OBSERVATORY VENICE SUMMER SCHOOL 2015

Integrated care: moving beyond the rhetoric

MiG Management im Gesundheitswesen

Integrated Care Experiences and Outcomes in Germany, the Netherlands and England

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European Observatory on Health Systems and Policies

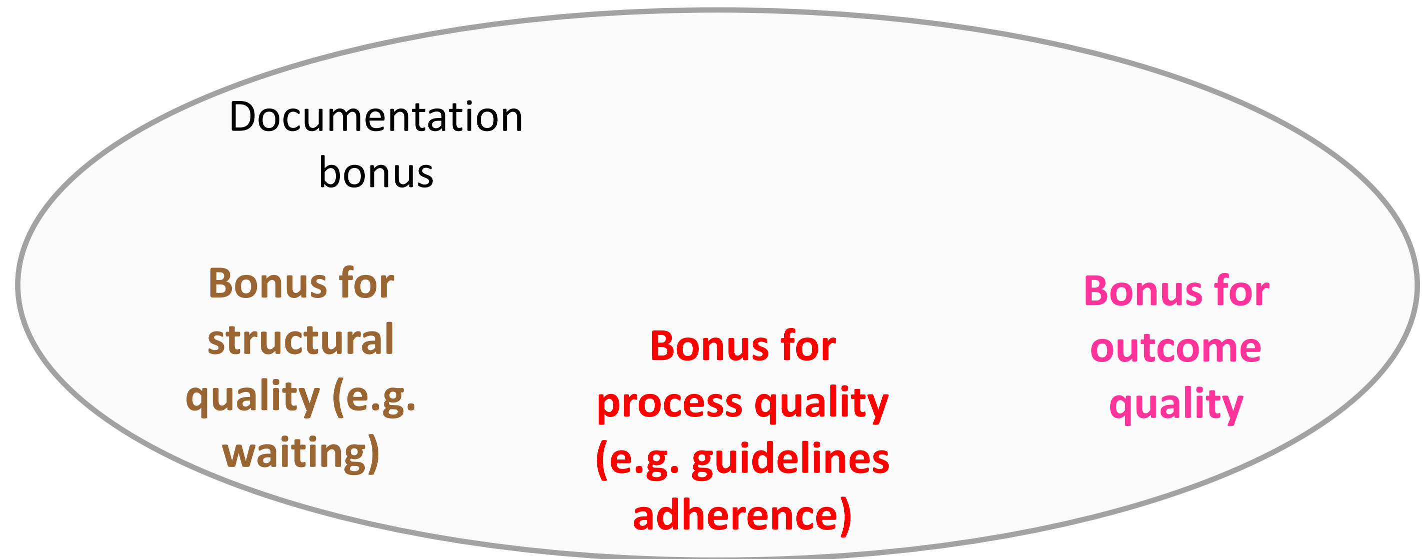
1. **How do we know that things work?**
   Usual approach: **get a systematic review** – but two problems: (i) they rely on already published papers = run well behind the latest developments; (ii) integrated care often not evaluated in controlled trials
2. We therefore aim to:
   (i) to take **a look at newer developments in European countries**, which are carefully evaluated but not yet included in systematic reviews;
   (ii) to explicitly address the role of **financial incentives**.

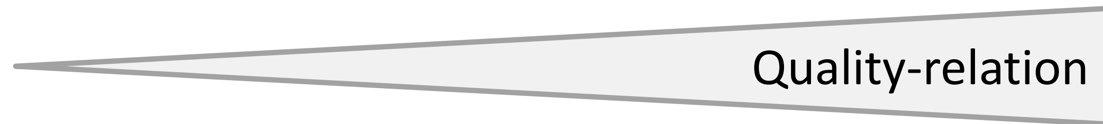
Capitation

or

Case-based

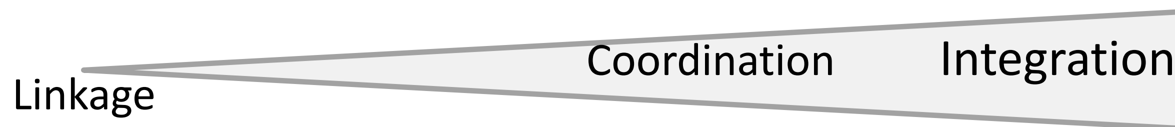
and





Structure **Process** **Outcome**

Paying for care coordination



Capitation

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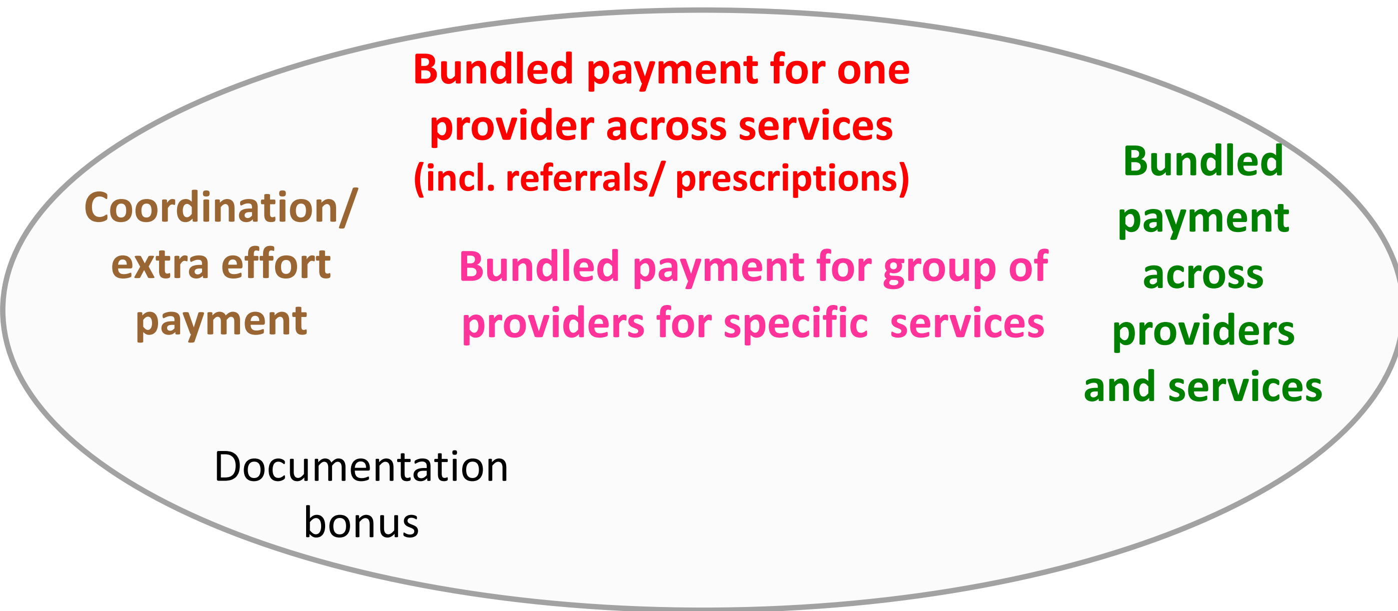
Case-based

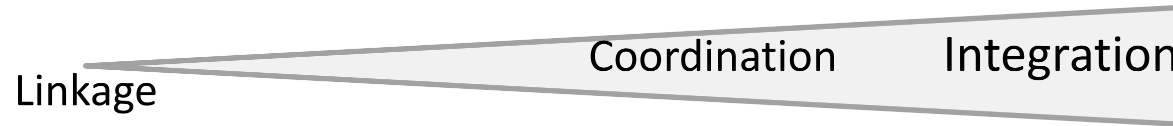
and/ or



Separate provision

Paying for care coordination

Full Integration



Capitation

or

Case-based

and/ or

and

Coordination/ extra effort payment

Bundled payment for one provider across services (incl. referrals/ prescriptions)

Bundled payment for group of providers for specific services

Bundled payment across providers and services

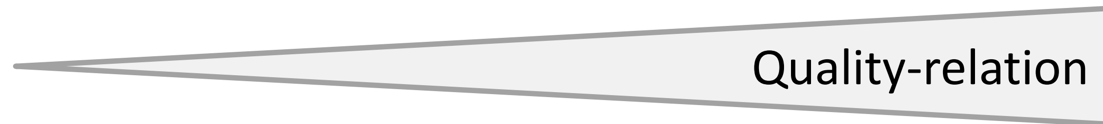
Documentation bonus

Paying for quality and coordination

Bonus for structural quality (e.g. waiting)

Bonus for process quality (e.g. guidelines adherence)

Bonus for outcome quality



Structure

Process

Outcome

Paying for quality

Our (admittedly simplified) model

MiG Management im Gesundheitswesen

	Primary prevention	GP care	Ambulatory specialist care	Ambulatory care by other providers	Secondary prevention	Accident & Emergency/ Emergency Room	Inpatient treatment	Rehabilitation	Continuing care	End-of-life care
"Healthy"										
Diabetes										
COPD										
Cardio-vasc. dis.										
Other chronic diseases										
Elderly in community										
Dementia										
Other mental health problems										
…										

Fragmentation all over,
between different patients, sectors and institutions,
within institutions etc.

The German Kinzigtal approach

- In Germany, integrated care contracts possible since 2000
- Currently 1,600 contracts net with ca. 1.9 million patients
- But most of them limited to acute care/ rehabilitation etc.
- Kinzigtal (since 2006) exception: population-based
- Financial incentive: shared savings contract

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Variety of activities included:
DMPs, case management,
central electronic patient record,
prevention programs, coaching of high-cost patients etc.

- Two shareholders: a physicians‘ network (2/3) and a management company (1/3)
- Contracts with two sickness funds (AOK and LKK; covering >50% of Kinzigtal population)
- **Target group**: entire AOK- and LKK-insured population of the Kinzigtal region
- **Triple Aim**: 1.improving the health of the population, 2. improving the individuals experience of care (quality of life) and 3.at the same time reducing the per capita costs
- **Funding:** providers receive “normal” fees directly from sickness funds; management costs and “profit” through shared savings

The Dutch bundled payment approach

- Since 2007 experiments with bundled payments
- Since 2010 “official” for diabetes, COPD & CVD, based on “care standards”
- Financial incentive: bundled payment to care group, covering all costs for particular indication, incl. other providers *(with incentive to shift costs to other indications)*

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The English Integrated Care Pilots approach

- 2008 “Equity and Excellence: Liberating the NHS”
- Call and selection of 16 Integrated Care Pilots (2009) with different foci “to achieve more personal, responsive care and better health outcomes for local population”
- Since 2011, also North West London Integrated Care Pilot
- Financial incentive: not really

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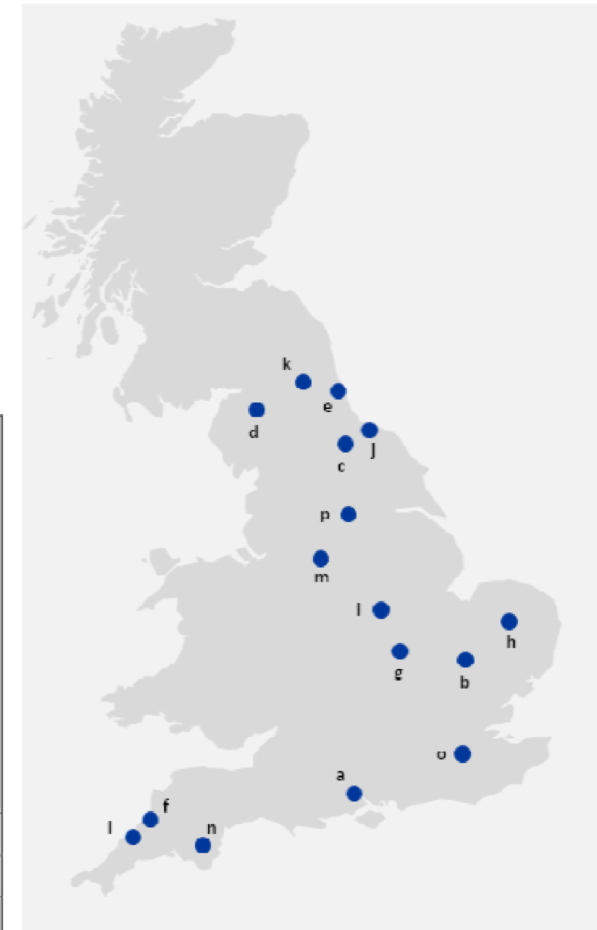

Results at a glance (sorry for over-simplifying)

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Intervention	Patient: Intermediate clinical outcomes and mortality	Patient: Use of hospital care	Patient: Process indicators	Patient: Patient experience	Provider experience	Costs per patient per year
Germany						
Gesundes Kinzigtal (GK)	**Decreased:** mortality (2.5 years after enrollment)[a]	**Increased:** admissions; **decreased:** length-of-stay		**Decreased:** changes in insurers	**Improved:** cooperation	–$203
The Netherlands						
Bundled payment system	**Improved:** control of blood pressure and cholesterol; **increased:** HbA1c; **decreased:** BMI	**Decreased:** specialist care	**Increased:** four checkups, foot/kidney exams; **decreased:** eye testing	"Cooperation and coordination for diabetes excellent"	**Improved:** perceived quality, patient-centeredness	+$388
England						
16 integrated care pilots (ICPs)		**Increased:** Emergency admissions; **decreased:** elective admissions and outpatient admissions		**Improved:** care plans/follow-up; **decreased:** listening to and involving patients, preferences taken into account	**Improved:** teamwork, communication, job depth and breadth	–$358[b] –$93[c]
North West London ICP	**Improved:** control of cholesterol improved; **unchanged:** HbA1c	No significant change in first year	**Improved:** care plans, diabetes testing	"Good idea, but no actual change"	**Improved:** interprofessional learning and collaboration, but deemed "time-consuming"	No significant change in first year

In summary …

- The **results** in these three countries are almost as **mixed** as those found in the systematic reviews discussed by Nolte and and Pitchforth (2013).
- The German **Kinzigtal** experience with its **broad scope** (both in terms of population included as well as services offered) and **clear financial incentives** should be an especially **worthwhile starting point** for future models both in Europe and in the United States.

Slides available at: **www.mig.tu-berlin.de**