Advancing comprehensive health care towards sustainable health systems

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What is the problem and why is it important?

- Advances in health care that keep people alive while controlling their conditions have led to growing numbers of people surviving with chronic illness
- Proportion of older people is rising, increasing the number of those with chronic health problems because of accumulated exposure to chronic disease risk factors over lifetime.
- Accelerated advances in medical technology provide potential for new methods of delivering and organising health care while ensuring that they provide value for money
- Growing expectations
- Financial pressures on economies and health systems

Incidence of multimorbidity increases with age but number of those affected is higher at younger ages

Figure 1 Distribution of the number of individuals with multimorbidity in Ontario across ages, by number of common chronic conditions and year.

In: Pefoyo AJ, Bronskill SE, Gruneir A, et al. The increasing burden and complexity of multimorbidity. BMC Public Health 2015;15:415.

URL:
http://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1733-2

Source: Koné Pefoyo et al. (2015)

Multimorbidity is associated with unplanned admission to hospital

Figure 1: Predicted probability of unplanned admissions to hospital and potentially preventable unplanned admissions to hospital by deprivation quintile.

In: Payne RA, Abel GA, Guthrie B, Mercer SW.. The effect of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study. CMAJ 2013;185:E221-8.

URL: *http://www.cmaj.ca/content/185/5/E221.long*

Source: Payne et al. (2013)

Challenges of treating multiple conditions

- A 76-year old woman with heart failure: *"later she developed diabetes … we controlled her blood pressure with tablets which worsened her renal function. A statin lowered her cholesterol, but her liver function went haywire … Beta blockers made her breathing worse and her warfarin had to be stopped after a gastric bleed … there always seemed to be a new symptom or drug side effect to deal with…."*

Source: BMJ 2006;332:1221

Evidence base for interventions targeting multimorbidity

- Bleicher et al. (2015): systematic review of programmes in the US
  - 27 studies with comparator (13 RCTs) across 5 models of care
  - Care / case management and disease management associated with improvements in patient satisfaction, selected measures of clinical outcomes and utilisation
- Smith et al. (2016): Cochrane review of interventions for improving outcomes in patients with multimorbidity in primary care
  - Service delivery design e.g. case management, multidisciplinary team work (12 RCTs); patient-oriented (6 RCTs)
  - Evidence mixed: little/no difference for clinical outcomes; improvements in mental health outcomes; small improvements in patient-reported outcomes; little/no difference for utilisation measures
  - Interventions targeted at either specific combinations of common conditions (e.g. comorbid depression), or specific problems for people with multiple conditions may be more effective

JA CHRODIS Multimorbidity care model

Dimension	Component
Delivery system design	1. Regular comprehensive assessment of patients 2. Multidisciplinary, coordinated team 3. Professional appointed as coordinator of individualised care plan and contact person for patient and family ('case manager') 4. Individualised care plan
Decision support	5. Implementation of evidence based practice 6. Training members of the multidisciplinary team 7. Developing a consultation system to consult professional experts
Self-management support	8. Training of care providers to tailor self-management support based on patient preferences and competencies 9. Providing options for patients and families to improve their self-management 10. Shared decision-making (care provider and patients)
Clinical information systems	11. Electronic patient records and computerised clinical charts 12. Exchange of patient information across providers and sectors 13. Uniform coding of patients' health problems 14. Patient-operated technology
Community resources	15. Supporting access to community and social resources 16. Involvement of social network, incl. friends, family, neighbours, patient associations

Sources: JA-CHRODIS report on care pathways

Role of evidence-based guidelines

- Guidelines have potential to improve care for people with chronic disease
- But they rarely account for those with multiple conditions
- Reflects the way evidence is generated (focus on single conditions, exclusion of certain groups from clinical trials)
- Tend to lack recognition of age and general frailty
- Application might lead to overtreatment, complex management regimes or polypharmacy

Exclusion of patients with concomitant chronic conditions in ongoing randomised controlled trials targeting 10 common chronic conditions

Source: Roland & Paddison 2013; Buffel du Vaure et al. (2015)

Potential time spent by patients on health-related activities (hours/month)

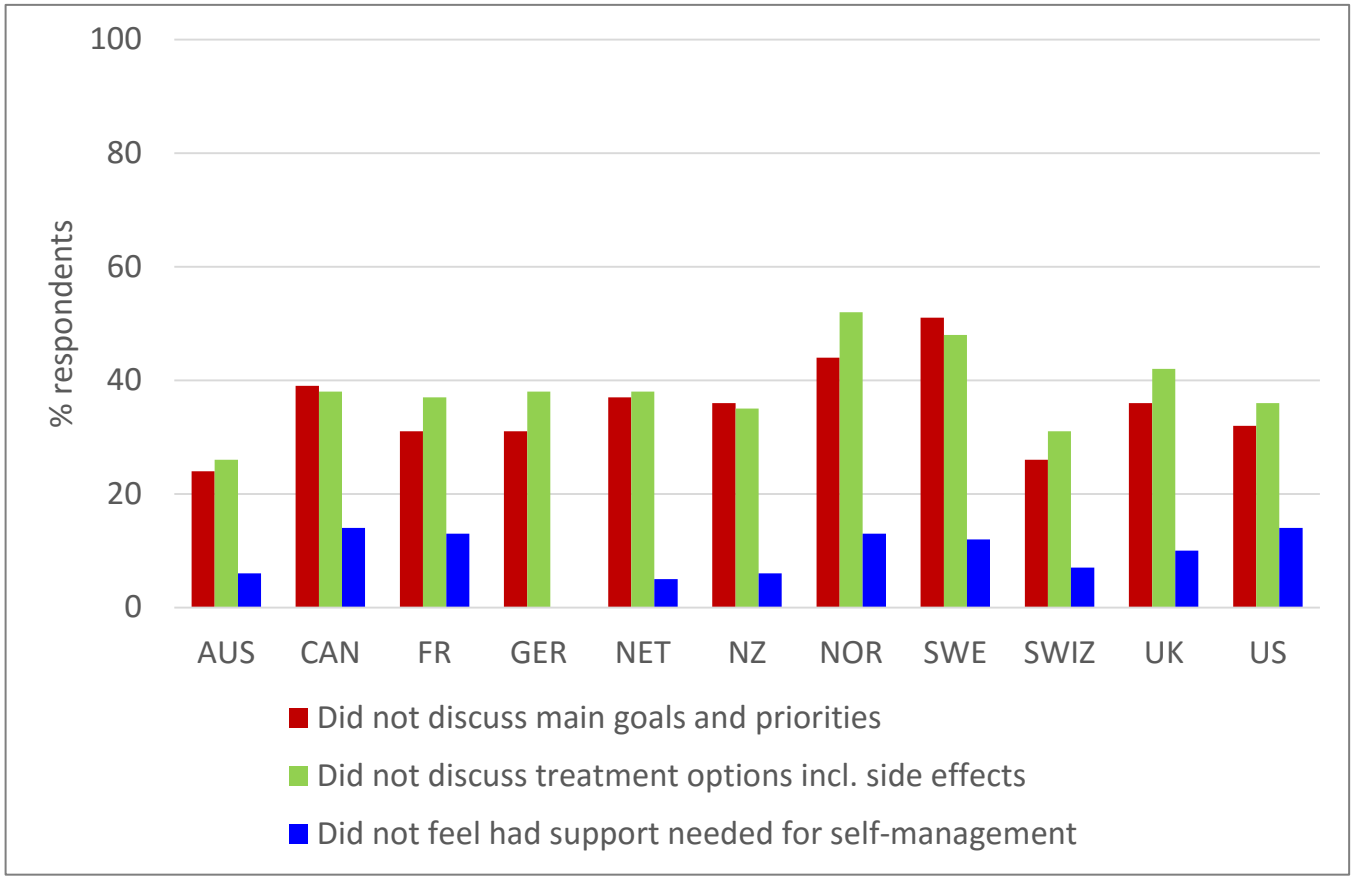
Figure 2: Time spent by patients in health-related activities (hours/month) by activity and multimorbidity profile. CHD, coronary heart disease; COPD, chronic obstructive pulmonary disease.

In: Buffel du Vaure C, Ravaud P, Baron G, Barnes C, Gilberg S, Boutron I. Potential workload in applying clinical practice guidelines for patients with chronic conditions and multimorbidity: a systematic analysis. BMJ Open 2016;6(3):e010119.

URL: *http://bmjopen.bmj.com/content/6/3/e010119.long*

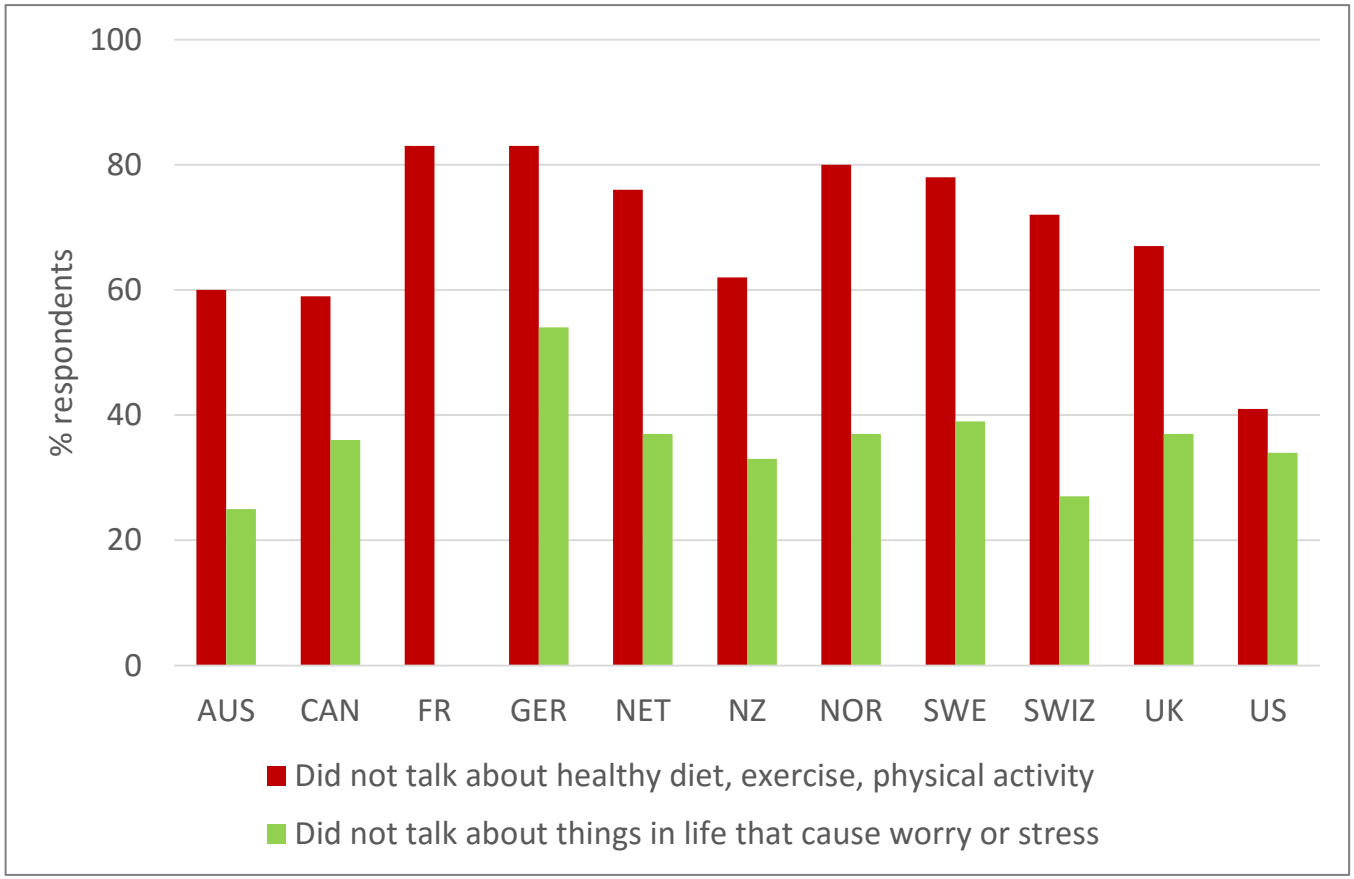
Source: Buffel du Vaure et al. (2016)

Engagement of service users in their own treatment remains suboptimal…

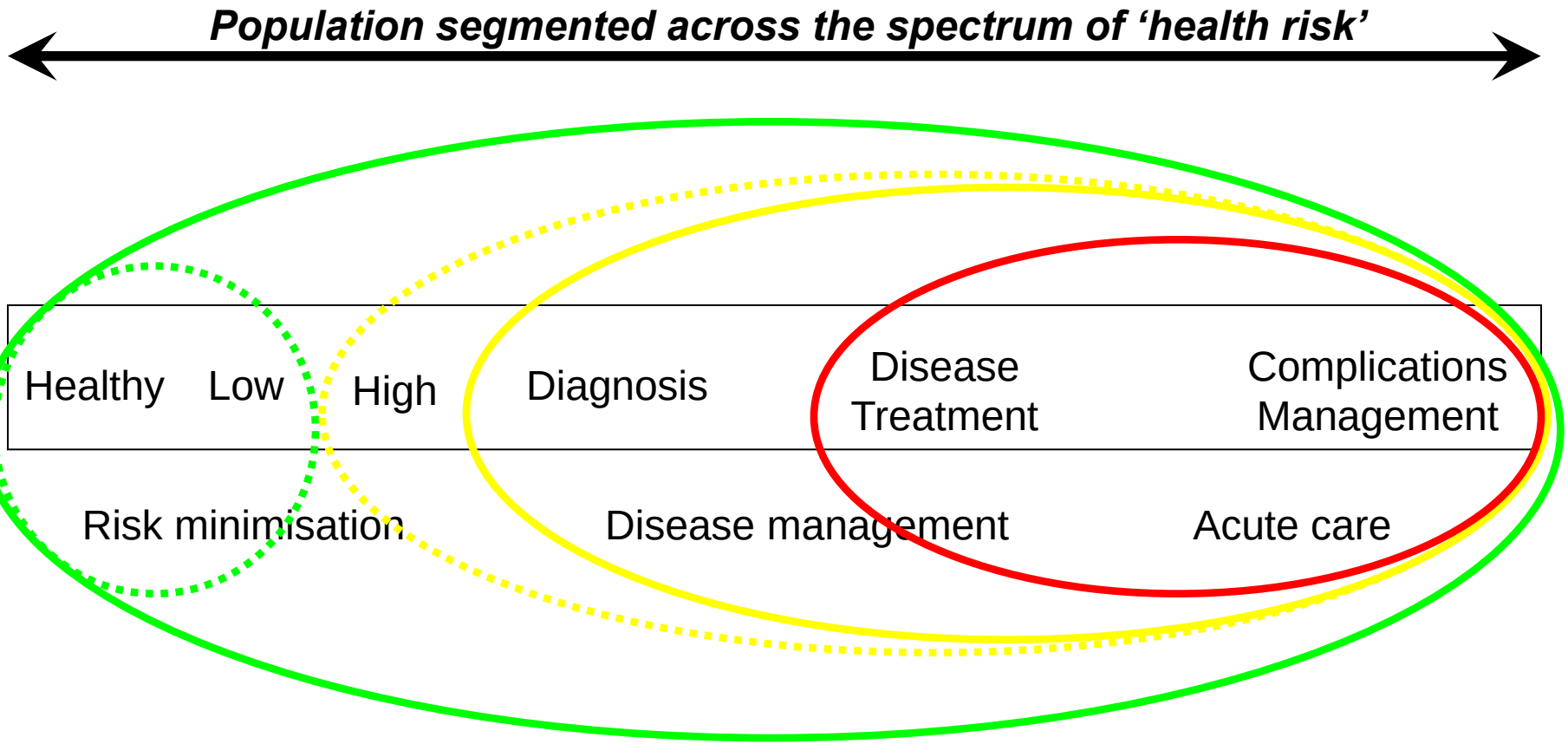


Source: Osborn et al. (2016)

… as does the proactive engagement in wider health related behaviours



Source: Osborn et al. (2016)



Source: adapted from Petersen & Kane 1997

Continued institutional divide hinders coordination along the care continuum…

"It is not yet in our habits to consider that chronic disease is a public health problem [...] I think that in France the culture, ***the medical or health culture, is more concerned on acute care than on prevention****. […] the health authority has organised a lot of information and prevention campaigns and they are communication campaigns, but communication is not prevention." (France)*

"[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....*** *" (The Netherlands)*

…which is also reflected in resource allocation:

"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)*

Source: Knai et al. (2014)

…as does the misalignment of incentives…

For providers:

*"the current financing system pays the actions of the professions. So it pays the doctor, it pays the nurse, **but it doesn't pay working together and it doesn't pay self-management of the patients**. […] it starts with the treatment of complications." (The Netherlands)*

…and funders:

*"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)*

Source: Knai et al. (2014)

…and of political priorities and mismatch between political will and implementation

"This is due to the political situation right now where everything you do is connected to whether you want to gain votes: if you do prevention and risk minimisation then you tell people not to smoke and do more exercise, and on that you will lose votes because nobody wants to quit their smoking; but they do if they get lung cancer, then they want acute care. ***You have to focus on acute care because that is what is selling votes****" (Denmark)*

In France, the 2009 health reform defined patient education as a national priority but:

"[T]he nursing profession is collectively in agreement for [...] developing and implementing patient education programmes but this is based on the assumption that they have money to do it and at the moment they don't […] ***The law now says that patient education is mandatory. However where the financing comes from is still not clear****" (France)*

Source: Knai et al. (2014)

What needs to be done?

Provide the (regulatory) context to enable innovation

- The policy context within which services are being designed and delivered will be crucial to encourage innovation
- Those with oversight of the system must provide ***adequate and sufficient political support for change*** to ensure that the necessary actions are taken to reconfigure organisational structures, remove barriers to change and invest in education and training of the workforce to ensure appropriate skill mix, and information technology
- High level political support particularly important in relation to ***adequate resourcing*** as comprehensive care means bringing together different funding streams, different levels of decision-making, and different entitlements, etc
  - Central level can introduce mechanisms to help overcome these challenges through for example introducing single budgets
  - Need to ensure that change is ***comprehensive***, ***consistent*** and ***contextually appropriate***

What needs to be done?

Balance 'top-down' and 'bottom-up' and deliver consistent messages

- Need to strike a balance between centrally defined requirements and local autonomy
- Actors operating at the different levels of the health system are faced with different pressures and consequent priorities that are not necessarily compatible or may even be contradictory
- Particular challenges for organisations arising from policies initiated by health care reformers on one hand and established ways of delivery on the other, which are likely to result in a gap between ***policy intent and actual implementation***
- Need to create a policy environment that provides the means for those who are asked to implement change to acquire the actual ***capacity and competence*** to do so will be critical for success

What needs to be done?

Learning from experience

- Systematically ***assess existing inefficiencies*** in health service delivery and disincentives for the patient or the provider to receive or deliver the highest quality care (such as access or cost)
- Need to ***use existing evidence*** to better understand how specific local conditions influence the outcomes of a given approach to inform implementation
  - Understanding the structural, organisational and cultural prerequisites for success
  - An innovation found to be successful in a given context will likely need to be adapted to enable widespread take-up

Incorporating the patient perspective

- Support for people with chronic conditions needs to ***account for the social and cultural context and norms*** within which they live
  - Need to understand patient preferences and the importance they place on health outcomes
  - Need to be considered partners in the care process that is sensitive to the contexts within they make decisions (e.g. 'experience-based co-design')

Thank you!

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