Chronic diseases and adaptation of the health care system

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Chain care

Cure and care for people with specified diseases is delivered in chains, every institution or care provider has its own role in the process

Successful Example: Stroke services

- Hospital stay now 7 days
- Reactivation outside the hospital
  - At home
  - Institutionalised

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Context of chronic diseases

- Risk Factors: Obesity, Sedentary lifestyle, Smoking

- Major social, economic, cultural changes
  - Globalisation:
    - New technologies
    - Nutrition transition
  - Urbanisation
    - Exposition to new products and unhealthy goods
    - Employment with less physical activity
  - Ageing of the population
    - Impact rises with longer exposition over life time

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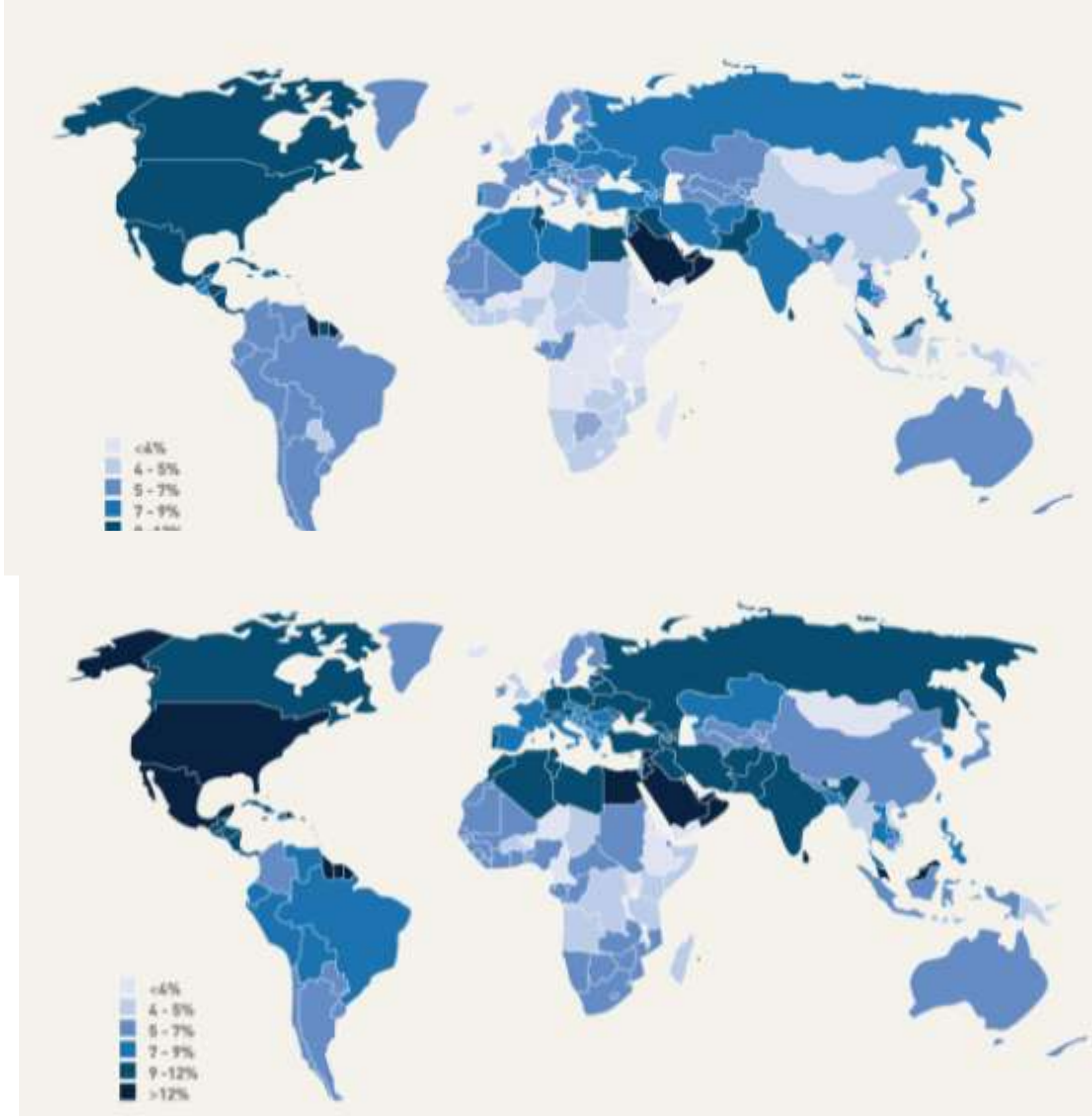
Prevalence (%) estimates of diabetes mellitus (20-79 years), 2010 (above) and 2030 (below)



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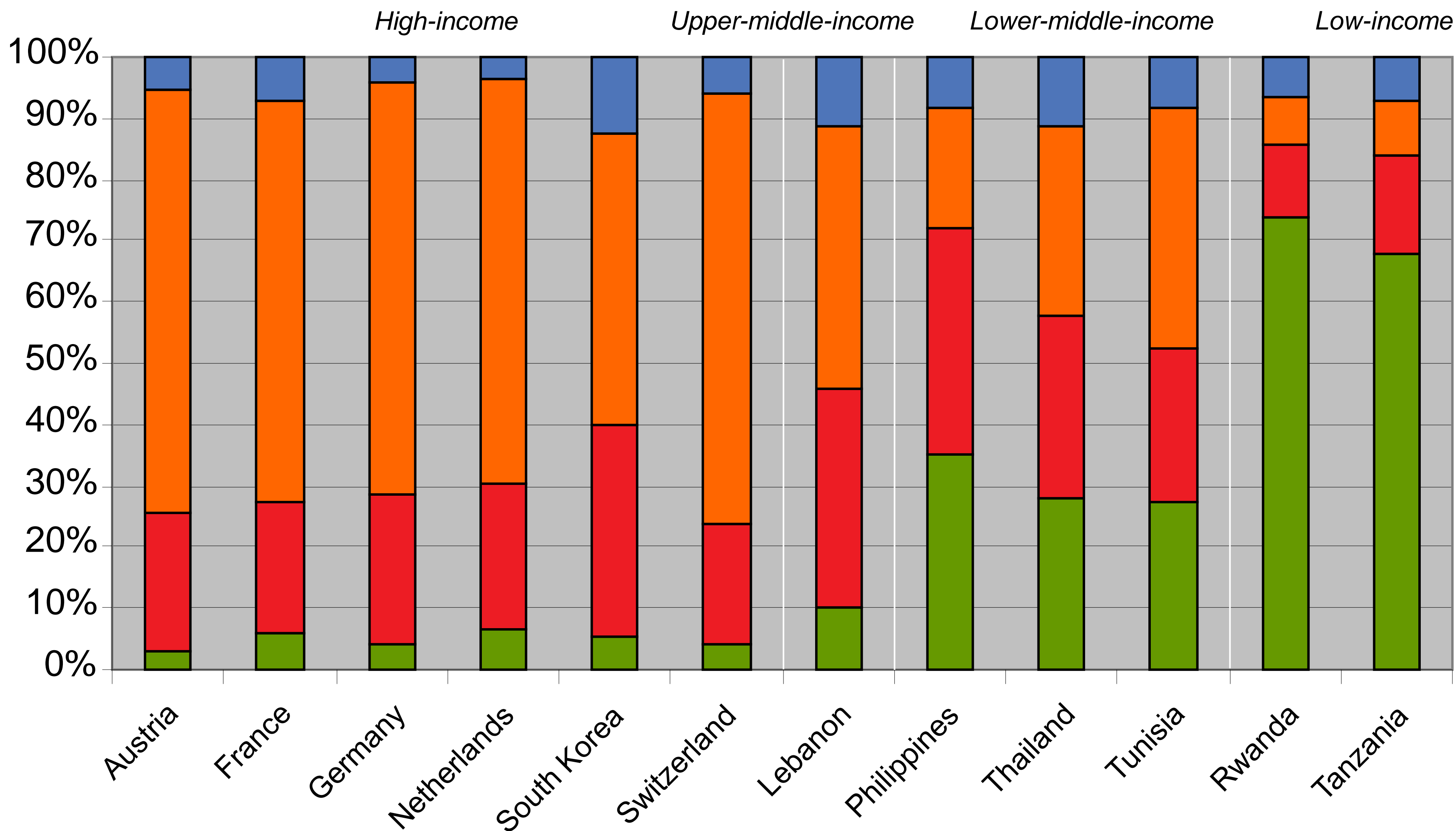
Source: Diabetes Atlas 2009 International Diabetes Federation (IDF)

Percentage of deaths from noncommunicable diseases



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Are we ready to face these challenges?

- **Financial burden** >
  - Increasing costs, more intensive and long term treatment
- **Focus on treatment not on prevention**
  - Less investment in prevention and health promotion
- **Focus on acute model of care rather than a chronic care model**
- **Insufficient quality despite high resource input, e.g.**
  - Inefficient use of facilities
  - Fragmentation between intra- and extramural care
- **Institutional barriers towards better care for chronic conditions**
  - Various policy levels involved (national and regional level)
  - Competition between health care funds

System adaptation in the Netherlands

The Netherlands: one private health insurance for all (2006)

Than: prevention was not included!

- Private insurance with strong public guarantees;
  - Insurers must accept everyone,
  - For all insured persons: the same price per police
  - For all insured persons: one legal basic package

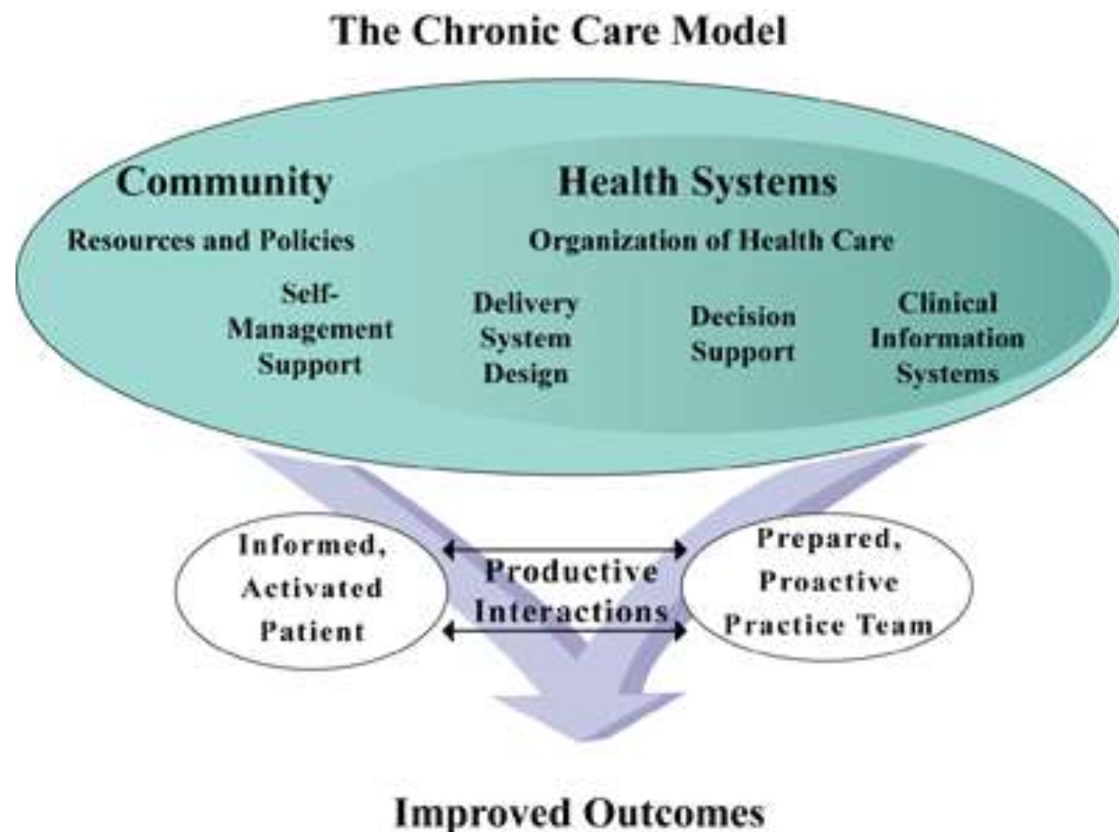
Prevention

The Netherlands:

Prevention (lifestyle interventions) for individuals with high risk for chronic disease are now part of the insured package (2007).

- Collective prevention is a responsibility of the government
- Health promotion agency's deliver campaigns, prevention programmes

The Chronic Care Model



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Programmes on chronic diseases

Core elements of chronic care model:

- Collaborative (multidisciplinairy) practice models e.g. Disease management programmes
- Shift form demand driven to pro-actively seeking needs of patiens.
- Patient self management education, commitment
- Shift from intuition to evidence in clinical practice; evidence based guidelines
- Population identification processes
- Process and outcomes measurements, evaluation and management
- Reporting and feedback loop

Areas for further development

- Guidelines and DMP's for multimorbidity
- Rewarding systems for quality of care
- Incentives and increased responsibility of patients
- Information technology to support new measures
- Improve patient skills of self management
- Targetting high risk groups
- National targets and strategies