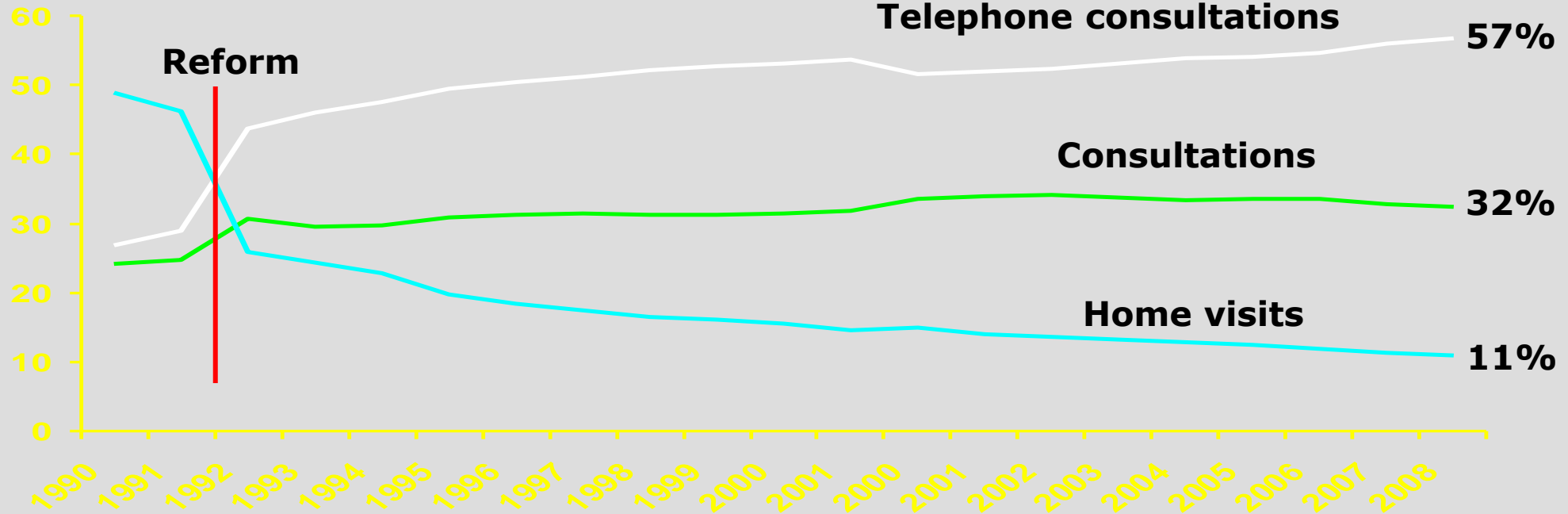
Bemanding : Senior      Yngre læge      Prakt. læge  
Inklusion : Patienter med "Primary care" problemer (41%)  
Metode : Kontrolleret intervention m. follow up  
(interview + spsk til pt & prakt. læger)  
Resultat      Tilfredshed :      ingen forskel (ca. 80%)  
(n = 4641pt)      Brug af praksis < 10 dage efter : ingen forskel

Omkostning incl. afledte :

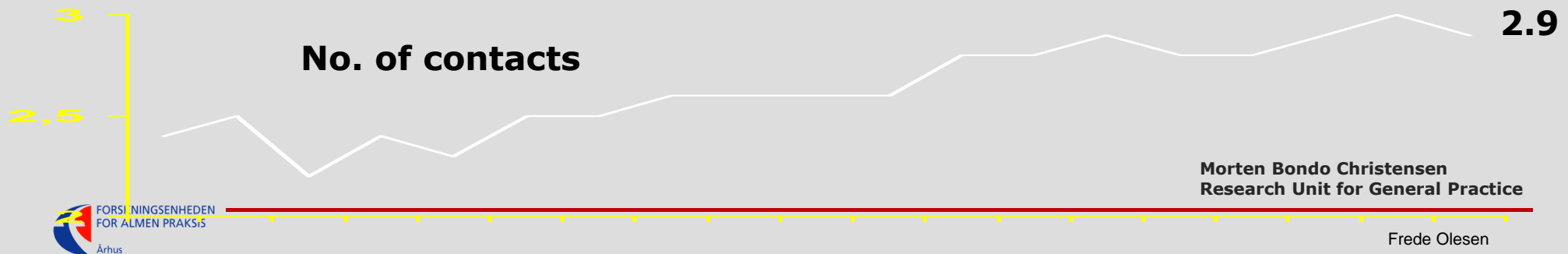
	excl. henv.		incl. henv.	
	£	Relativ	£	Relativ
Senior :	19,30	100	68,25	100
Yngre :	17,97	93	44,68	77
Prakt :	11,70	61	32,30	55

# Contacts to the out of hours service 1990-2001

Percent



Mill

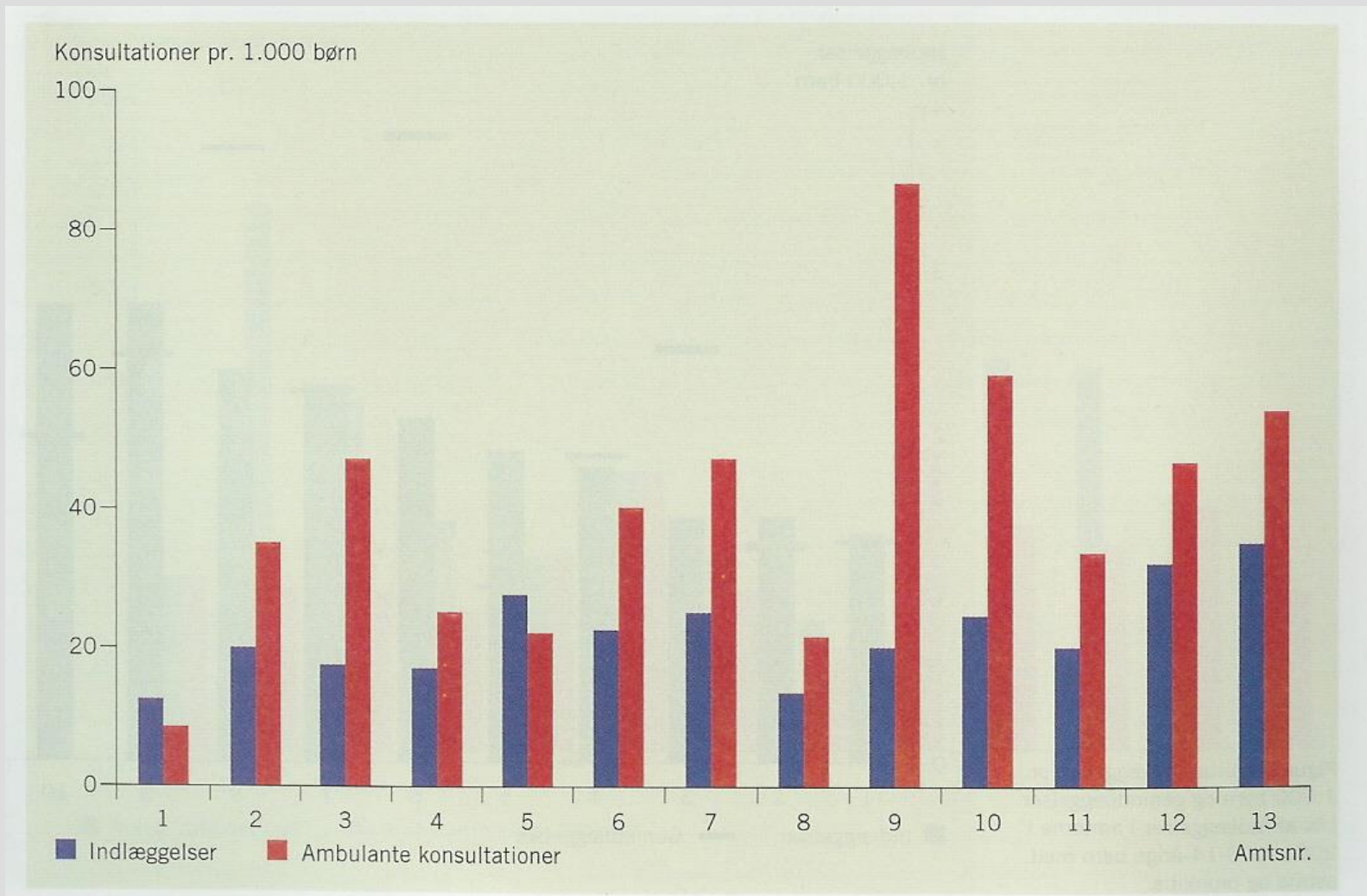


# The new A&E service in Copenhagen

- **We transformed triage from GPs to nurses**
  - can anybody be surprised that major changes in triage happened?
  - number of 112 and hospital referrals were raised substantially
- **We changed consultations from GPs to hospital pediatricians**
  - can anybody be surprised that number of hospital admissions raised substantially

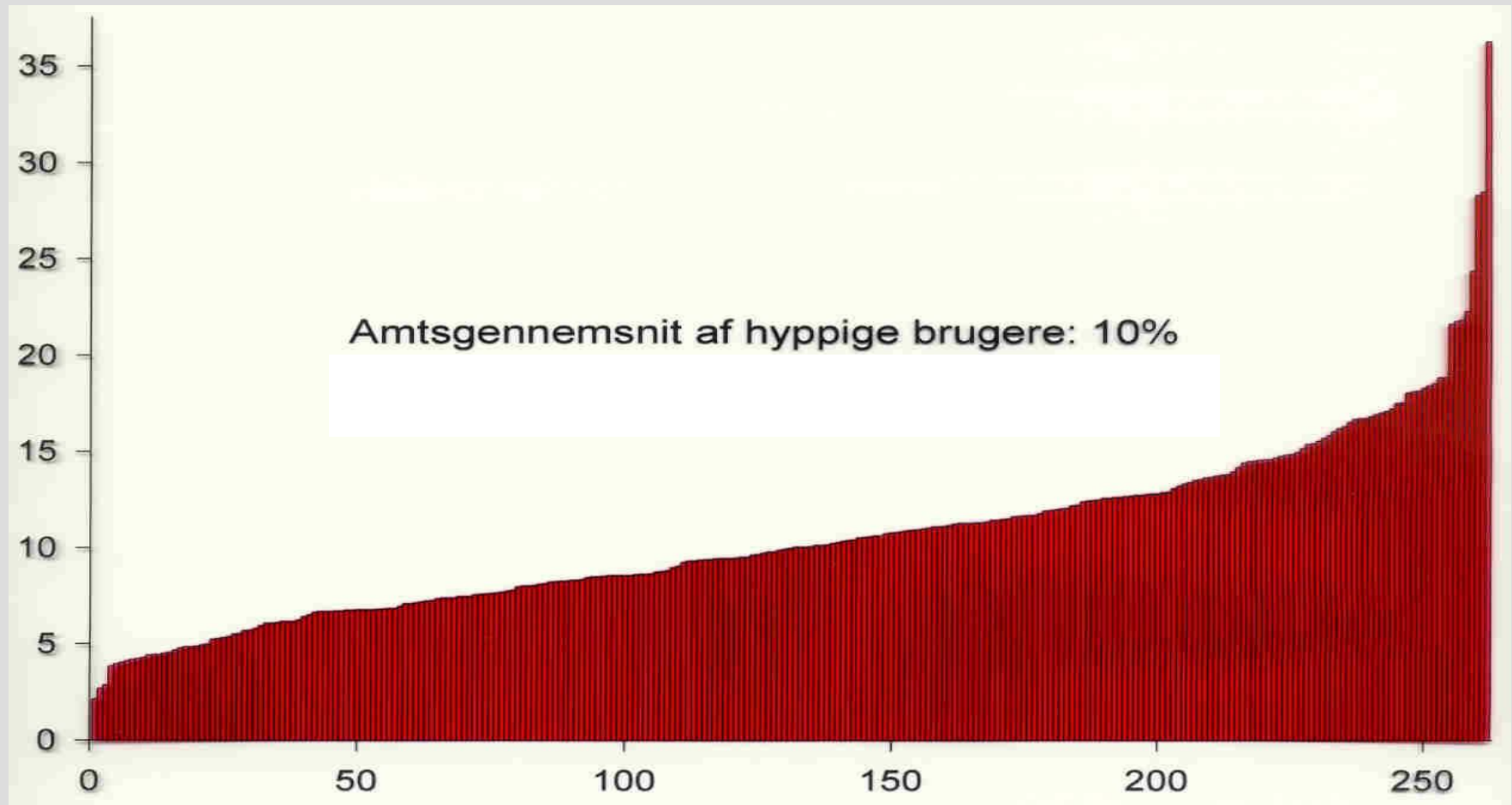


# Variation in hospital bed days for childrens astma (blue) and use of ambulatory asthma care visits (red) in 13 Danish counties



# % of practice pop. as frequent attenders

**Frequent attender = belongs to upper 10% of attenders in a county. N=255 GPs.**





**Number of consultations in the GPs surgery in day time in 268 GP settings in Aarhus county 2003**

**X-axis: 268 GPs ranged according to activity. Y-axis number of consultations**

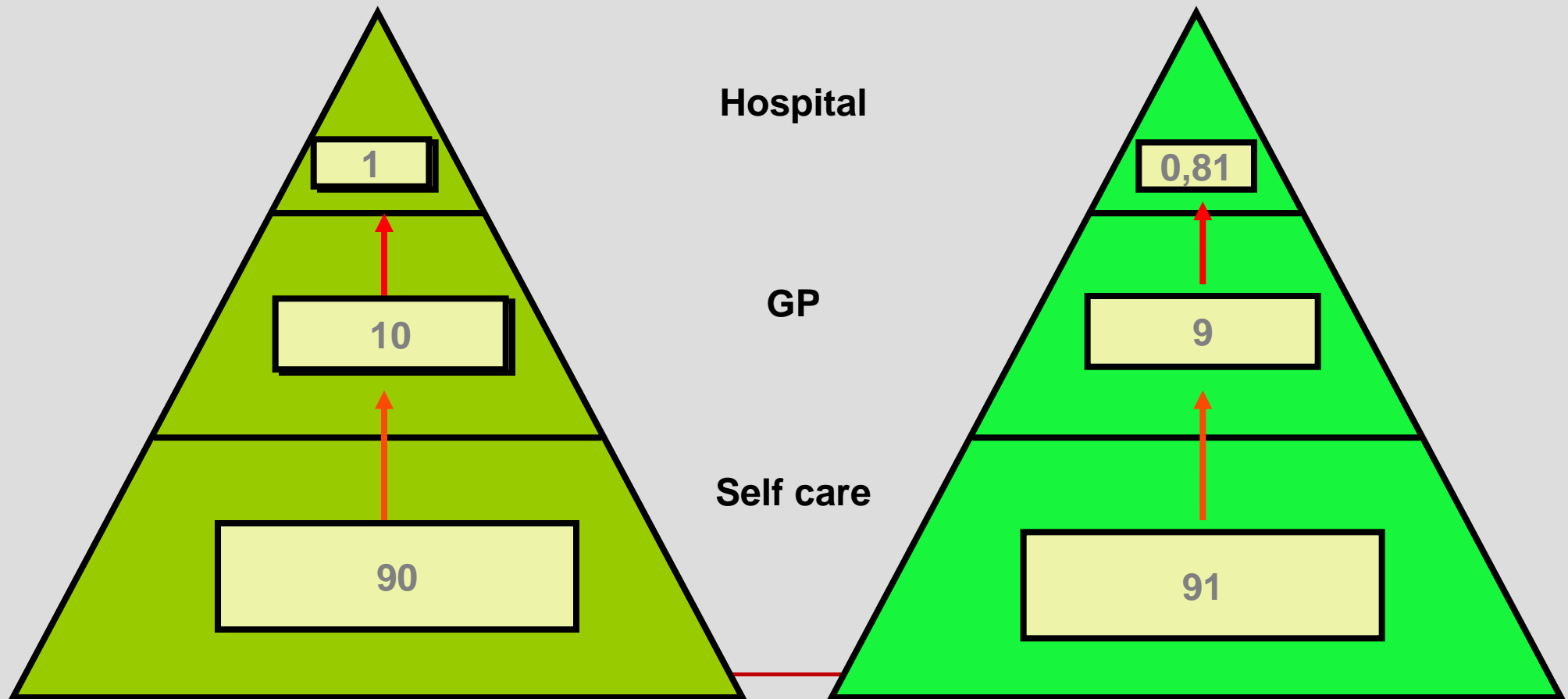
**90% variation: 1,7**



Kilde: Vedsted et al. Almen lægepraksis i Danmark, 2005

# A health care system has different boundaries

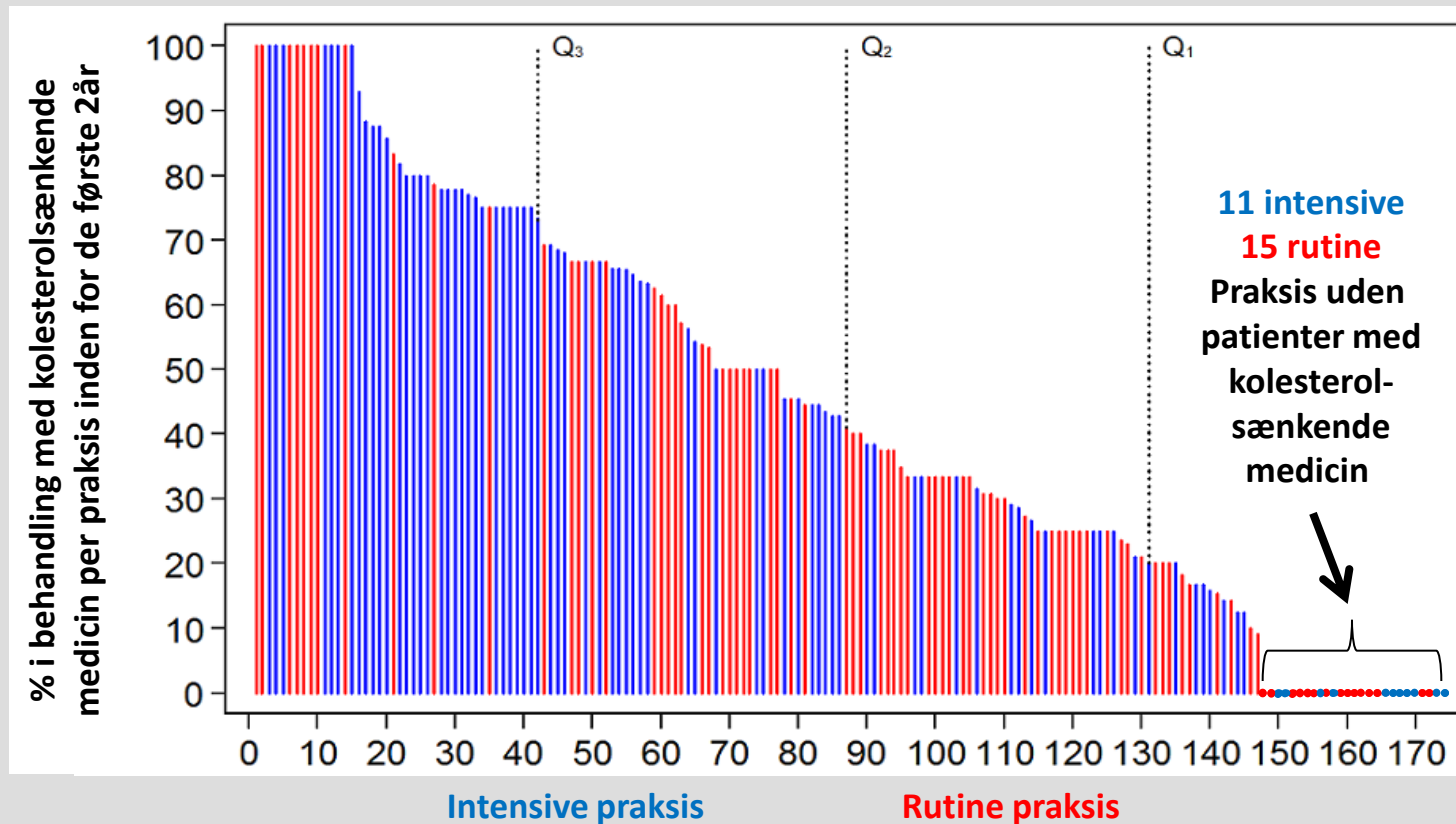
- a small change can have major consequences



# Risiko for et kardiovaskulært tilfælde

Justeret for alder, køn, hjertekarsygdom, cancer og kolesterolsænkende medicin inden screening

Odds ratio	1	1.7 (1.0-3.1)	3.1 (1.6-6.0)	2.6 (1.3-5.2)
Intervention:	1	2.5 (1.2-5.6)	2.9 (1.2-7.0)	2.0 (0.8-5.6)
Control:	1	0.5 (0.2-1.4)	3.9 (1.5-10.1)	3.0 (1.2-7.6)



[www.addition.au.dk](http://www.addition.au.dk) – slide udlånt af Torsten Lauritzen

# PROMS and PREMS in cancer follow up

- **PROMS: patient recorded outcome measures**
- **PREMS: patient recorded experience measures**
- **A tool to enable patient centred follow-up and meet patients' needs**

# PROM – a communication tool

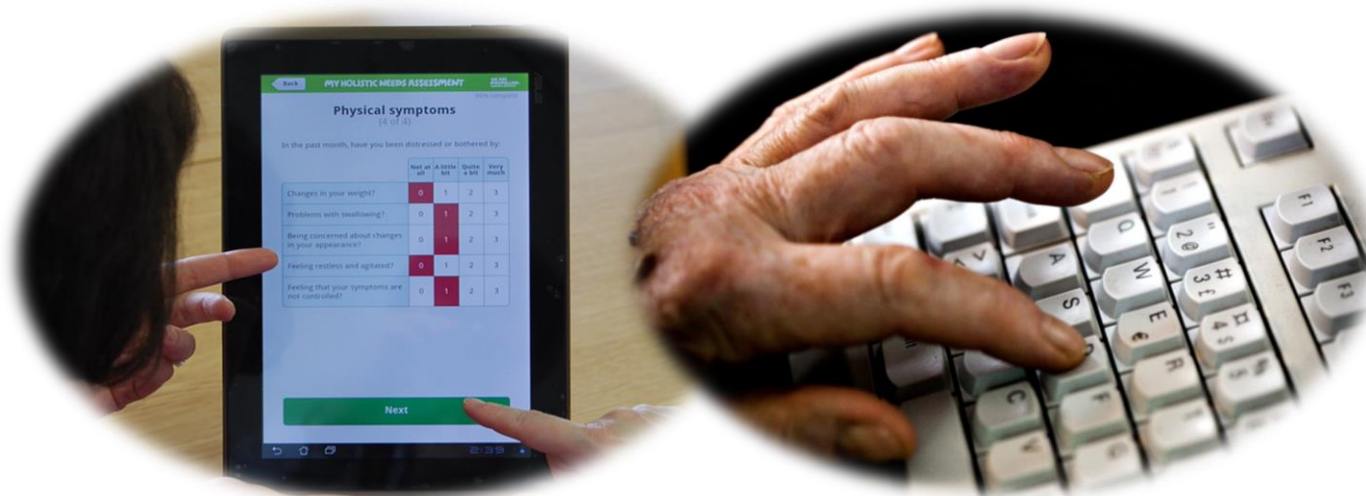
for instance in targeted follow up for prostate cancer

Follow-up  
**3 months**

Follow-up  
**6 months**

Follow-up  
**12 months**

L



# HISTORIK VISITATION • STAMDATA VIS BESVARELSE

		Sø 23 nov 14	Ma 19 jan 15	Sø 12 apr 15	
<b>Generelt</b>	Vægt (kg)	Antal kg: 88	Antal kg: 89		
	Højde (cm)	Antal cm: 173	Antal cm: 174		
	Arvelighed		3	3	
	Livskvalitet		5		4
	Helbred		3		4
	Påvirkning helbred		3		3
	Anden sygdom		1		1
<b>Vandladning</b>	Kateter		1		1
	DANPSS score		4		13
	Tømningsscore		1		1
	Fyldningsscore		0		2
	Blandet score		3		10
<b>Rejsning</b>	Seksualliv		2		1
	Tilfredshed		1		4
	Hjælpemidler		2	Ikke besvaret..	
	IIEF 5		22		0
	Selvtillid		3	Ikke besvaret..	
	Hårdhed		4	Ikke besvaret..	
	Fastholde (hyppighed)		5	Ikke besvaret..	
	Fastholde (vanskelighed)		5	Ikke besvaret..	
	Tilfredsstillende samleje		5	Ikke besvaret..	
<b>Trivsel</b>	Trivselsindex		68		56
	Humør		2		3
	Energi		2		4
	Interesse		4		4
	Udhvilet		3		3
	Afslappet		2		2
	Søvnbesvær		3		3
	Deprimeret		3		2
	Tilstand forværres		4		4



- **Assessment:**
- **Blood sample + PROM**

**A**



**Letter**

**B**



**Telephone  
(doctor/nurse)**

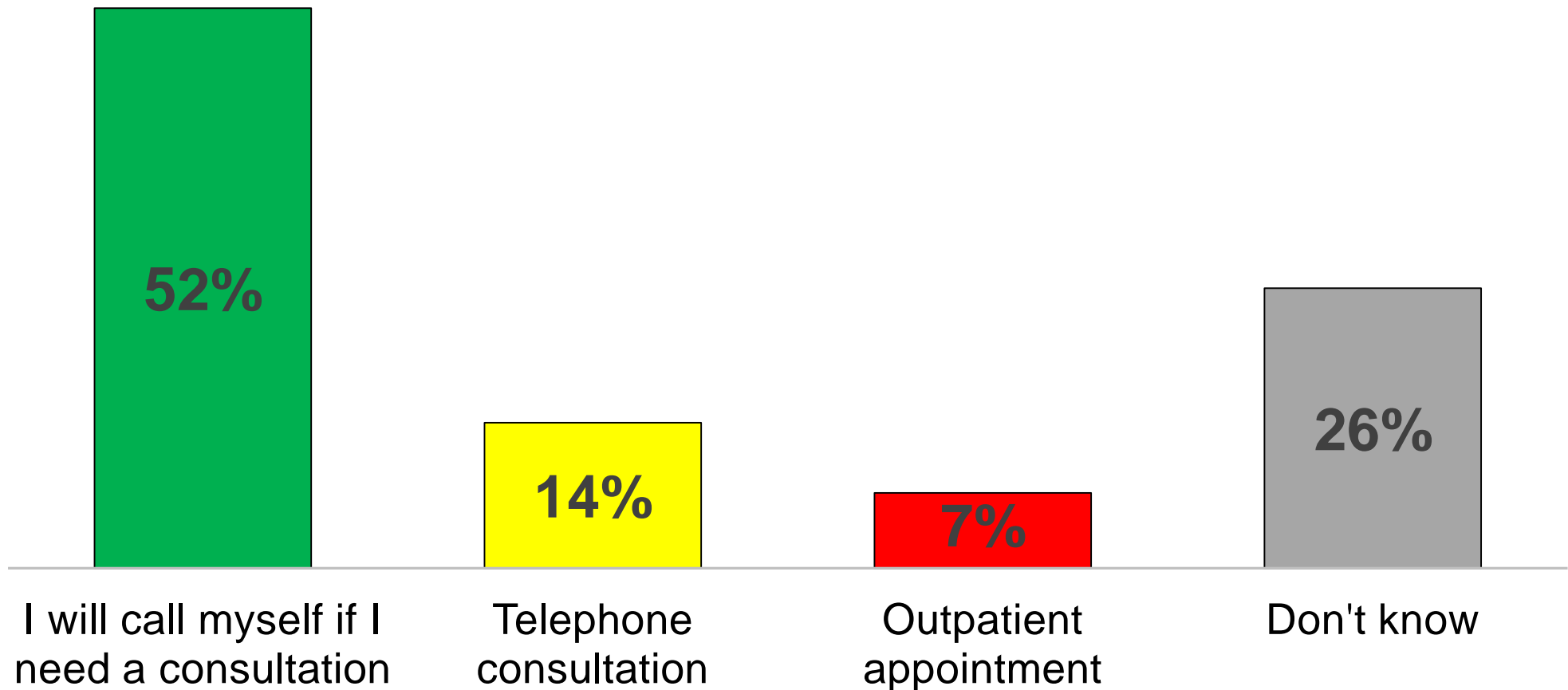
**C**



**Outpatient  
appointment  
(doctor/nurse)**

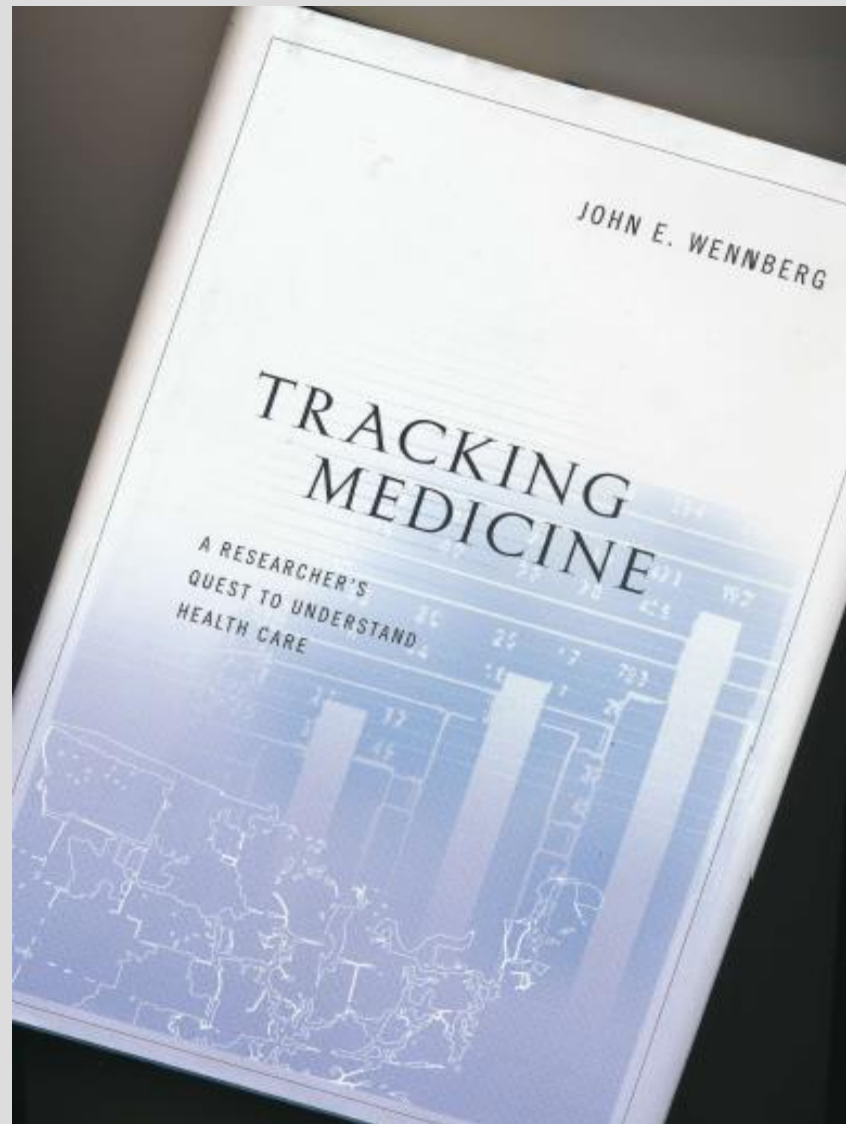


# What is your need for a consultation at hospital? (n=42)



# **International variations raise questions: palliative care and outgoing teams**

- **More than 80 % prefer to die at home**
- **The Netherlands: 30% die in hospital**
- **Denmark: 55% die in hospital**
- **Denmark: hospital-based outgoing palliative teams**
- **The Netherlands: focus on GPs and local district nurses**



# Evidence and health care delivery

## ■ Effective care:

- Advantage much bigger than disadvantage
- All in guideline target group should be treated
- Variation = underconsumption = bad performance

## ■ Preference-sensitive care:

- There are different treatment options(for instance: operation/prescription/wait and see)
- Information of patient and shared decisionmaking essential
- Variation sensitive to doctors preferences and doctor-paternalism

## ■ Supply-sensitive care :

- Supply and access will increase consumption.
- For instance number of follow-up visits. Interval between follow up. Available medical technology

# Some observations and interpretations

- what matters for variation??

- Organisation of service ... (A&E – palliative care)
- Culture (A&E – palliative care)
- Distance (A&E)
- Physicians profession and skills (A&E London)
- Physicians beliefs about good or bad care (astma, palliative)
- Understanding of PROMs and patients needs (prost. cancer)
- Physicians competence, knowledge or personal beliefs (cholesterol)
- Incentives (pay for performance in GP, DRG-groups, municipalities)
- A lot of blind spots among physicians and decision makers
- Lack of understanding of Wennbergs 3 groups

# Problem number 1

- education and knowledge among health care planners

- **Health care planners and a growing number of administrators do not understand, that wants and needs are so dynamic as they are**
  - the most ignorant group think that all needs are something objective
- **They do not understand even simple determinants of wants and needs**
- **Too many believe in simple market mechanisms**
  - the example with Danish municipality remuneration to regions
- **Nearly none of those who do understand something do know Wennbergs groups**
  - look for instance into debate about priorities in medicine

# Problem number 2

- problems with the doctor community

- **Lack of understanding of the same problems**
- **Lack of interest in health services research**
- **Insufficient knowledge about the dynamic on the boundaries between different parts of health care**
- **A special Danish problem??**
  - any problem: might be solved if we had more staff belonging to my profession
  - any problem might be solved if we had more money and staff

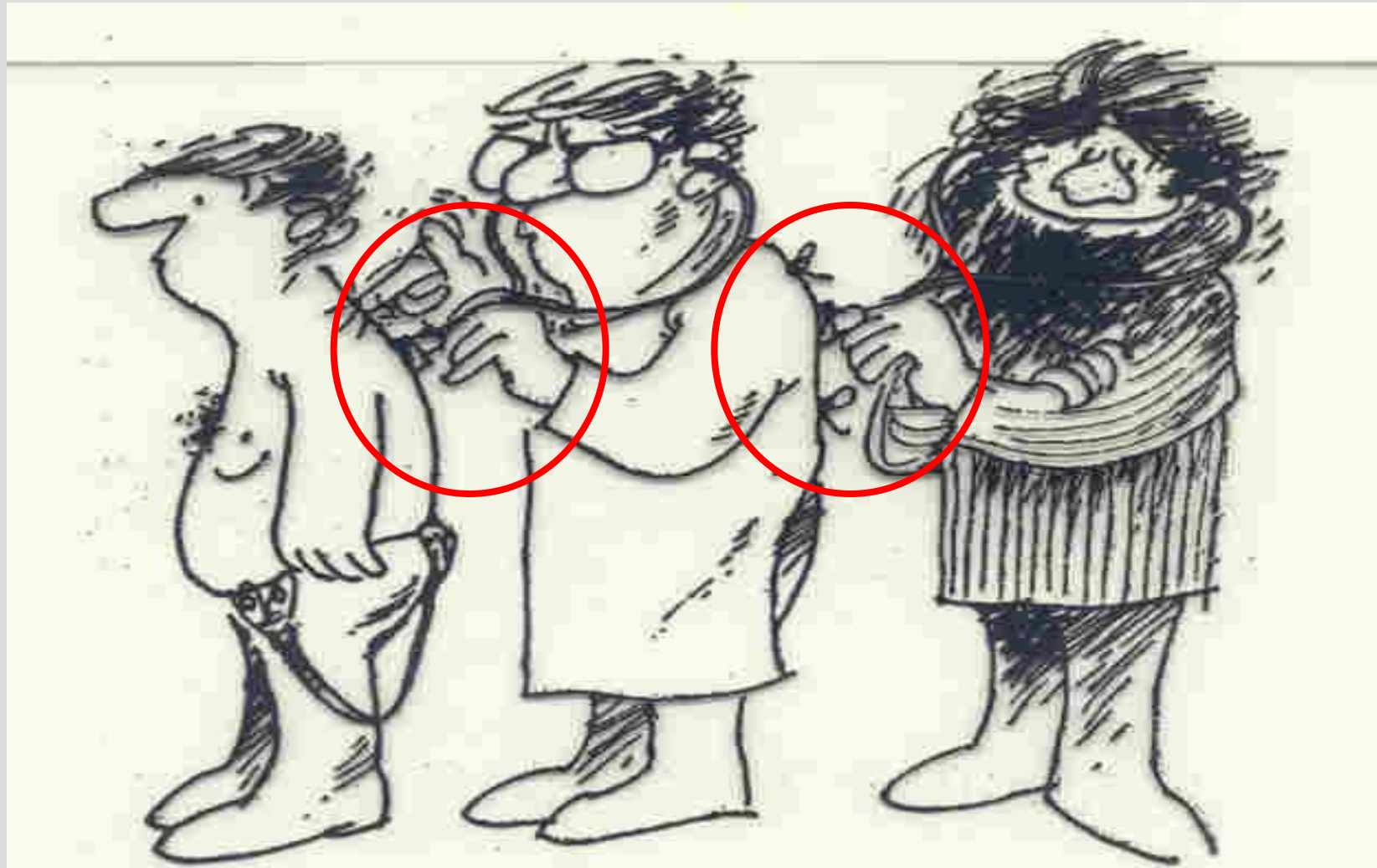


# Some of the problems in summary

- Education in determinants for use of health service are minimal
- Understanding of Wennbergs 3 groups are not explicit
- Lack of awareness on an ever ongoing up-prioritation of most initiatives and activities in group 2 and 3 followed by regular cost cutting in all 3 groups. Leads to quality problems in group 1.
- Incentive and budget problems and failures
- Too bad medical leadership in health care – an educational gap
- Lack of willingness to collaborate between administrative and medical leaders
- Too few see health care as a total system
- Physicians do not take quality deviations serious enough

# Are modern challenges reflected in the quality and research agenda

- we need much more research in ways to deliver good health care



# Conclusions

- **The fact: variation will continue to exist**
- **The good news: variation may lead to good new developments**
- **The problems and challenges:**
  - The professional medical and administrative understanding of the nature of variation must be improved substantially
  - All administrative staff and medical staff must use much more time on this book:
  - A special administrative education for candidates to medical leaderships – a new educational line in specialisation
  - Much more health services research

