Chronic Care in Europe

Towards High Performing Health Systems

Becoming the Best: Building Sustainability
High Performing Health Systems

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There is a growing number of people with chronic illness

- ~20% to over 40% of population in EU aged 15 years and over report a long standing health problem
- ~ 2/3 of those who have reached pensionable age have at least 2 chronic conditions
- People with chronic diseases are more likely to utilise health services
- Individual chronic diseases (e.g. diabetes) account for 2-15% of national health expenditure in some European countries

Sources: van den Akker et al., 1998; DZA 2005; Suhrcke et al. 2005; Eurobarometer 2007

Requirements for chronic illness care

Goals

- enhance functional status, minimise distressing symptoms, prolong life through secondary prevention and enhance quality of life

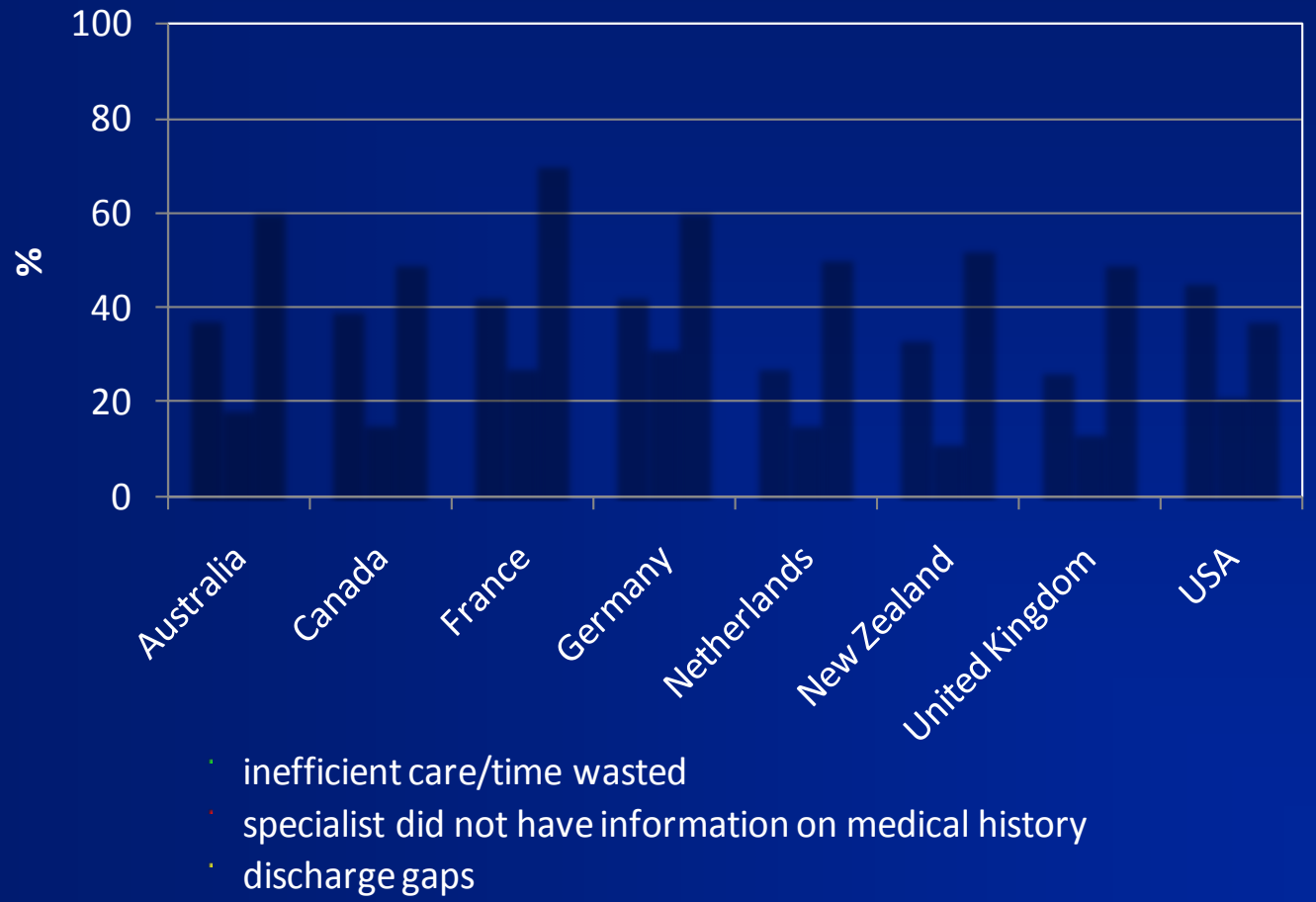
Requirements

- complex response over extended period of time
- co-ordinated inputs from a wide range of professionals
- access to essential medicines and monitoring systems
- promotion of active patient engagement

Healthcare not well equipped to meet requirements of chronic illness care

- Fragmentation of services acting as barrier to coordination of services along the continuum of care
  - structural and financial barriers dividing providers at the primary/secondary care (& at the health and social care interface)
  - distinct organisational and professional cultures and differences in terms of governance and accountability
- Failings in care coordination not only in countries traditionally characterised by fragmentation
  - *'[v]ery few health systems, even those that rate high on primary care, achieve high coordination of care' (Starfield et al. 2005)*

Patients with chronic disease report deficiencies in care coordination



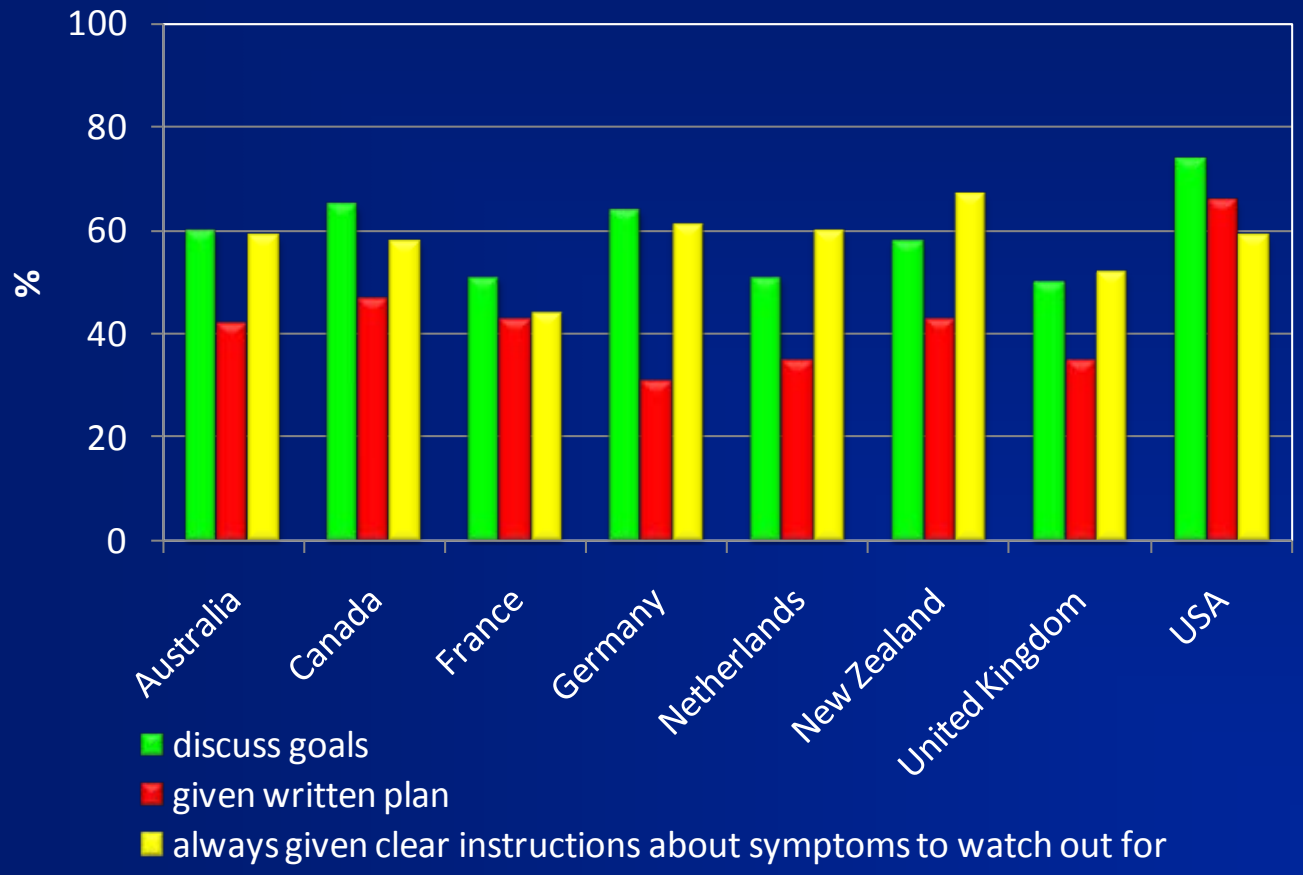
Source: Schoen et al. 2009

Evidence that care coordination improves outcomes

Main focus of intervention *(number of studies)*	**Proportion (%) of studies with positive outcome for**		
	Health	**Service user satisfaction**	**Cost saving**
Changed relationships between service providers *e.g. case management, multi-disciplinary teams (33)*	65.5% *(19/29)*	66.7% *(8/12)*	16.7% *(2/12)*
Coordination of clinical activities *e.g. joint consultations, shared assessments (37)*	61.3% *(19/31)*	33.3% *(4/12)*	20% *(3/15)*
Improving communication between service providers *e.g. case conferences (56)*	55.3% *(26/47)*	54.5% *(12/22)*	14.3% *(2/21)*
Support for clinicians *e.g. supervision for clinicians, reminder systems (33)*	57.1% *(16/28)*	57.1% *(8/14)*	8.3% *(1/12)*
Information systems to support co-ordination *e.g. care plans; decision support; register (47)*	60.5% *(23/38)*	36.8% *(7/19)*	15.4% *(2/13)*
Support for health/social care service users *e.g. education, reminders; assistance (19)*	35.3% *(6/17)*	50.0% *(3/6)*	14.3% (1/7)
All studies	55.4% *(36/65)*	45.2% *(14/31)*	17.9% *(5/28)*

Source: Powell Davies et al. 2008

Support for patient engagement and self-management remains sub-optimal



Source: Schoen et al. 2009

What does this mean for health systems?

- An effective response to the rising burden of chronic disease requires a health system environment that allows for the development and implementation of structured approaches to chronic disease management
- Countries are developing new models of healthcare delivery to achieve better coordination of services across the entire continuum of care
- *Review of approaches and models in place in 13 countries across Europe*

	HE (US$ PPP)	Principal funding	Governance of the public health system
Austria	3,836	Statutory health insurance	Responsibility shared by central government, nine state governments and corporatist actors; states responsible for hospital sector
Denmark	3,630	General taxation	Responsibility shared by central government, regions and municipalities
England (UK)	(3,230)	General taxation	Responsibility is at central level by government and agencies at arm's length from government; local organisations organise healthcare delivery
Estonia	1,226	Statutory health insurance	Responsibility concentrated at the central level with some involvement of local authorities especially in the hospital sector
France	3,778	Statutory health insurance	Responsibility traditionally concentrated at national level with gradual decentralisation of (selected) governance functions to regional agencies
Germany	3,692	Statutory health insurance	Responsibility for the health system shared by central government, 16 state governments and corporatist actors; states responsible for hospital sector
Hungary	1,419	Statutory health insurance	Responsibility for the health system is at central level by government and agencies at an arm's length from government
Italy	2,825	National and regional taxation	Responsibility for the health system is shared by the central government and the 20 regions with regions having extensive autonomy
Latvia	1,112	General taxation	Responsibility for the health system is concentrated at the central level by government and agencies at an arm's length from government
Lithuania	1,178	Statutory health insurance	Responsibility for the health system is concentrated at the central level
Netherlands	3,749	Statutory health insurance	Responsibility for the health system shared by federal and local authorities and corporatist actors
Spain	2,791	National and regional taxation	Responsibility for organising publicly funded healthcare rests largely with the 17 regions; national government sets regulatory framework and allocates funding
Switzerland	4,620	Mandatory health insurance	Shared by the federal and 26 cantonal governments with the cantons having extensive autonomy

Conceptual framework for assessment: Chronic care model

Source: Wagner 1998

The majority of approaches tend to focus on populations with defined conditions

- Most frequently targeted conditions: diabetes type 2, asthma/COPD, cardiovascular disease (chronic heart failure, IHD, stroke), cancer, mental health problems
- Approaches with generalist focus tend to be organised around older people
  - Frequently available in selected regions only and/or operated as pilot studies
- Types of approaches vary across and within countries
  - Care coordination (GP acts as principal coordinator) and
  - Multidisciplinary team working (frequently led by GP)
  - Managed discharge
  - Nurse-led care
  - Case management

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Strengthening coordination through structured disease management

- 'Disease management programmes'
  - *Austria*: 'Therapie aktiv' (diabetes) (national); regional projects
  - *Denmark*: DMPs (various) (national through regions)
  - *France*: Sophia (diabetes) (national)
  - *Germany*: DMPs (various) (national)
  - *Hungary*: DMP (asthma) (national); diabetes care management (national)
  - *Netherlands*: Care groups (various) (national)
- wide variation in extent to which non-medical staff is involved in care delivery *(e.g. Netherlands, Hungary, Italy)*
- GP/family physician tends to remain principal provider/'care coordinator' *(e.g. Austria, Germany, France)*

Strengthening the role of nurses in care delivery and coordination

- Common in systems with tradition in multidisciplinary team working
  - Nurse-led clinics
    - *England*, *Hungary, Italy, Netherlands*
  - Nurse-led case management
    - *England*, *Italy, Netherlands, Spain*
- Challenging in systems where primary care traditionally provided by doctors in solo-practice and few support staff
  - Enhanced functions in care coordination or case management under development/piloted *(e.g. Denmark, France; Lithuania)*
  - Enhanced functions in patient self-management support and/or selected medical tasks but under supervision of GP/physician *(Austria, France, Germany)*

Reducing barriers between sectors

- Managing the primary/secondary care and/or secondary care/rehabilitation interface
  - Provider networks (*France*)
  - Integrated care contracting (*Germany*)
  - Care Coordination Pilot *(Hungary)*
  - 'SIKS' project (*Copenhagen, Denmark*)
  - 'From On-demand to Proactive Primary Care' *(Tuscany, Italy)*
  - (some) Reform pool projects (*Austria*)
  - Stroke service Delft *(Netherlands)*
- Managing the health and social care interface
  - (some) Integrated Care Pilots (*England*)
  - Partnership for Older People Project *(England)*
  - Multifunctional community centres *(Hungary)*
  - Improving intersectoral collaboration (pilot) *(Lithuania)*

The majority of approaches are funded from 'usual' sources

- Start-up funding
  - *Supporting payers* (municipalities, Denmark; integrated care pilots, England; integrated care contracts, Germany)
  - *Supporting providers* (provider networks, France)
- Financial incentives
  - *Incentivise payers* (municipalities, Denmark; DMPs, Germany)
  - *Incentivise providers* (DMPs, Austria; GPs (diabetes care), Denmark; provider networks, France; DMPs, Germany; some regional projects, Italy; care groups, Netherlands; Quality & Outcomes Framework, UK)
  - *Incentivise patients* (provider networks, France; DMPs, Germany; care groups, Netherlands)

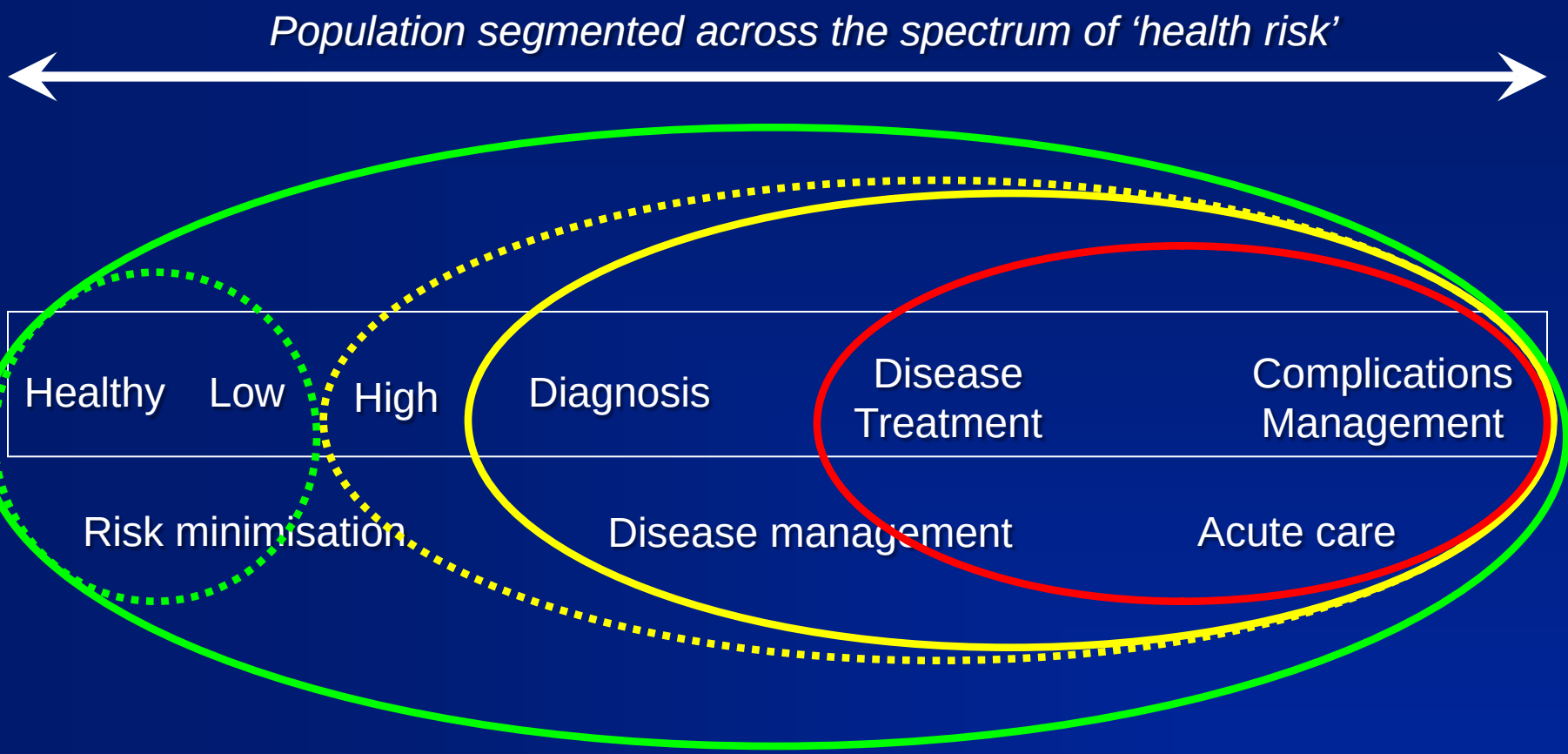
Approaches generally provide some form of patient self-management support

- Wide variation in the level of support provided
  - Provision of information material (eg brochures, interactive website) ⇨ access to coaching and counselling
  - Patient involvement in development of treatment plan and goal setting common in theory, level of implementation in practice unclear
- Support typically provided by health professionals
  - Typically provided by physician or trained nurse
  - Lay-led support uncommon (eg Expert Patients Programme (EEP) in England; EEP adaptation in selected regions in Spain)

The use of elements of decision-support and clinical information systems varies

- Elements of decision-support most commonly include guidelines and protocols
  - Dedicated staff training common for those strategies that involve delegation of tasks to non-medical staff

- Use of clinical information systems tends to be the least developed strategy in most approaches
  - Usually limited to participants within a given care approach and/or standardises documentation for quality assurance
  - England and Estonia provide examples for consistent use of standardised electronic medical records, electronic booking and reminder systems throughout the primary care system



Source: adapted from Petersen & Kane 1997

Integrating prevention into chronic care

- *"In Austria the area of risk minimisation ... is still considered as less important (perhaps not in theory, but certainly when it comes to finding financial means for those programmes). Approaches concerning disease management are starting to get some attention at the moment. Provisions for acute care are very good"*

  [Austria]

- *"[T]he Netherlands is good at the diagnosis phase and good at complications treatment [and] the last few years is gaining more interest in disease management ... Risk minimisation or prevention, the discussion is starting, the discussion of who is in charge of risk minimisation, the people themselves or local government or the health insurer... This is the discussion that runs now."*

  [Netherlands]

Fragmentation of responsibilities remains a challenge...

- *"[W]e have a very complicated political and governmental structure […]; the national and regional governments […] have the competencies for most things you can think of. But then we have councils […] in charge of the whole social thing and they don't manage the same budget and they don't have the same bosses or interests. So there you have the big problem"*

  [Spain]

- *"[S]o we have ambulatory care, hospital care, we have some services, public or private, in trying to do some preventive care but they are very disconnected and fragmented ... prevention is weak and is a big issue, the reaction to that from the state has been, you know, they just produce plans .... There is not a systemic reaction to how to improve prevention in general."*

  [France]

... as does the creation of new responsibilities...

- *"[T]he municipalities should have a central place in [solving] problems of the healthcare sector. [They have the responsibility] to create new health centres [...designed to overcome] barriers to coordination [but] municipalities do not have the competence and knowledge about healthcare. And there is no systematic development in this area; [...] it is dependent on learning from the regional level"*

[Denmark]

... and a continued misalignment of (financial) incentives

- *"the practitioners are paid by fee for service; [...] their vision of healthcare has been for a long time about patients coming to your office and your primary issue is to diagnose..."*

  [France]

- *"[T]the problem with primary prevention is that sickness funds are in competition [but] primary prevention [efforts] have to be not only targeted to our own insurees but also on the insurees of other sickness funds. So we are not very motivated to make big primary prevention programmes when we know that other organisations will take benefit from it and we have to pay for it."*

  [Germany]

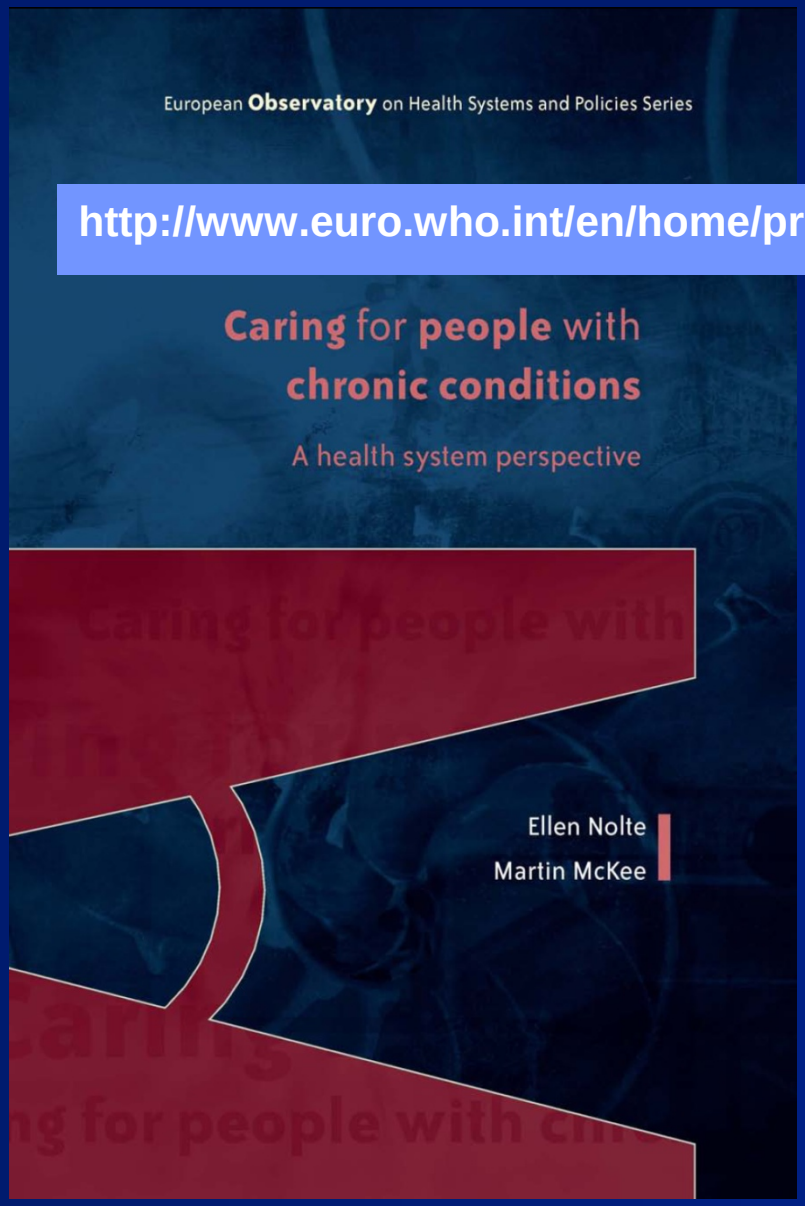
Towards high performing health systems

Key elements

- Provision of adequate incentives
- Creation of an appropriately prepared workforce
- Information technology
- Embedding prevention in all stages
- Creation of systems to enable patients to self-manage effectively

Need for

- Contextually appropriate approaches
- Consistency of policies
- Balancing top-down and bottom-up
- Ongoing evaluation (what works best in what circumstances)



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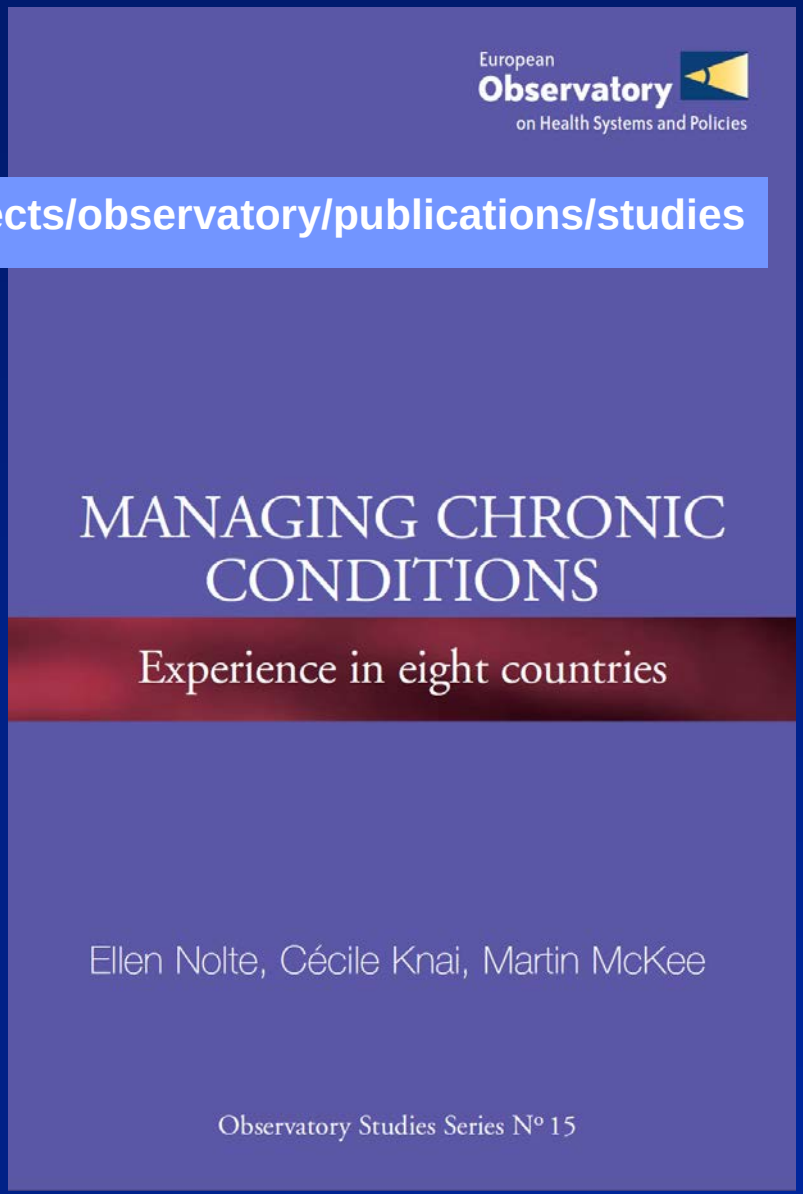

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DISMEVAL

Developing and validating
DISease Management
EVALuation methods for
European health care systems

READ Developing and validating DISease Management EVALuation methods for European health care systems *(Summary PDF 1.2Mb)*

Structured disease management is widely seen as a means to improve the quality and reduce the cost of care, and to improve health outcomes for the chronically ill. Yet, while intuitively appealing, the evidence on the ability of such approaches to actually do so remains uncertain. What we know about the impact of disease management is mainly based on small studies on high-risk patients, often undertaken in academic settings. There is a need to learn more about the effects of large, population-based programmes using universally accepted evaluation methods that are scientifically sound and are also practicable in routine settings.

The DISMEVAL project aims to support this process through reviewing approaches to chronic care and disease management in Europe and through testing and validating possible evaluation methods and so provide evidence for best practices.

About the project

The project brings together a multi-disciplinary team of 10 partners in 7 EU countries. It is funded under the European Commission's 7th Framework Programme: Theme Health and runs for three years, from 1 January 2009 to 31 December 2011.

Publications

- DISMEVAL project summary (57Kb)
- DISMEVAL Fact Sheet (1.2Mb)
- DISMEVAL Literature Review (569Kb)
- DISMEVAL Poster (190Kb)

News

- DISMEVAL publication of a comprehensive review of current state of the art in disease management evaluation
- 5th meeting of the DISMEVAL Scientific Committee to take place 13 May 2011 in Madrid


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