Tackling chronic diseases in Europe: financing and redesign of health systems

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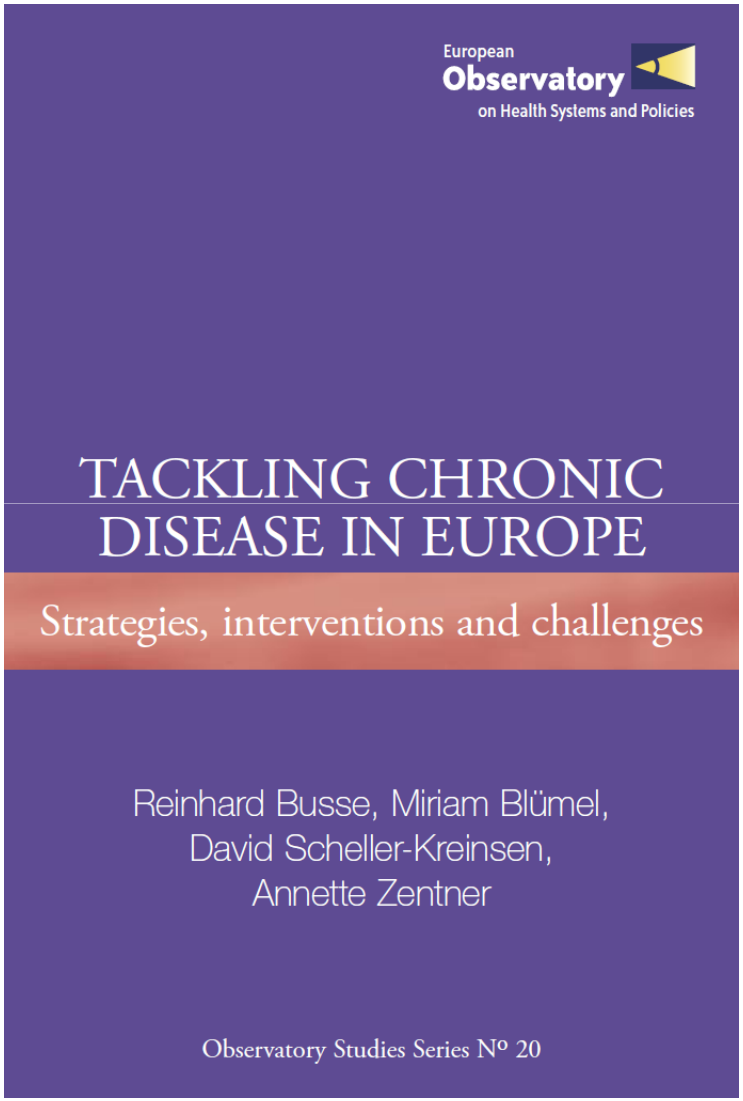
European
Observatory
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TACKLING CHRONIC DISEASE IN EUROPE
Strategies, interventions and challenges
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Managing chronic diseases…

is the "ongoing management of conditions over a period of years or decades" (WHO),

which goes beyond cardiovascular/cerebrovascular disease, diabetes and asthma/COPD to include cancer and HIV/AIDS (as survival rates and times have visibly improved), mental disorders (depression, schizophrenia, dementia/ Alzheimer's…) as well as certain disabilities (sight impairment, arthroses …) –

and is potentially the greatest health care challenge.

Disease Burden and deaths from noncommunicable diseases in the WHO European Region by cause (2008)

	Disease burden		Deaths	
	DALYs (millions)	Proportion from all causes (%)	Number (millions)	Proportion from all causes (%)
Cardiovascular diseases	34.76	23	4.58	50
Neuropsychiatric conditions	28.93	19	0.33	4
Cancer	17.09	11	1.87	20
Digestive diseases	6.94	5	0.42	5
Sense organ diseases	8.43	6	0	0
Respiratory diseases	5.91	4	0.38	4
Musculoscetal diseases	5.44	4	0.03	0
Diabetes mellitus	2.66	2	0.15	2
All noncommunicable diseases	*116.10*	*77*	*8.03*	*87*
All causes	151.46	100	9.22	100

Economic consequences of chronic diseases

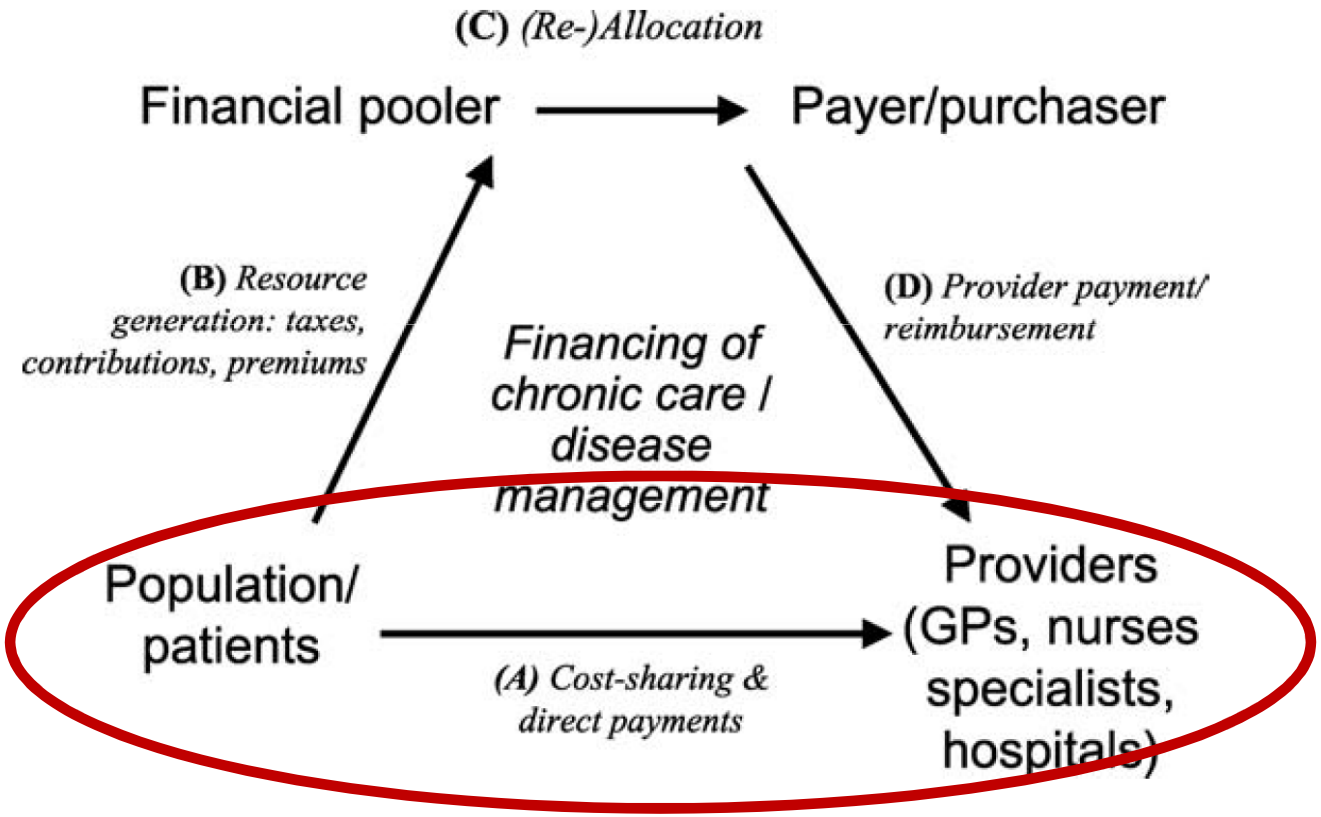
- Microeconomic perspective:
  - Chronic diseases effect consumption and savings (capital formation), labour productivity and supply as well as education (human capital formation)

- Macroeconomic perspective:
  - Health is a robust predictor of economic growth
  - Mortality, DALYs and reduced life expectancy can be expected to reduce economic growth
  - 1% increase in the mortality rate decreases the growth rate of per capita income in the following years by approximately 0.1%

Predictions for Europe (WHO)

- Deaths directly attributable to diabetes are predicted to rise from about 166,000 in 2009 to over 209,000 in 2030
  - Growth of diabetes type 2 is partly a result of rising obesity levels, especially among children
- Fewer deaths (-1%) and DALYs (-17%) from stroke are predicted between 2009 and 2030
  - Incidence and mortality are declinig, but prevalence rises due to improvements in treatment and the ageing population prone to strokes
- Number of people in Europe aged 60 years and over with dementia is estimated to rise from 7.7 million in 2001 to 10.8 million in 2020
  - Number can even double until 2040 (15.9 million) without effecive prevention and treatment

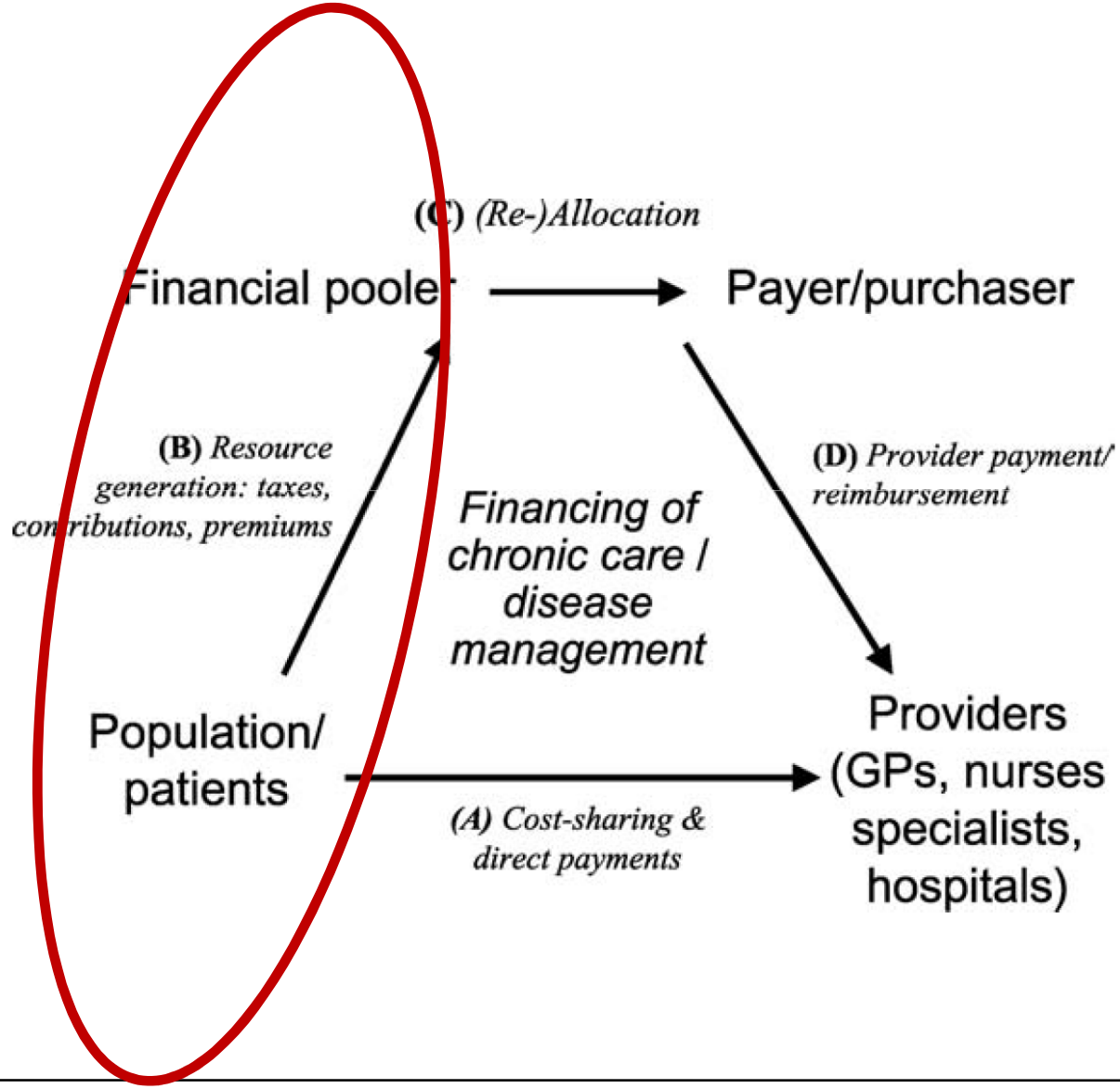
Financial relations between stakeholders in health care



Relationship A: cost-sharing and direct payments

- Financial incentives for patients to take part in a Disease Management Program (DMP) or an integrated care model (CCM) are rare
  - Reduced cost-sharing for patients enrolled in a DMP in Germany
  - Lower annual limits on co-payment in Germany (1% vs. 2% of net income)
  - Exemption from co-payments for chronic disease care (ADL) in France if patients present their previously agreed care protocol at every physician visit

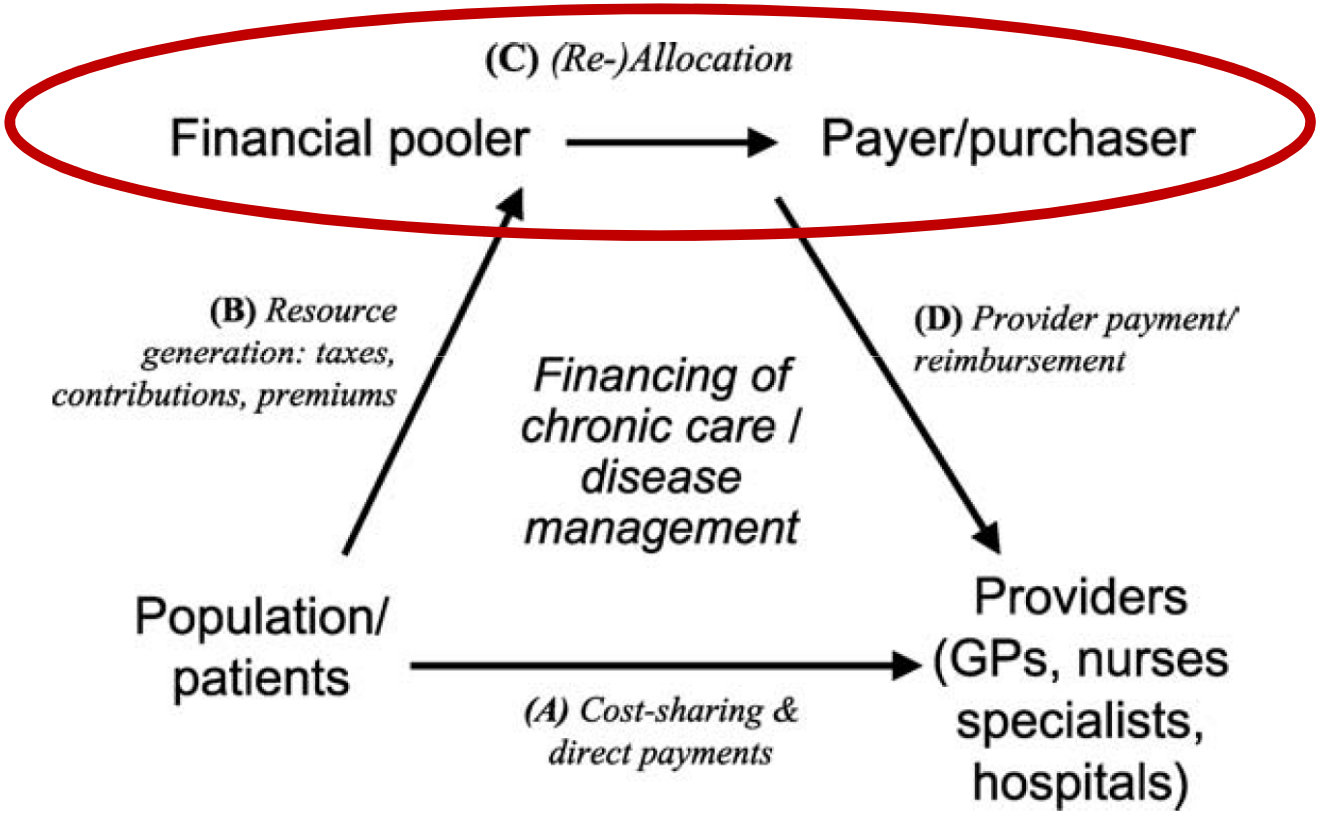
Financial relations between stakeholders in health care



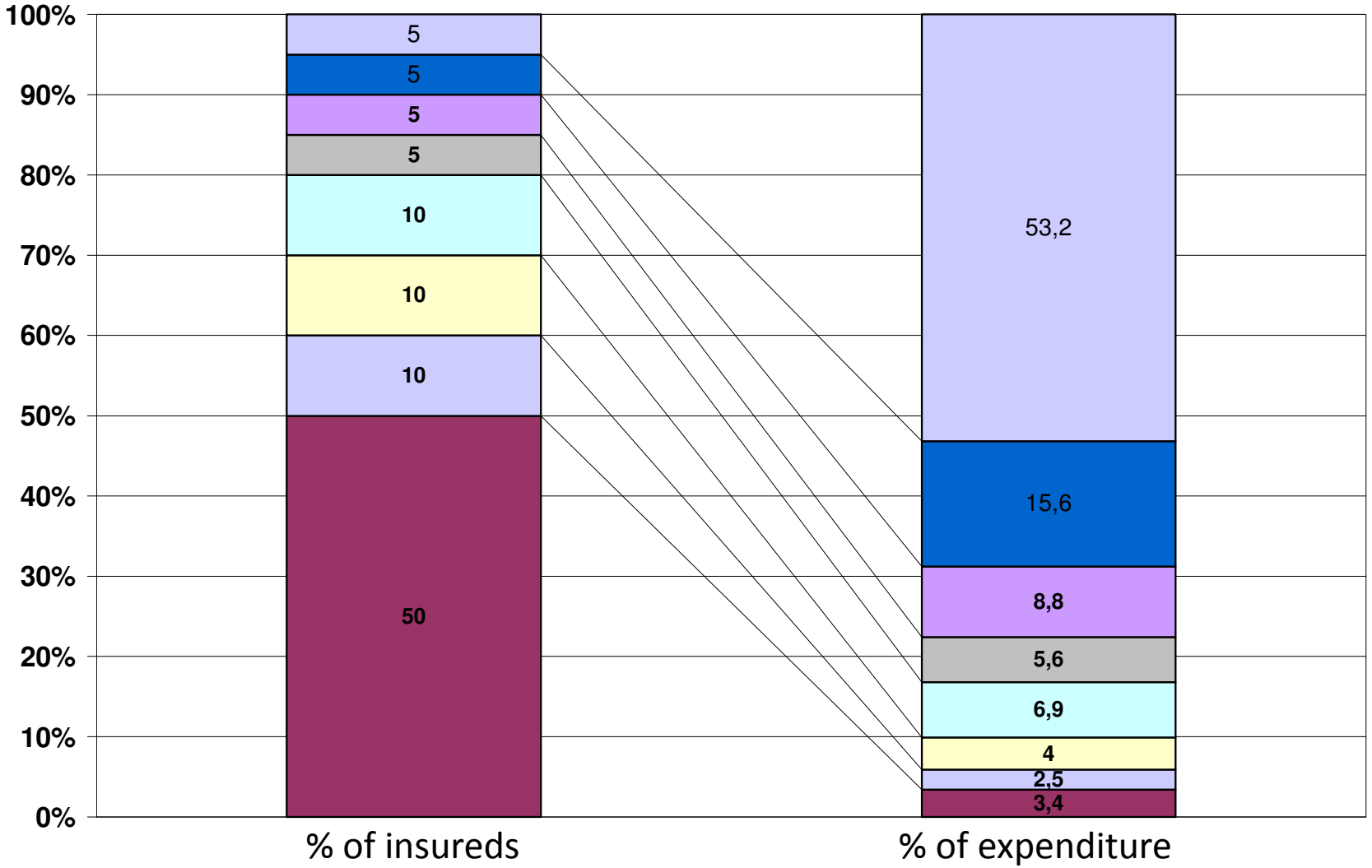
Relationship B: resource generation

- Lower premiums or contribution rates for patients who take part in a DMP or CCM
  - ➢ There are no such schemes in Europe

Financial relations between stakeholders in health care



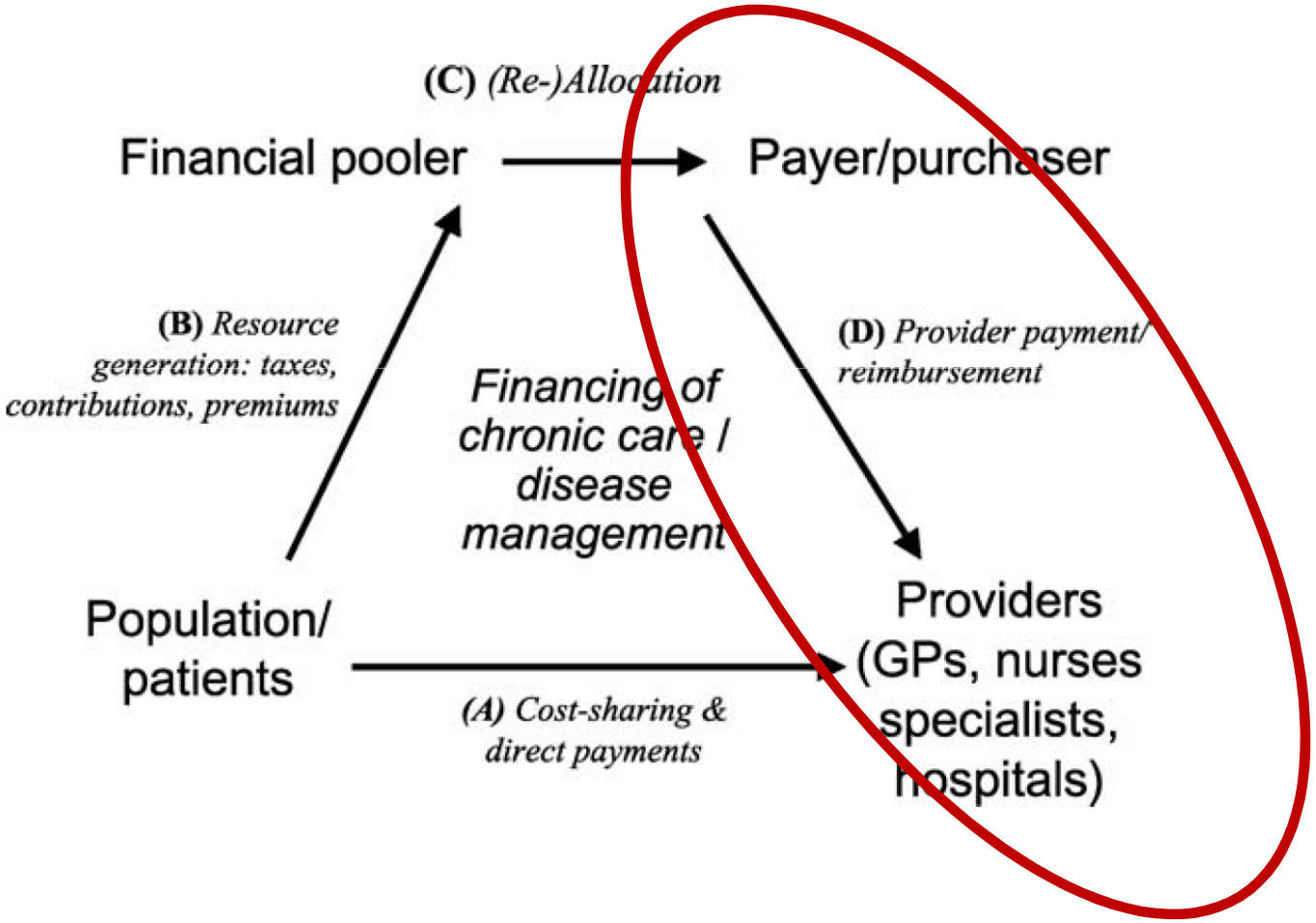
How attractive are patients with chronic conditions for health insurers?



Relationship B: cost-sharing and direct payments

- Chronic disease management may attract even more chronically ill and lead to financial difficulties
- To avoid „cream skimming“ chronic diseases must be included in the formula for calculating the allocations to payers
- Financial incentives for payers are rare:
  - Germany: between 2003 and 2009 participation in a DMP was a seperate category in the risk structure compensation scheme
  - Since 2009 risk structure allocation includes supplements for persons suffering from one of 80, mainly chronic, diseases

Financial incentives between stakeholders in health care



Weakness of traditional ways of paing providers for chronic care

Fee-for-service

- Ill patients usually attractive
- Overprovision of services
- Underreferral

Salary

- Tendency to average provision

Capitation

- Ill patients not attractive
- Underprovision of services
- Overreferral

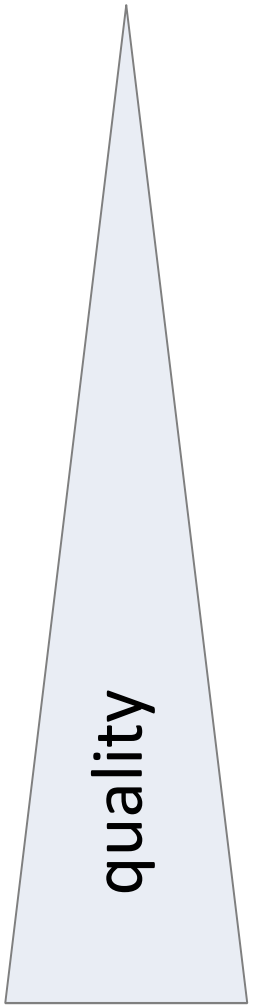
- None provides incentives for producing high quality outcomes
- None provides incentives for care coordination

Paying for quality of care

Structure: access time, provider's function as a gatekeeper or for including patients in registers

Process: for treating chronically ill according to established practice, e.g. adherence to guidelines

Outcome: short- or long-term clinical outcomes or patient satisfaction



Financial incentives to improve quality of care

targeting structures of care	targeting processes of care	targeting outcomes of care
Per patient bonus for physicians for acting as gatekeepers for chronic patients and for setting care protocols or providing patient education (FR)	Points for reaching process targets (UK: QOF; FR: CAPI; AUS: PIP)	Points for reaching outcome targets (UK: QOF)
Bonus for DMP / PIP recruitment and documentation (GER; AUS)	P4P (mainly hospitals, US)	P4P (mainly hospitals, US)
Points for reaching structural targets (UK: QOF; FR: CAPI)		

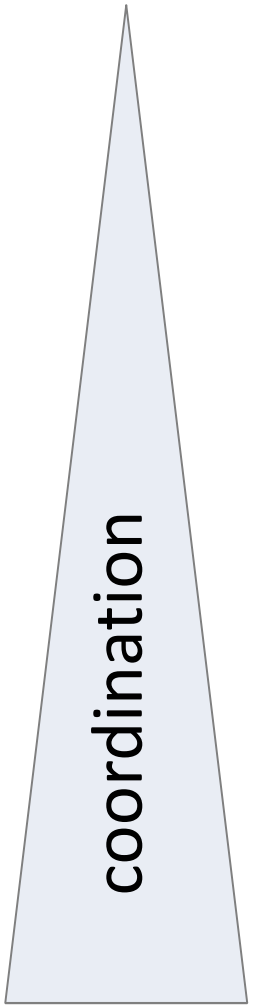
Paying for care coordination

1st level: separate payment for coordination or extra effort

2nd level: bundled payment across services (for one provider but incl. referrals/ prescriptions)

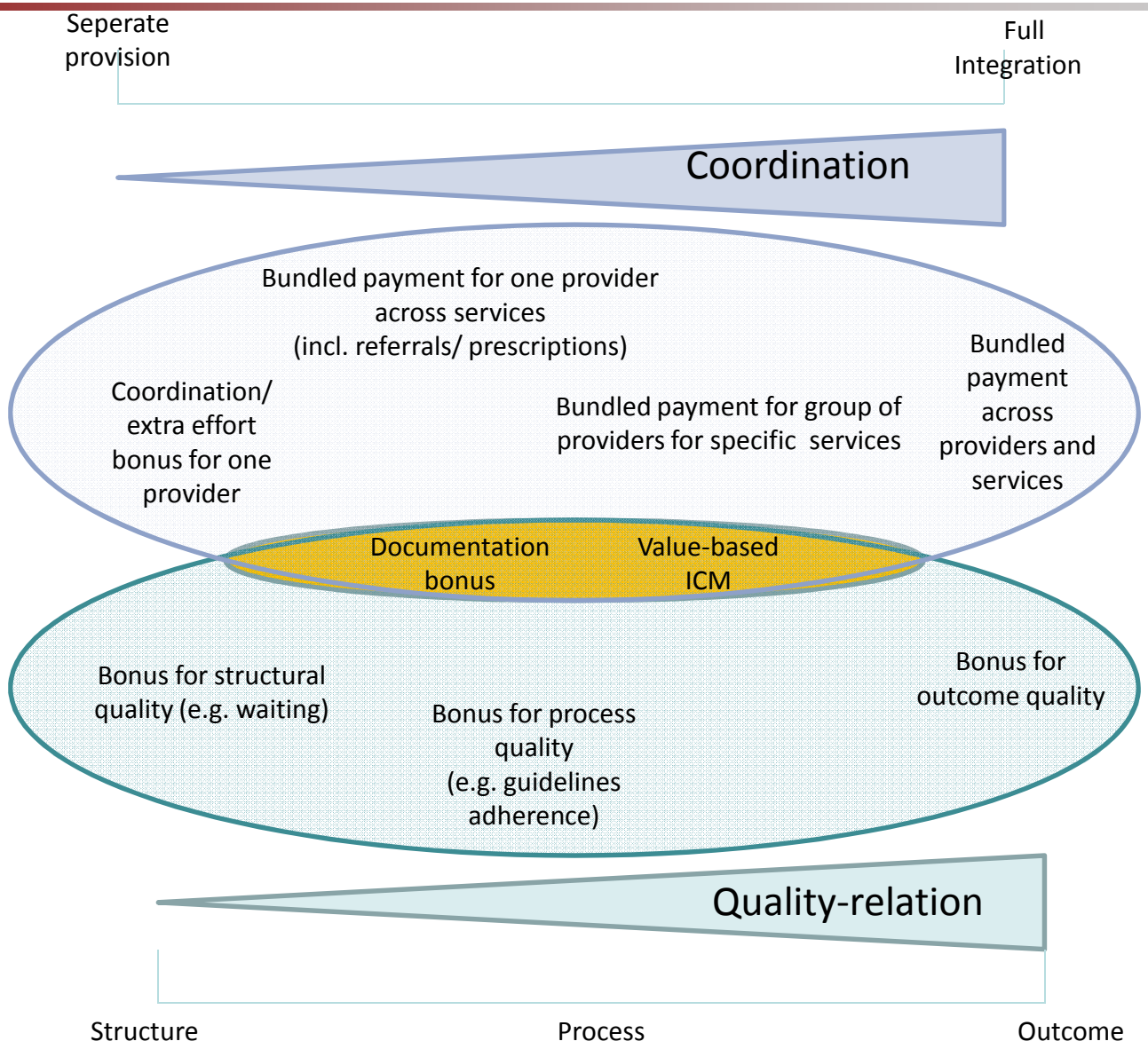
3rd level: bundled payment across providers (but restricted to a set of activities, e.g. only those related to one disease)

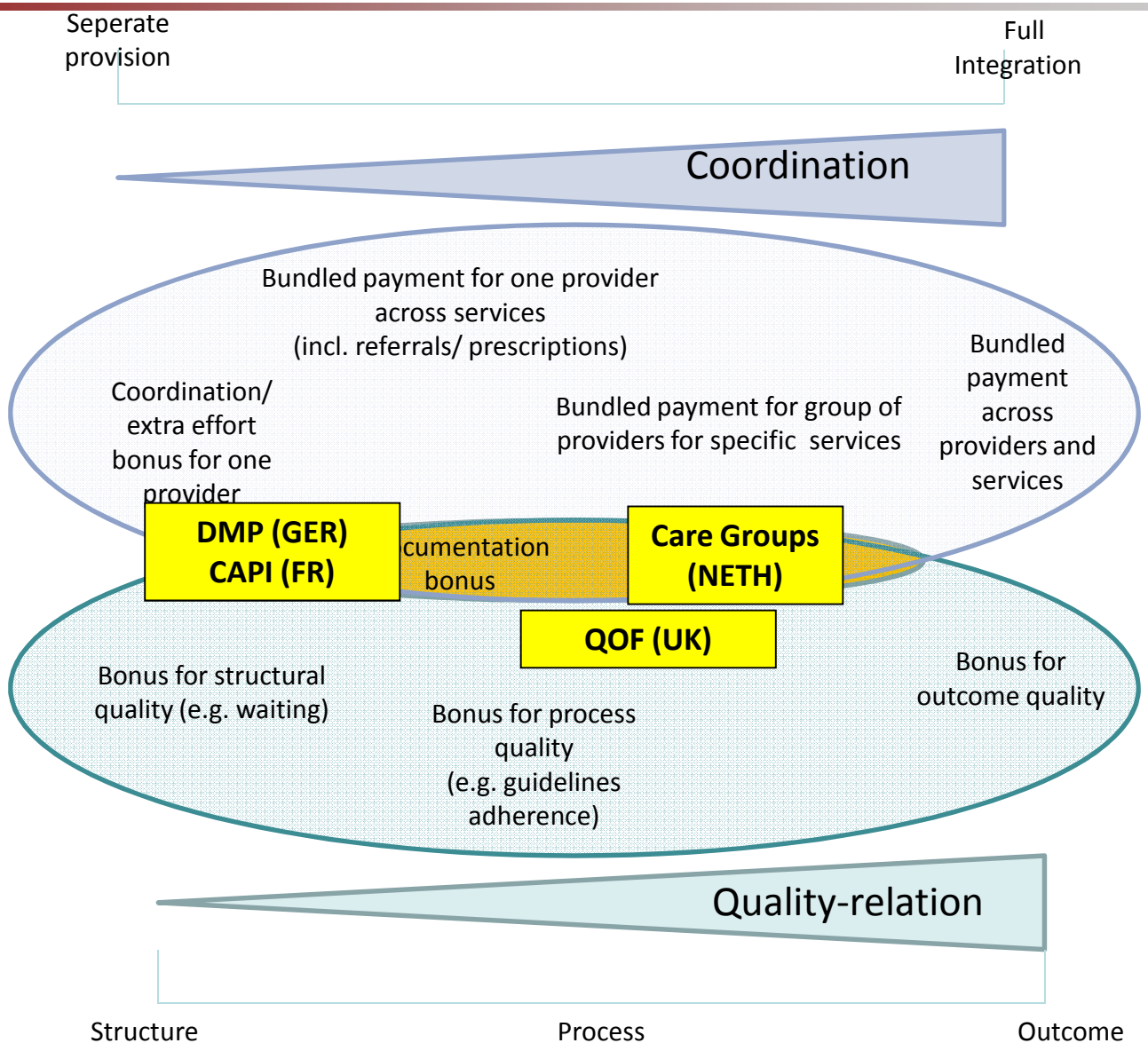
4th level: bundled payment across services and providers



Financial incentives to improve care coordination

… for coordination/ extra effort	… for bundling across services	… for bundling across providers	… for bundling across services and providers
"Year of care" payment for the complete package of chronic disease management (UK) or service incentives (AUS)	GP "fundholding" (UK)	1% of overall health budget available for integrated care → majority of integrated care (GER)	1% overall health budget available for integrated care → population-based integrated care (Kinzigtal; GER)
Per patient bonus for physicians acting as gatekeepers for chronic patients/ for setting care protocols/ providing patient education (FR)		Payment for professional cooperation and diagnostic-related bundled payment (FR)	Shared savings for Accountable Care Groups ; tested in Physician Group Practice demonstration (US)
Bonus for DMP recruitment and documentation (GER) or initial payments (AUS)		Integrated Care Groups (NL)	
Service outcome payments (AUS)		Bundled payment for acute-care episodes (US)	


Seperate provision
Full Integration
Coordination
Bundled payment for one provider across services (incl. referrals/ prescriptions)
Coordination/ extra effort bonus for one provider
Bundled payment for group of providers for specific services
Bundled payment across providers and services
Documentation bonus
Value-based ICM
Bonus for structural quality (e.g. waiting)
Bonus for process quality (e.g. guidelines adherence)
Bonus for outcome quality
Quality-relation
Structure
Process
Outcome


Seperate provision
Full Integration
Coordination
Bundled payment for one provider across services (incl. referrals/ prescriptions)
Coordination/ extra effort bonus for one provider
Bundled payment for group of providers for specific services
Bundled payment across providers and services
DMP (GER)
CAPI (FR)
cumentation bonus
Care Groups (NETH)
QOF (UK)
Bonus for structural quality (e.g. waiting)
Bonus for process quality (e.g. guidelines adherence)
Bonus for outcome quality
Quality-relation
Structure
Process
Outcome

Conclusions

- Care for people with chronic conditions is an issue with increasing importance in all industrialized countries
- Countries have been experimenting and working towards care models in response to the fact that chronic diseases can rarely be treated in isolation
- These models try
  - ➢ to coordinate and potentially integrate care
  - ➢ with the aim of providing higher quality of care
  - ➢ while also being efficient

Conclusions

- A shift from incentives which simply take into account the presence of chronically ill towards incentives designed to improve structural and process indicators
  - Although a trend towards more quality-related payment can be observed, financial incentives for the delivery of quality outcomes are still limited
  - A separate trend towards more bundling of payments across providers, services or both ("integrated care") can be observed (main incentive: profit-sharing for efficiency)
- The challenge – paying for successful coordination AND quality (rather than just efficiency) – still remains
  - The current rare approaches need to be evaluated
  - Further models need to be developed

Thank you very much for your time and attention!