

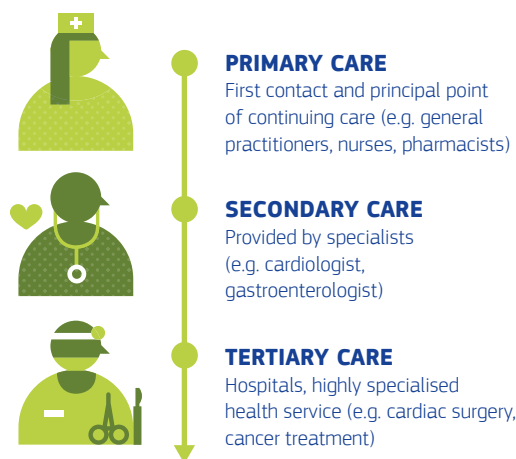
Integrated care and chronic diseases management

A European Innovation Partnership on Active and Healthy Ageing priority

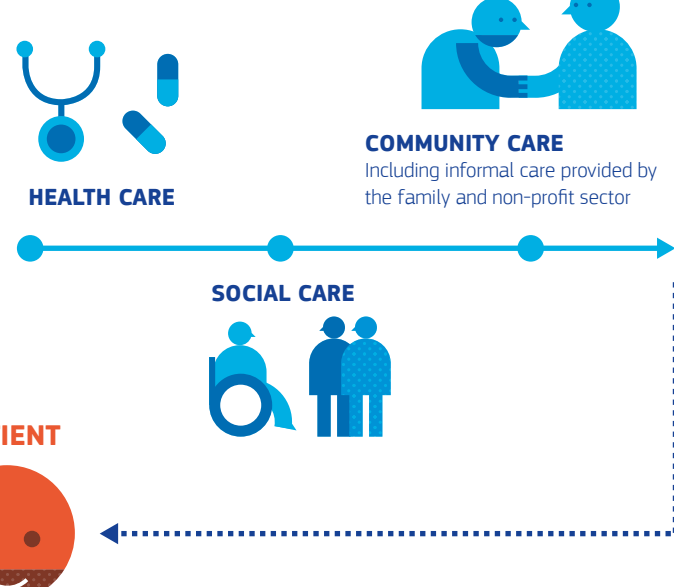
WHAT IS INTEGRATED CARE?

Integrated care is the **coordination of care**:

VERTICALLY, ACROSS THE LEVELS OF HEALTH CARE:



HORIZONTALLY, ACROSS DIFFERENT TYPES OF CARE DELIVERY:



Some relevant features:

- ✓ **Shift from reactive service delivery** (after adverse health events, e.g. a cardiac arrest) to **preventive and proactive care** (prevent and manage chronic conditions, e.g. maintain healthy blood pressure / cholesterol level)
- ✓ **Patient-centred approach and active involvement** of the patients in understanding and managing their own diseases (patient empowerment)
- ✓ **Move from institutional to community / home based care**

WHY DO WE NEED INTEGRATED CARE?

FOR PATIENTS



2 out of 3 people in retirement age have at least **two chronic conditions**

FOR HEALTH SYSTEMS



70% of healthcare costs are spent on chronic diseases

41% of healthcare costs are dedicated to **hospital care**

9% of GDP: Public spending on health

+1.5% of GDP: Projected increase by 2060

It is necessary to offer **alternative care models** to improve quality of life, health care and reduce avoidable hospitalisations / costs

➡ **Integrated care model**

WHAT ARE THE ADVANTAGES OF INTEGRATED CARE MODELS?



FOR HEALTH AND SOCIAL CARE SYSTEMS

- Better coordination** among health and social care professionals
- Higher efficiency**, improved healthcare processes, supported by IT
- New organisational models** and use of technologies for remote care (e.g. at home or at work)



FOR PATIENTS

- Better quality** and more timely care, easier navigation within the healthcare system
- Personalised approach**, involvement in the management and decision about their diseases
- Higher autonomy** and possibility to remain at home thanks to the use of remote monitoring services



FOR CARE GIVERS

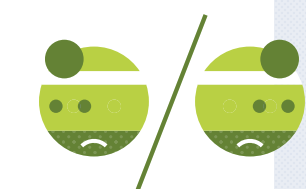
- Higher support** in providing care
- Easier navigation** through health system

WHAT ARE THE CURRENT BARRIERS TO THE IMPLEMENTATION OF INTEGRATED CARE MODELS?



Current solutions are **proprietary** (i.e. belong to a single provider) and cannot be extended to other needs or target users, leading to **market fragmentation**

Legal and regulatory uncertainties (i.e. data protection)



Health and social care sectors often operate in **silos**

Lack of financial incentives (public procurement / lack of innovative reimbursement models)



The European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) supports private and public actors across the EU to implement integrated care models. Target: implementation of integrated care programmes in 20 regions by 2020.

HOW CAN IT BE IMPLEMENTED?



The European Innovation Partnership on Active and Healthy Ageing (EIP on AHA)
The European Innovation Partnership on Active and Healthy Ageing (EIP on AHA), set up in 2012, gathers stakeholders at EU, national and regional level from the public and private sector across different policy areas. Together they share knowledge and expertise on common interests and engage in activities and projects to find innovative solutions that meet the needs of the ageing population.

Under the framework of the EIP on AHA, the Action Group on integrated care works to improve the quality of life and health outcomes of older people with chronic conditions and reduce unnecessary hospitalisations by promoting new health care models based on a better integration of the different levels of health and care services.

