So wirkt Case Management in Österreich

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EUROPEAN CENTRE FOR SOCIAL WELFARE POLICY AND RESEARCH
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EUROPÄISCHES ZENTRUM FÜR WOHLFAHTSPOLITIK UND SOZIALFORSCHUNG
IN ZUSAMMENARBEIT MIT DEN VEREINTEN NATIONEN

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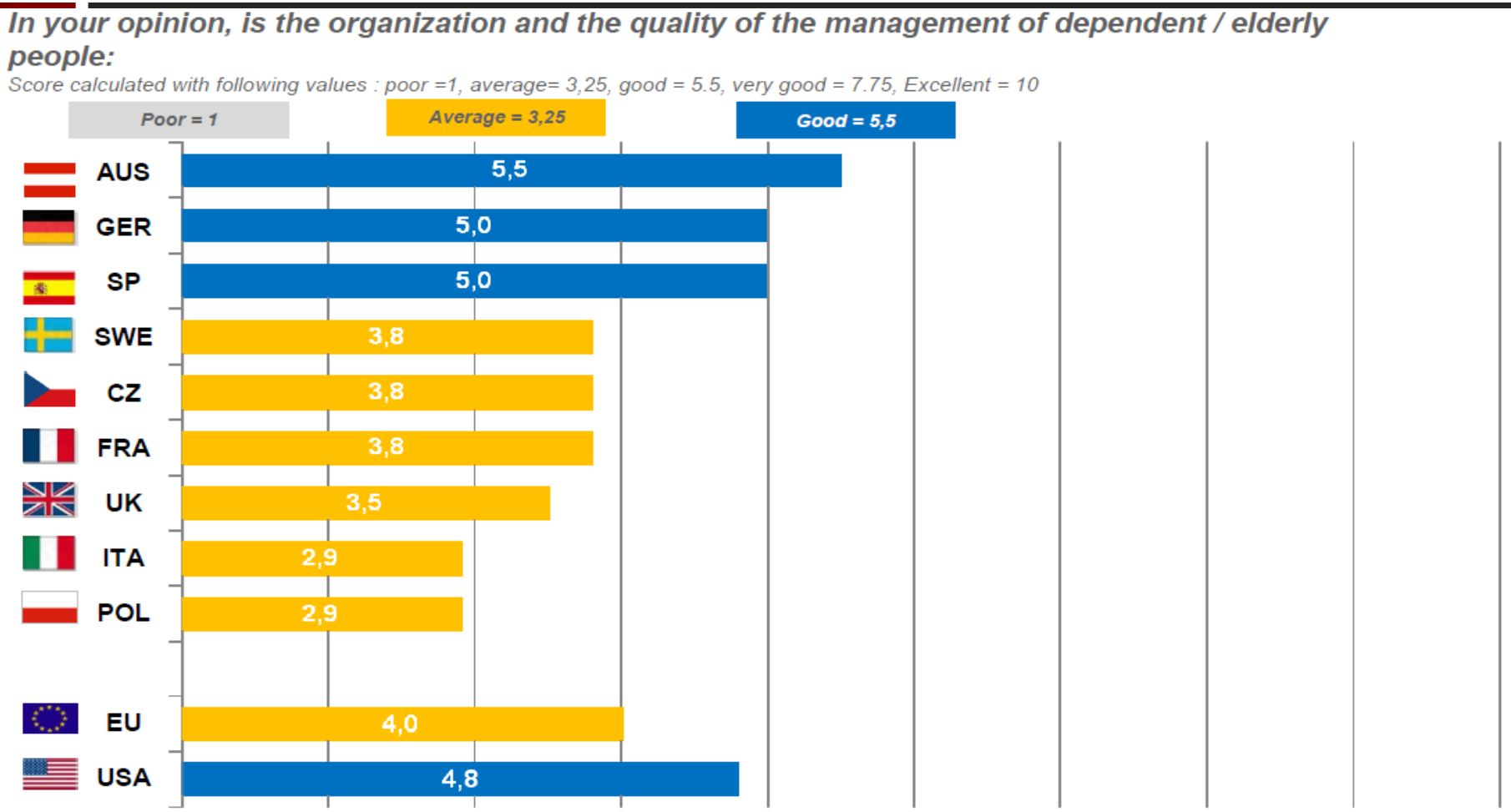
Überblick

- Wo ist und wo soll sich Case Management ansiedeln?
- Effekte von Case Management in DMP Diabetes
- Systembedingungen für bessere Koordination der Versorgung
- Case Management ein Thema von Beschäftigungsentwicklung und Produktivität ?
- Case Management als „social innovation“?
- Zusammenfassende Überlegungen

Offenbar wird jetzt schon das Managment von älteren Patient/inn/en als gut eingeschätzt?



Quelle: Barometre Cercle Sante, Sept. 2012.

Wo ist Case Management in Österreich verankert?

Integration: ein verschachteltes Konzept, (Leutz 1999)

- Arten
  - Verknüpfungen (Linkages)
  - Koordination
  - Vollständige Integration
- Stufe
  - Systemische Integration
  - Organisatorische Integration
  - Klinische Integration
- Formen
  - Vertikale Integration, „Versorgungskette in gemeinsamer Eigentümerschaft“
  - Horizontale Integration, „Monopolisierung durch Konsolidierung innerhalb der Versorgungssektoren“

Wir wissen wenig über die gesamte Wirkung von Patient/inn/en Management

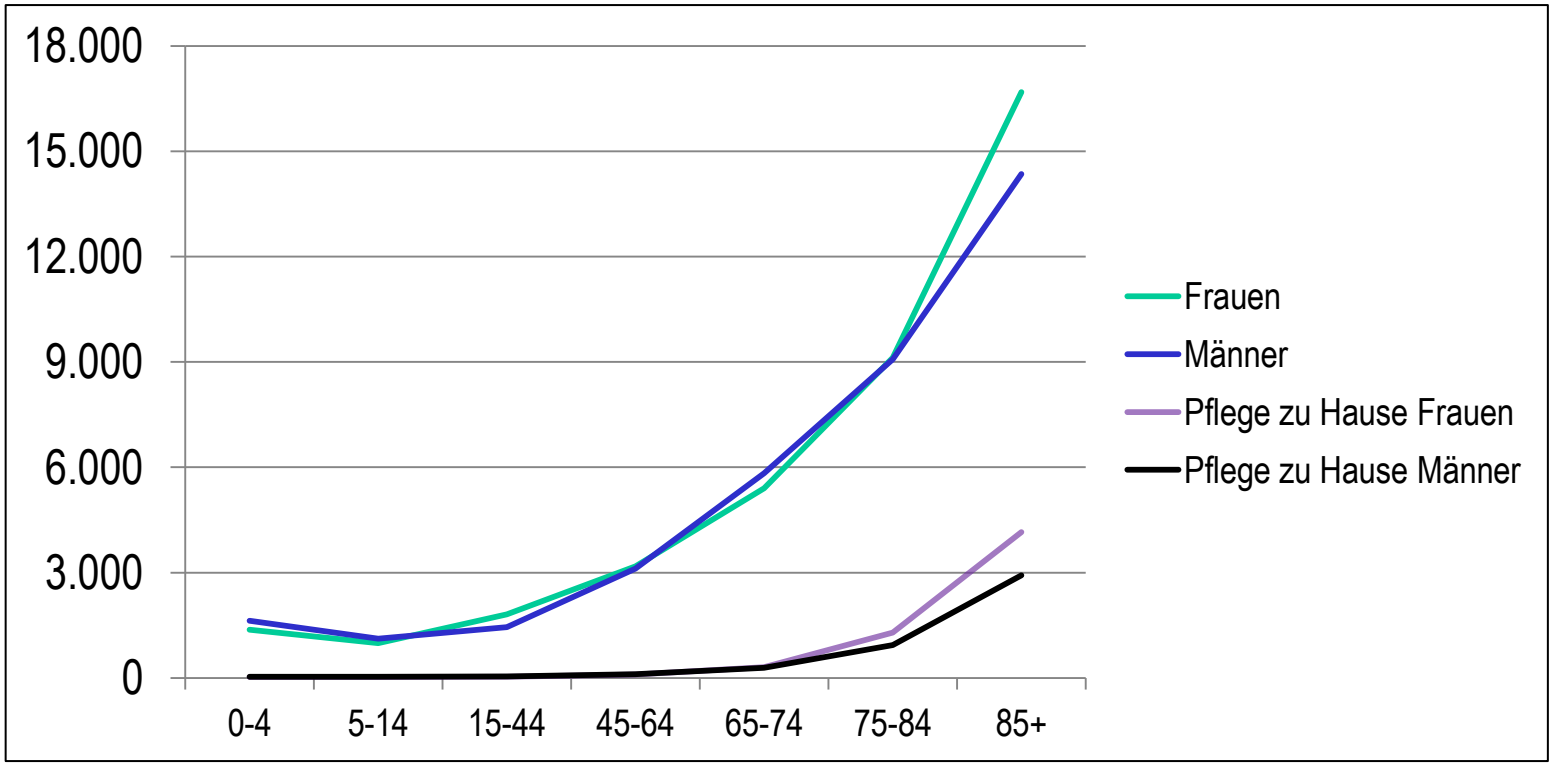
Nutzen des Entlassungsmanagements für die Gesundheitspolitik

- Der Nutzen für die Gesundheitspolitik wird vor allem in der Reduktion von Verweildauern,
- einer Reduzierung von raschen Wiederaufnahmen und darin gesehen, dass Pflege zu Hause
- im Vergleich zu stationärer Versorgung als kostengünstiger eingestuft wird.

PIK (2003) Zusammenfassung, Endbericht

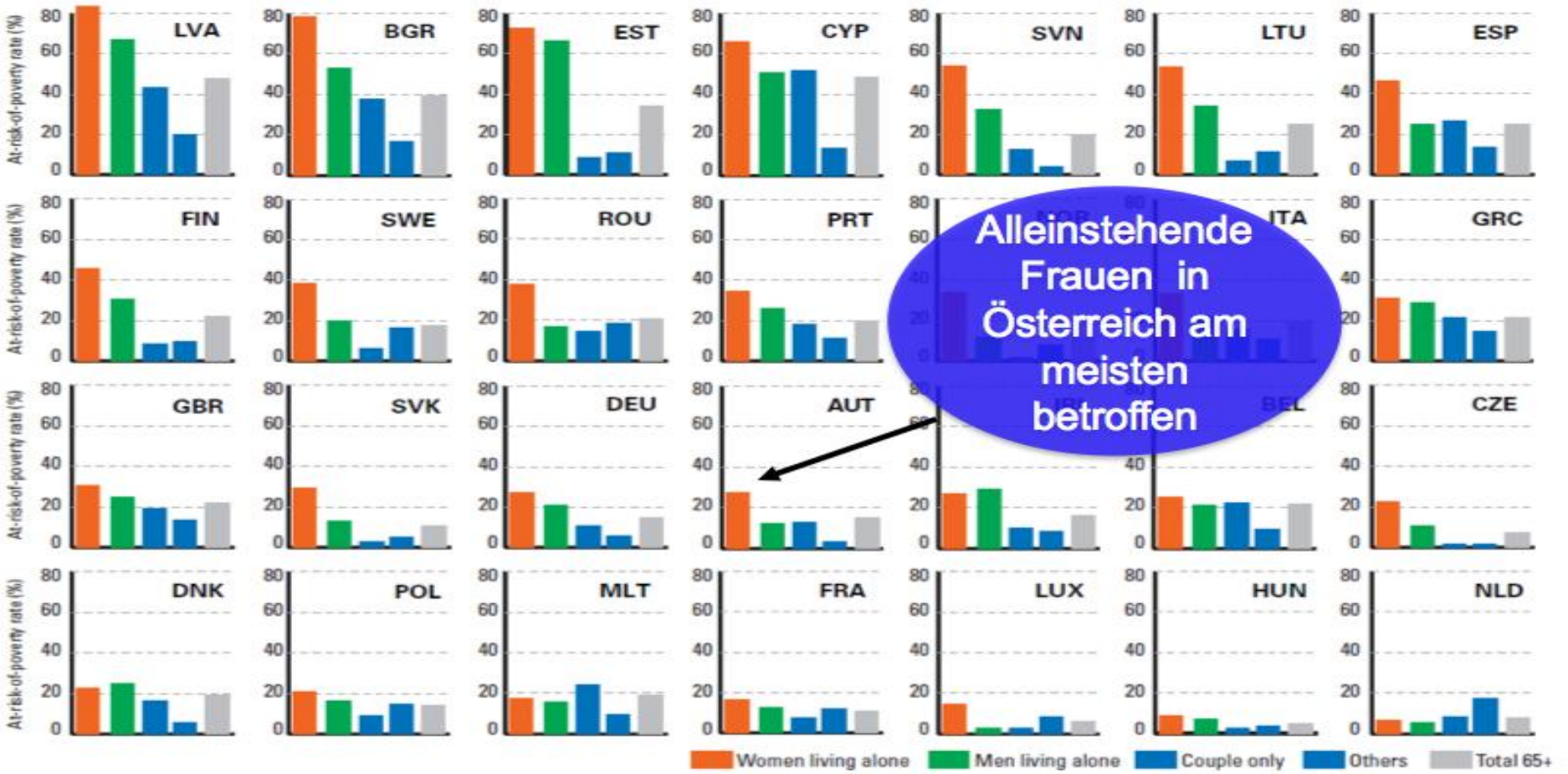
Wir brauchen dennoch Case Management, aber für wen?

Health expenditure by Gender and Age groups in Austria, Euro per capita, 2007



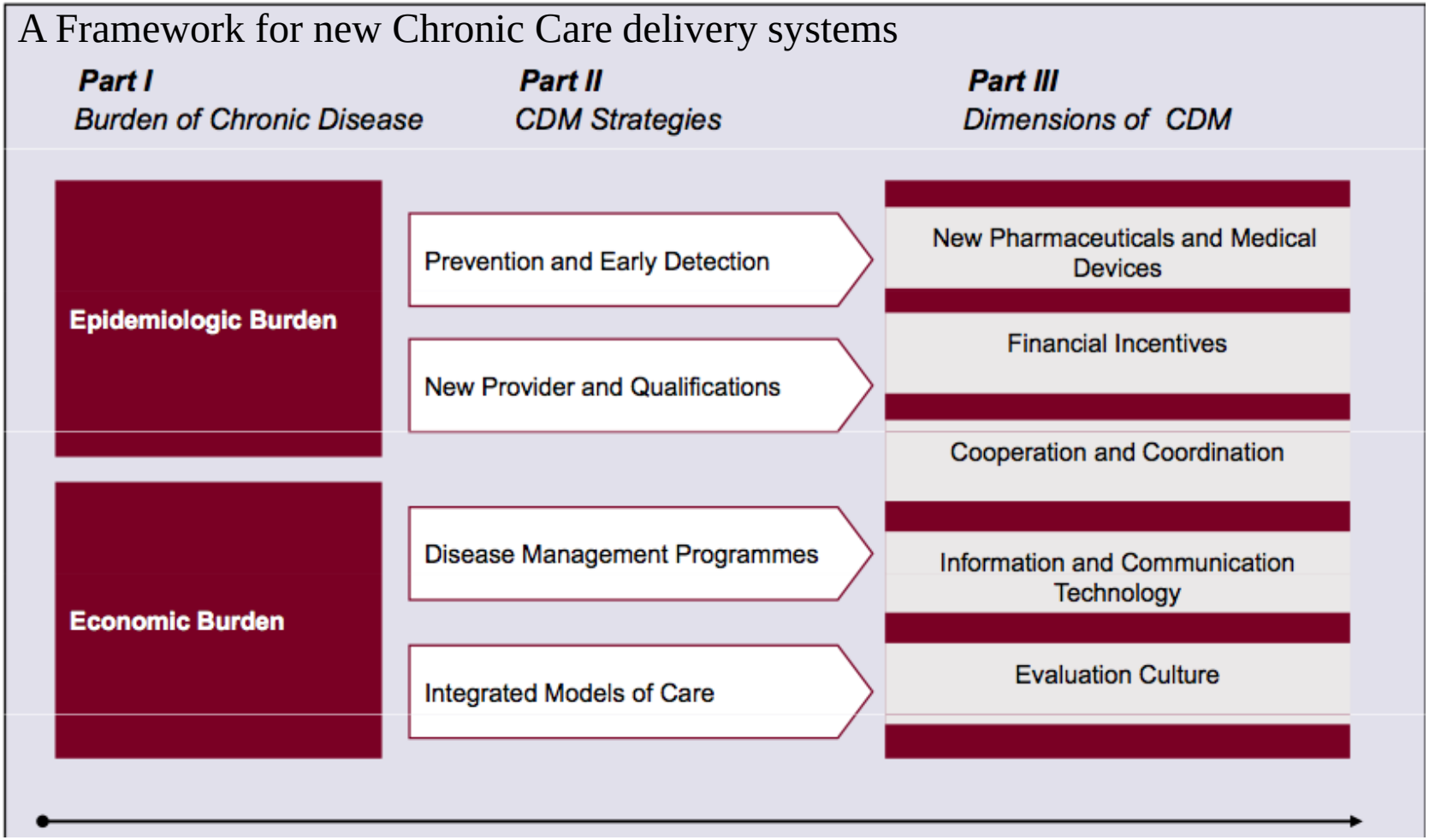
Source: Statistik Austria 2012, eigene Berechnungen

Armutsgefährdete alleinstehende Frauen ?



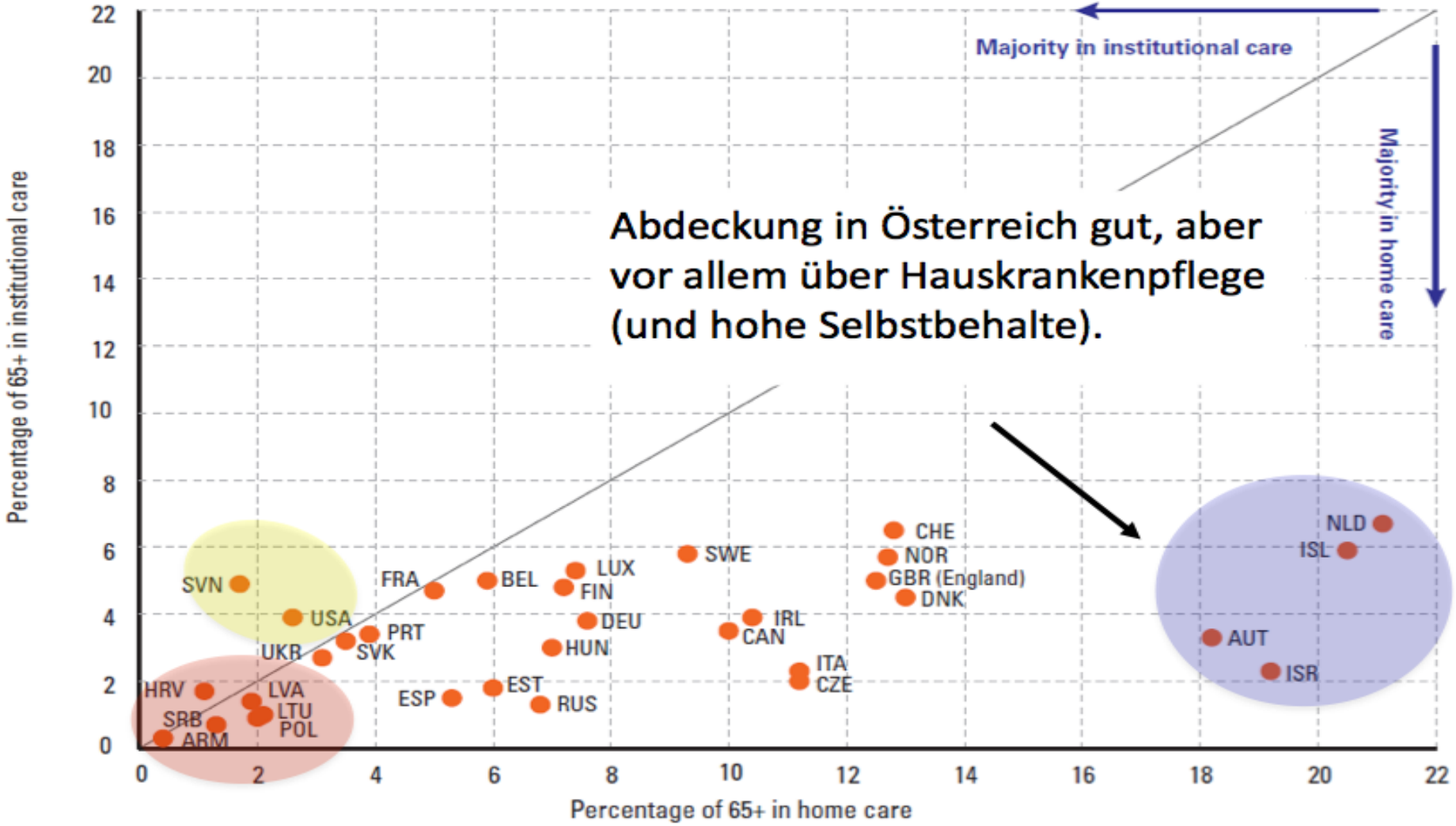
Quelle: Rodrigues, Huber & Lamura (Hrsg.) (2012), based on SILC-data 2011.

Und wie viel davon?



Source: Busse, Reinhard et al. Tackling Chronic Disease in Europe. WHO European Observatory on Health Systems and Policies. Studies Series No 20. 2010

Soll Case Managment das gute und länger zu Hause sein ermöglichen?



Soll sich case managment auf strukturierte Behandlungsprogramme beschränken?

- 2007, Diabetes type 2 programme launched („Therapie Aktiv“) and implemented in 6 of 9 Austrian Länder.
- 2009: Federal guideline Diabetes implmented
- 2011 approximately 27,000 patients are currently enrolled (7%) and 900 physicians participate (8% of physicians registered with health insurance)
- Ongoing discussion of expanding DMP in other areas as already implemented in Germany (coronary heart disease, asthma, diabetes mellitus type 1).

Source: Hofmarcher et al. (forthcoming). Health Systems in Transition.

DMP Diabetes mellitus II entspringt einem Reform Pool Projekt mit Innovationskraft

- Reform pool projects have been slow to take off mainly because there is no financial incentive for physicians to participate in such projects. (As compared to Germany, where prior to 2008, funds were withdrawn from contracts to finance Integrated Care projects).
- Many projects also require additional funds either from the sickness fund or at the regional level, leading to a disincentive to approve projects.
- Federal oversight of the reform pool funds and projects is limited, which could lead to redundancy of efforts and a lack of scale-efficiency in some regions.
- The highest number of projects were funded in 2007 (23), costing €11 Million but project activity dropped in 2008 and signficantly in 2009, with only one project granted in the first part of the year.
- Of all funds available, only 16% has been put to use, but this varies greatly by region with over 30% used in Styria and only 1.5% in Tirol (Czypionka 2009).

Qualitätsverbesserungen in DMP durch case management?

- Evaluations have accompanied the phasing-in of the DMP in Austria.
- In Salzburg (Sönnichsen et al. 2010) results show significant reduction of HbA1c level, reduction in systolic blood pressure, weight and cholesterol levels and significant changes in participation in trainings and also in examinations (HbA1c check-up, eyes and feet examination)
- Similar results in Styria: compliance levels increased, e.g. DMP patients with insulin dependency measure blood sugar more often
- In Lower Austria an increase in physician contacts, greater number of examinations for the early detection and prevention of complications, and fewer hospital days (total days, not only those related to diabetes) for those enrolled.
- Results also point to more targeted use of medication, improvement of the quality of life of patients and a delay or prevention of complications.

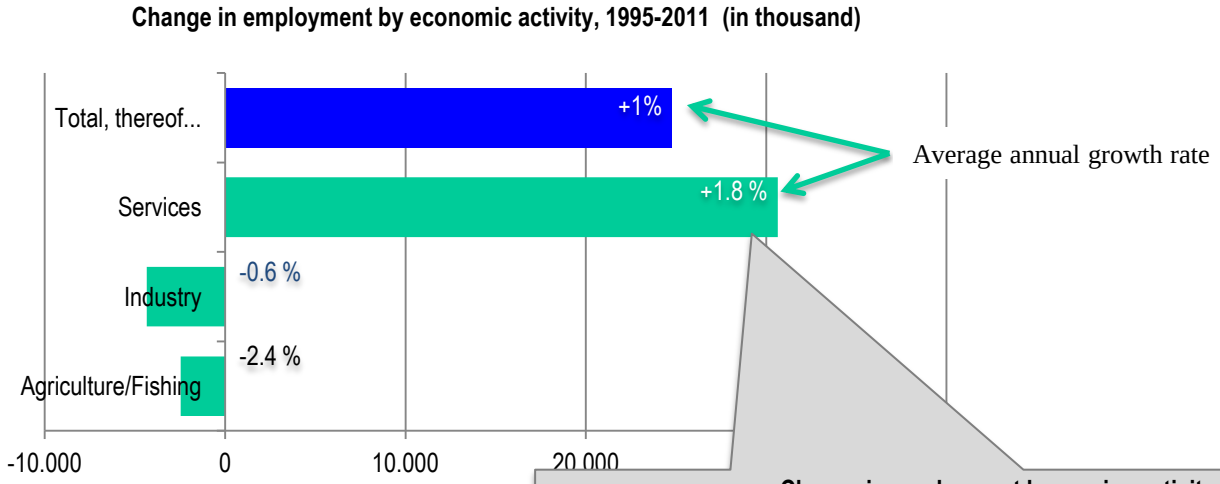
Kostendämpfung in DMP durch case management?

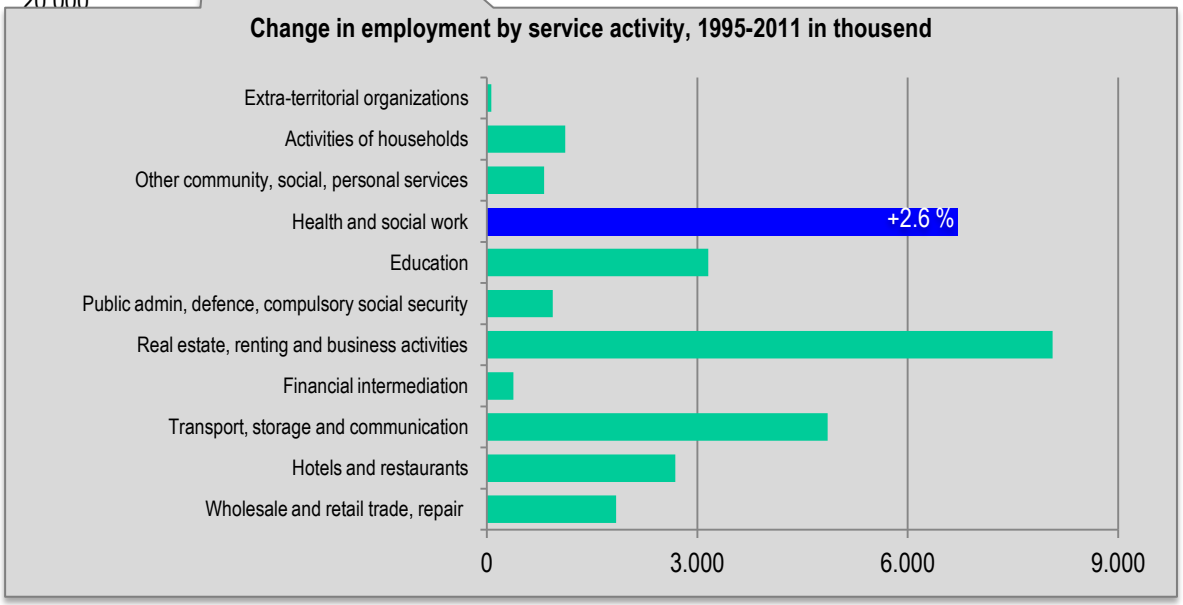
- Results in Austria indicate that cost of inpatient care could be reduced by DMP while the number of physician visits rose.
- Evaluation in Styria revealed that between 2007 and 2008 cost per patient in the no-intervention group was higher than in the DMP group, with an even greater difference when compared to 2008.
- Differences largely explained by reduced inpatient care cost with a simultaneously moderate increase in cost for ambulatory care providers. In Lower Austria cost for drugs per DMP patient have been found to exceed average cost per insured person in all sickness funds (Ruh et al 2009)

Jenseits von Disease Managment:
4 Bedingungen für verbesserte Koordination der Versorgung
(OECD 2007)

- Improved information transfer
- Better incentives for care coordination
- Rebalancing spending towards ambulatory care
- Breaking down regulatory barriers including enhancing mutual professional esteem and improved integration of health and long-term care

Die Beschäftigung im Gesundheitswesen steigt robust aber belastet auch die Budgets, wenn die Produktivität nicht (weiter) deutlich steigt





Note that data 1995-2007 and 2008-2011 follow NACE 1.1 and NACE 2 classifications, respectively
Source: Eurostat

Schlüsselthemen für verbesserte Arbeitsproduktivität (in der Versorgung von Chronikern)

Hofmarcher et al 2012 forthcoming

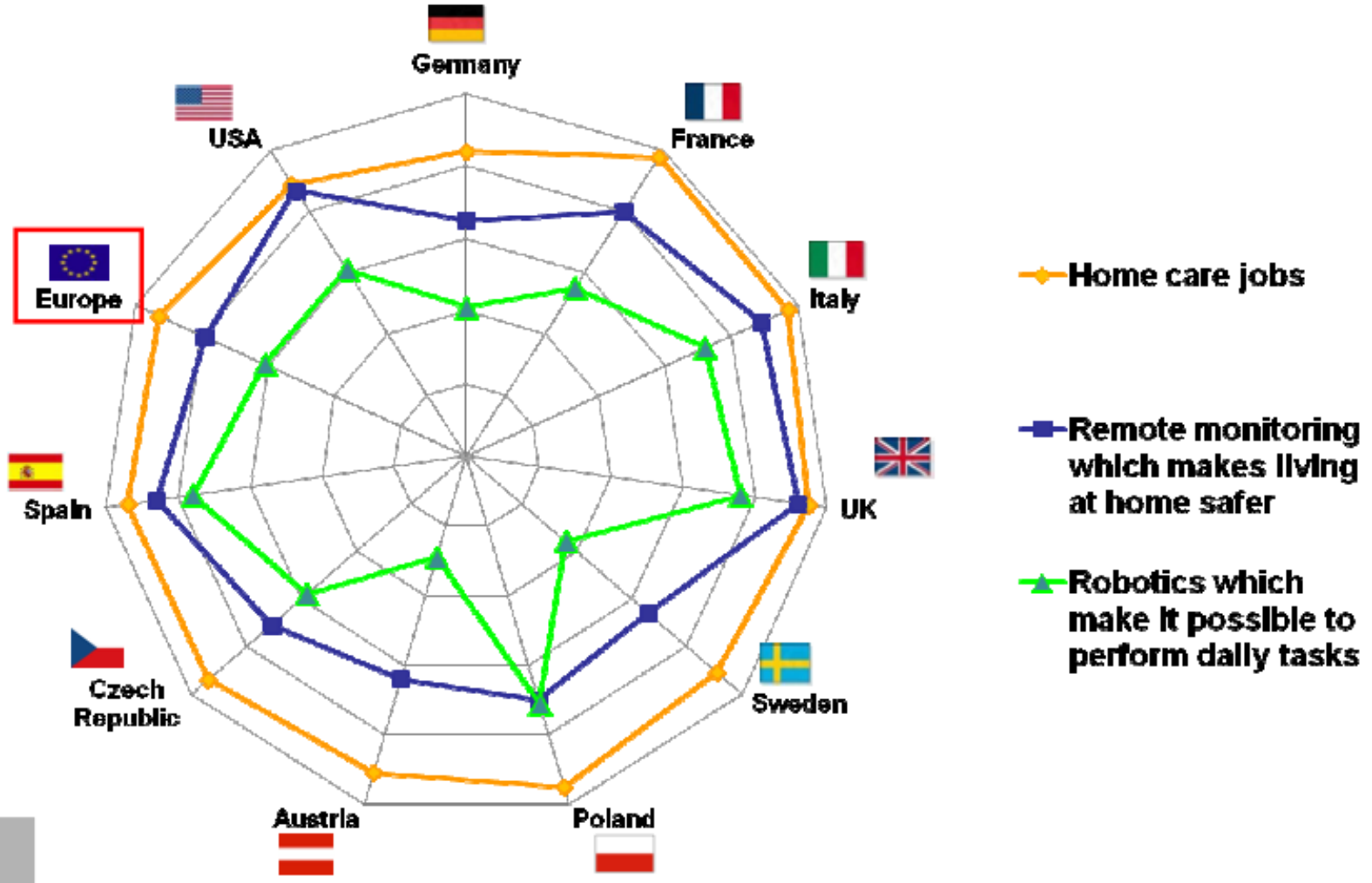
- Given fragmentation in funding and care delivery **greater national leadership to support integrated care** is needed to address systemic barriers to integrated care, e.g DK
- **Financial incentives and payment reforms** must be designed to reward care coordination and multi-disciplinary care teams which redefine professional roles, e.g. GER, US
- Replacing fee-for service forms of payment by **bundled value-based payments** is key to re-organize care delivery and encourage providers to work together and share responsibility for quality and costs, e.g. NL
- Focus skill-mix and promote change management through **teaming up to deliver mulit-disciplinary care and re-defining professional roles**

Was die Erwartungen immer dämpfen wird

- Health and long-term care provision is
  - a mulitask, multi-prinicpal, and multi-outcome undertaking (Dixit 2002)
  - with poorly measurable outputs and poorly contestable markets (Preker/Harding 2007)
- Leutz´s (1999) 5 laws of integrating care remain generically valid:
  - 1: You can't integrate all of the services for all of the people
  - 2: Integration costs before it pays
  - 3: Your integration is my fragmentation
  - 4: You can't integrate a square peg into a round hole
  - 5: The one who integrates calls the tune

Was wünschen sich die Leute?

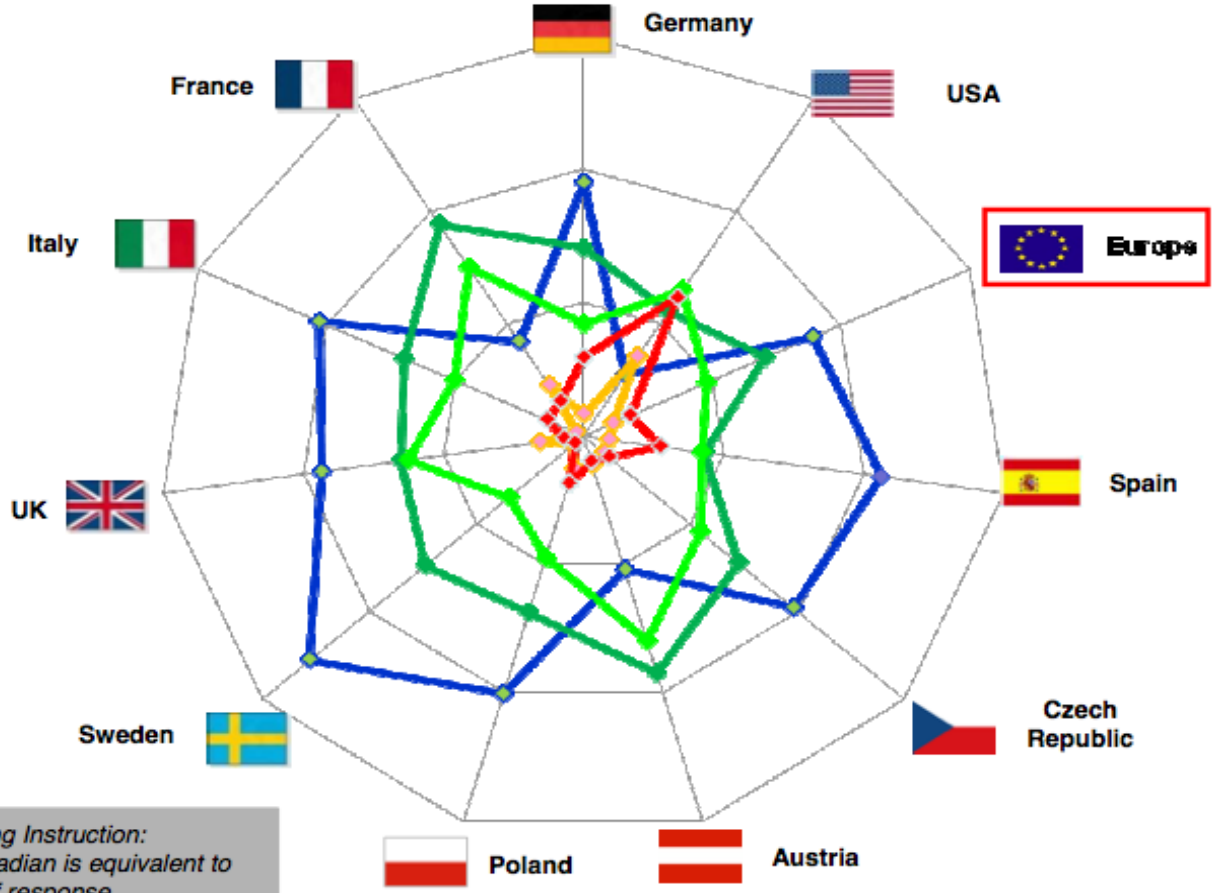
To help dependent elderly people stay in their homes, do you think we must develop...?

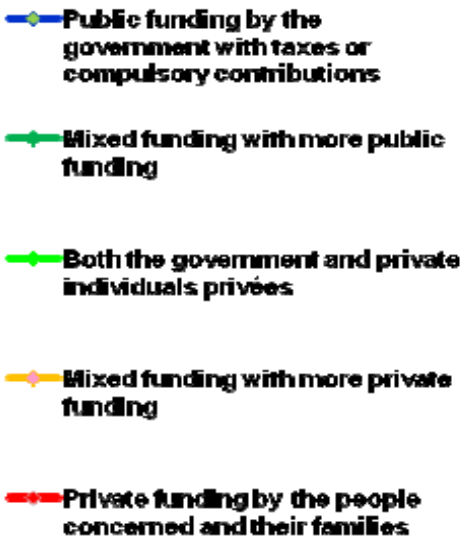


Quelle: Barometre Cercle Sante, Sept. 2012.

Case Management in Österreich bleibt halb privat, halb öffentlich?

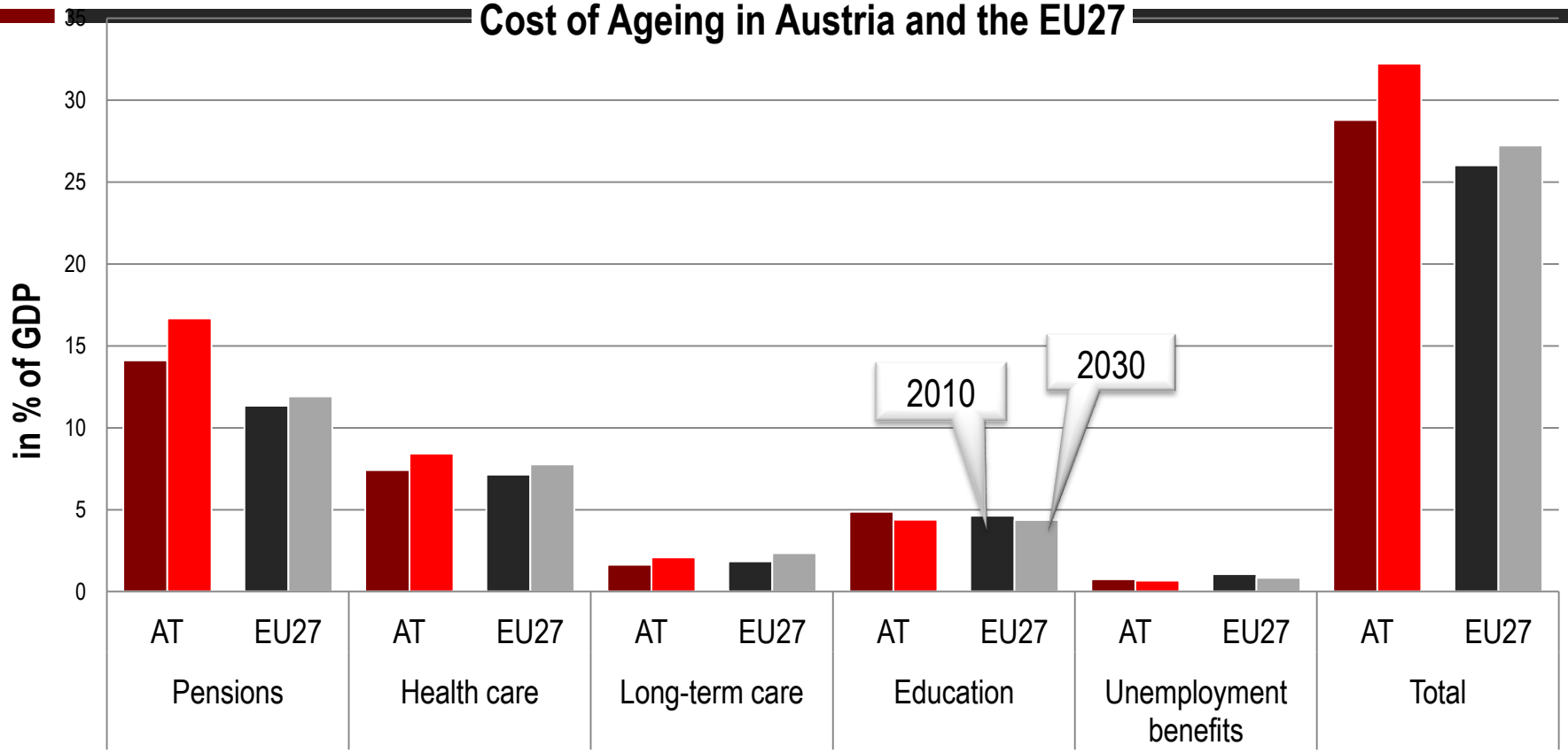
In your opinion, who should pay for the services and assistive devices which make it possible to meet the daily needs of elderly and dependent persons?





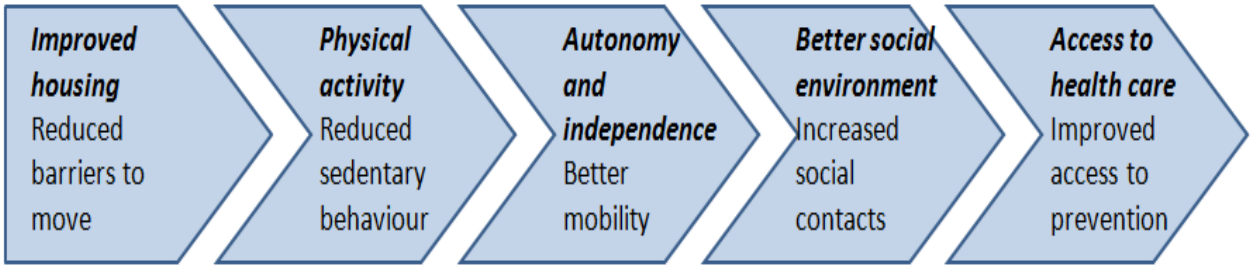
Quelle: Barometre Cercle Sante, Sept. 2012.

Die altersbezogenen, öffentlichen Ausgaben werden natürlich steigen



The projections for public spending on health and long-term care are based on the AWG refernce scenario, respectively.
Source: European Commission (2012). The 2012 Ageing Report, own calculations.

Case Managment für Aktives and Gesundes Altern?



Source: Rodrigues et al (forthcoming)

What does it tell us in terms of policy-making?

- Life-cycle approach: invest early
- Coordination of different policies is key… back to that in a minute
- Too broad to tackle? Identify priority areas, gaps, laggards

How to measure Active Ageing? Active Ageing Index (AAi)

Die Rolle der Koordinierung von “Gesundheit und Soziales” im Kontext der „Aktiv Altern Strategien“

- ‘Cure and care’ as an area of (social) innovation
  - European Innovation Partnership (EIP) on Active and Healthy Ageing
- Definitions and challenges
  - Multi-level governance
  - Coordination and integration of long-term care services and facilities
  - Social innovation

Zusammenfassende Überlegungen

- Entwicklung von Kriterien zur Etablierung und Verbreitung von best practice Case Management
- Job Profile und skill mix festlegen, e.g. Case Management ist nicht nur ärztlich
- Zielsetzungen von Case Management Modellen mit Systemzielen synchronisieren, e.g. „Umlagerungen“, Verringerung der gesundheitlichen Ungleichheiten im Zugang etc…
- Case Management sollte die Fragmentierung in der mobilen Pflege überwinden, aber wie?
- Evaluierungen festlegen nach internationalen Standards
- Networking und Marketing von „good practice case management“, e.g. European Innovation Partnership on healthy and active ageing: https://webgate.ec.europa.eu/eipaha/actiongroup/index/list

Selected readings

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- Preker, A.S. and Harding, A. (2007). Political Economy of Strategic Purchasing. In: Preker, A., Liu, X. and Velenyi, E.V. (Eds). *Public Ends, Private Means. Strategic Purchasing of Health Services.* Washington, D.C.: The World Bank.
- Sönnichsen A. et al. (2010). *The effectiveness of the Austrian disease mangement programme for type 2 diabetes: a cluster-randomised control trial*. BMC Fam Pract 11.

- Law 1: You can't integrate all of the services for all of the people:
  The fundamental questions here are: who you should target for integrated care? and what intervention is the most effective to use? Get the answers wrong and the result will often be unnecessary or uneconomic. For example, case management is a labour-intensive approach that is unlikely to be cost effective unless it is targeted accurately. Much of the evidence in the UK shows there remains a steep learning curve to getting this right.

- Law 2: Integration costs before it pays:
  Costs are unavoidable, but savings are not assured. There is an element of risk in integration, and this has never sat well with the risk-averse culture in health and social care (let alone in the current financial environment). As a result, and on the basis that it's far better to risk someone else's money rather than your own, many integrated care schemes remain limited to grant-funded and/or small-scale pilots with no real sustainable commitment behind them.

- Law 3: Your integration is my fragmentation:
  Even if a manager implicitly recognises the benefits of integrated care, they may feel it undermines or fragments their role. By its very nature, the process of integrated care requires strong leadership and skilful handling to broker the partnerships required to make it work. This is why so much research in this area focuses on the development of social capital to foster a common vision for change, and why financial inducements or enforced accountabilities alone can often commercialise relationships rather than promote collegiate working.

- Law 4: You can't integrate a square peg into a round hole:
  All integrated care is local and no one model can be effectively prescribed. Whereas the problem to resolve may look similar, (say, reducing re-admission rates to hospitals because step-down care is inadequate), the approach to solve it must be adapted to meet local circumstances. Hence, integrated care is not a solution that can be implemented wholesale or imposed from on high. It must be built from the bottom up, driven by local ownership, within a system that rewards this.

- Law 5: The one who integrates calls the tune:
  Integrated care has largely been the business of providers and has not necessarily reflected the values of patients and communities. Indeed, in many cases, dominant professional elites can emerge, reflecting their own values and interests above others. Effective integrated care networks need skilled managers to broker a common path between partners that have competing interests. True 'coalitions of the willing' are rare.