



Integrated Care Coordination System

Link Between PHC and Secondary Care

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Introduction – Hungary I.

Population: 10 076 581 (2006.)

male 4 784 579

female 5 292 002

Birth rate: 9,9 (per 1 000) (2006.)

Death rate: 13,1 (per 1 000) (2006.)

Growth rate: -3,1 (per 1 000) (2006.)

Infant mortality rate:

6,6 (per 1000 birth)

Median age: (2006.)

male 38,2 years

female 42,4 years

Life expectancy: (2006.)

male 69,0 years

female 77,3 years



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Introduction – Hungary II.

Hospital sector

Nr. of hospitals: 164 (2006.)
Nr. of hospital beds: 80 252 (2006.)
acute 59 901
chronic 20 351
Nr. of cases: 2 800 000 (2005.)
acute 2 607 000
chronic 193 000
Nr. of bed days: 21 574 558 (2005.)
acute 15 318 300
chronic 6 256 258
Average length of stay: 7,93 (2005.)
acute 6,07
chronic 32,17

Primary Health Care

Nr. of praxis: 6 847 (2006.)
adult, mixed 5 257
pediatric 1 590
Nr. visits: 70 911 000 (2006.)
adult, mixed 59 129 000
pediatric 10 670 000
night call 2 111 000
Nr. GPs: 6 768 (2006.)
Average population per praxis:
1 487 (2006.)

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Introduction – Hungary III.

Financing

- *social insurance with near comprehensive and universal coverage, public funded and provided health care*
- *purchaser-provider split (3rd party payment)*

Service delivery

PHC: *predominantly private (GP) owned delivery system*

SHC: *predominantly local-government owned delivery system*

[Consequences]

PHC - SHC: *independent, isolated, subsequently poorly coordinated care provision*

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Introduction – Hungary IV.

Budget (2006., EUR)

Total: 4 500 M€ *PHC: 280 M€* *SHC: 2 010 M€*

Financing methods

PHC: fix and capitation fee. (30-70%)

SHC - out-patient services: fee for service

SHC - acute inpatient services: DRG

SHC - chronic inpatient services: per diem

[Consequences]

PHC: increasing number of referrals to SHC

SHC: increasing number of visits, hospitalization

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Main goals of Health Care System

- **efficiency**
- **effectiveness** (*quality of services*)
- **equity** (*access to services*)
- **sustainability**

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Significant problems

1. inefficiency

Moral hazard (abuse)

Supplier Induced Demand

Poor coordination



unnecessary service delivery

2. effectiveness (*quality of services*)

Lack of selection of „old fashioned” services

Decentralized rights for service delivery

3. equity (*access to services*)

Inhomogeneous infrastructure

4. sustainability

Increasing demand for, but lack of financial resources.

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Options for the reform

- 1. Strengthening the purchasing function of the *National Health Insurance Fund Administration***
- 2. Introduction of the competitive insurance model**
- 3. Optimizing the *Integrated Care Coordination Pilot***

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Main goals of ICCP

- **increase efficiency** (*cost control*)
- **sustain or increase effectiveness** (*quality of services*)
- **sustain or increase equity** (*access to services*)
- **[Provide and guarantee additional resources for continuous development]**

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Integrated Care Coordination Pilot

Characterization

1. Care Coordination Organization (CCO) – health service provider only.
2. Contract with GP praxis - on volunteer basis. (Define population of CCO)
3. Optimizing the *Integrated Care Coordination Pilot*
4. Global budget based on adjusted (age, gender) capitation fee
5. New incentives – assets from savings for all actors
6. Strong IT background – access to medical records

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Consequences of new incentives

1. Focus on prevention

CCO is interested in keeping their population in health – good financial result positively correlates with the health status. (given income by capitation fee against decreasing costs)

2. All actors (PHC, SHC) interested in fast and effective recovery – meets the patients demand.

3. All actors interested to treat patients at lower level of care. (PHC, out patient dept.)

4. All actors become **cost-sensitive**.

5. Strong efforts to make all processes clear and transparent

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Tools of ICCP

- **prevention** (primary - education, secondary – screening programs, tertiary – disease management)
- **adjustment of interest** (financial incentives regarding of main goals, no punishment)
- **introduction of EBM protocols**
- **case management**, patient route analysis
- **performance monitoring** (providers, protocol compliance, effect of prevention programs, etc.)
- **permanent education** (independent, focusing on GPs)
- **COMMUNICATION**

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Sources of savings in ICCP

1. **Optimizing patient routes** – elimination of parallel and repeated procedures.
2. Optimizing and harmonizing diagnostic and therapeutic procedures – **common EBM protocols**
3. Decreasing number (cost) of services due to effective prevention

Best savings on hospital and drug cost.

Saving must be re-allocated to health care to improve quality of services.

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Link between PHC and SHC

Developing common EBM protocols

Consequences

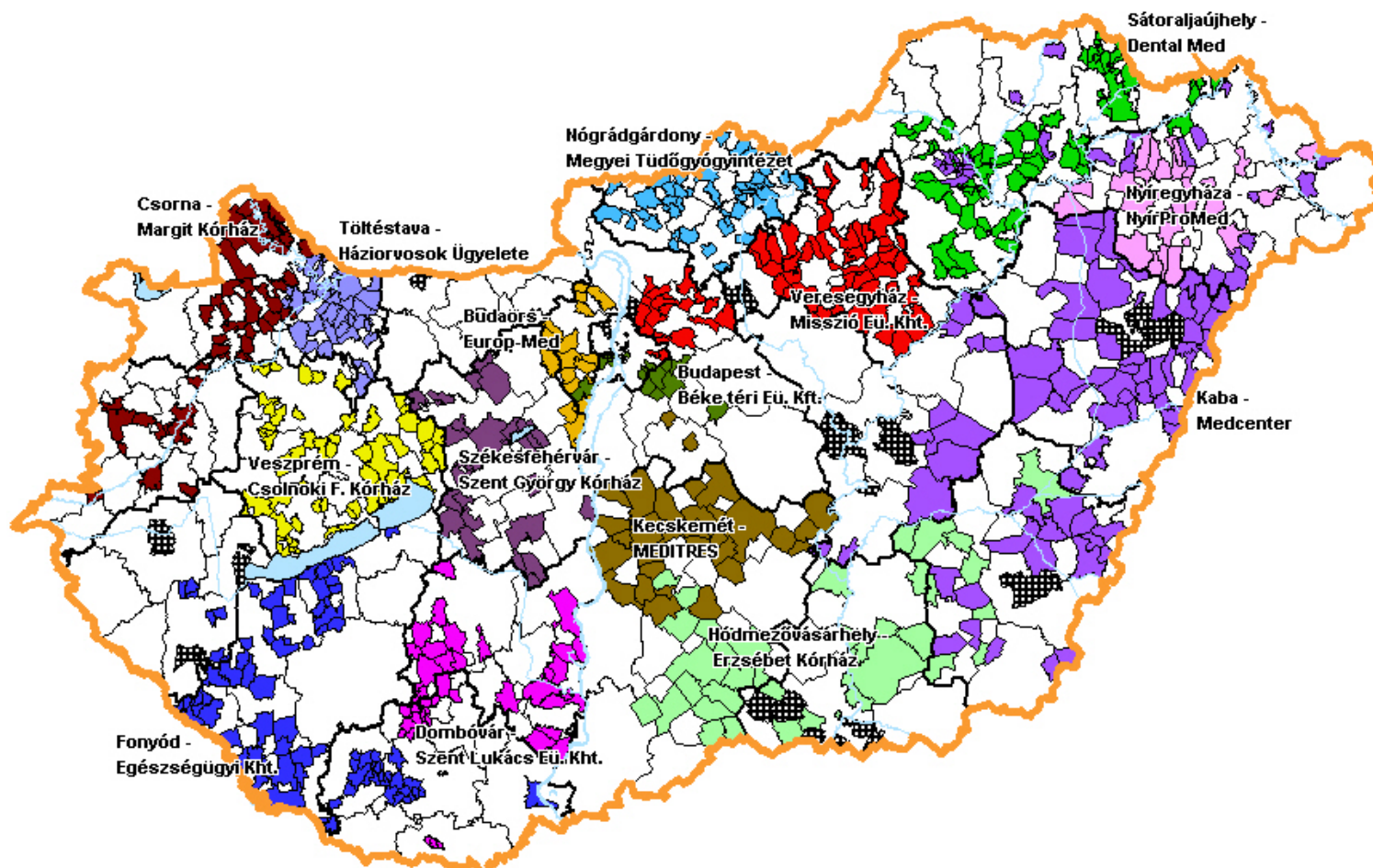
1. Definition the level of competences
2. Standardized referral criteria (medical/geographic)
3. Definition of quality measurement of services
4. Regular common education programs
5. Good personal relations between PHC and SHC professionals
6. Dissemination of best practice.

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ICCP map



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Csolnoky Ferenc County Hospital Veszprém

- **622 acute beds** [2 817 cases, 15 217 bed days (65%), average length of stay 5,4 days – March 2007]
- **74 chronic beds** [6 254 bed days (76,1%) – March 2007]
- **108 out patient services** [3 392 consulting hours/week, 41 329 visits in March 2007]



- **1 500 employee**
- **income 32 million €/year (2006.)**
- **Balance: -960 000 € (2006.)**

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Incentive system

Ratio from annual savings

GPs.....	30%
Out-patient clinics.....	15%
In-patient clinics.....	30%
CCO.....	25%

(CCO provides administration, IT infrastructure, monitoring systems, etc.)

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Results of ICCP 2003-2005.

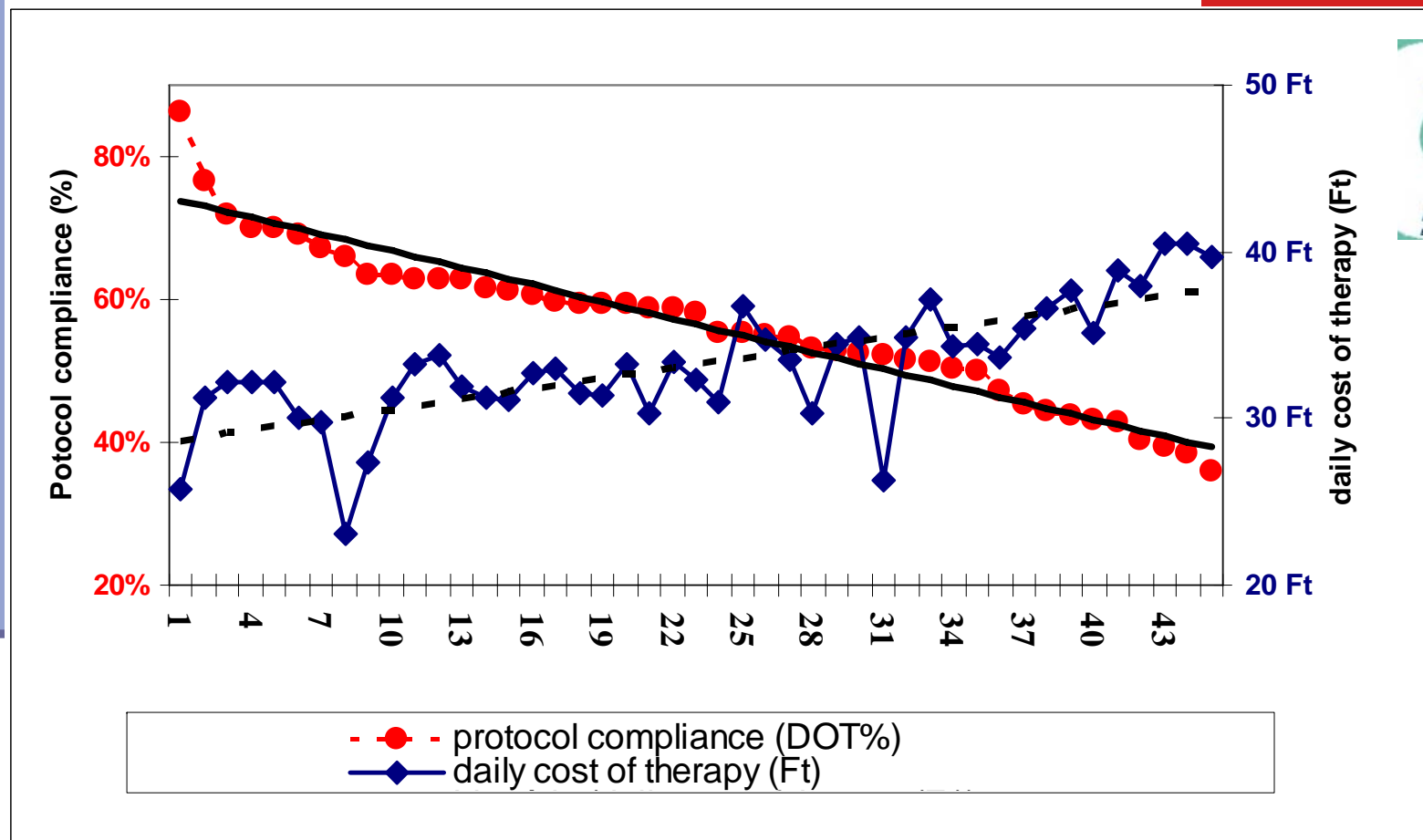
Indicator	2003.*	2004.	2005.**
<i>Nr. of GP praxis</i>	81	77	89
<i>Population involved</i>	126 665	123 218	143 026
<i>Total income - capitation fee (€)</i>	9 342 911	42 646 338	?
<i>Total expend. €</i>	9 066 706	40 609 311	?
<i>Balance (€)</i>	276 204	2 037 027	1 113 147
<i>Share of MCM €</i>	220 963	1 629 622	392 420
<i>Balance ratio (%)</i>	2,96%	4,78%	?

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Protocol compliance of GPs and cost of therapy



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Weakness and Threats of ICCP

Weaknesses

- Incentives to undertreat
- Incentives to „*cream skimming*”, „*risk selection*”

All weaknesses can be monitored, recognized and eliminated – question of will.

Threats

- Undermining actions of drug companies, hospital associations.
- Resistance of specialists – fear of losing freedom in medical decision.
- Resistance of actors making profit from obscured situations.

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Summary

ICCP in Hungary proved that cooperation between primary health care and secondary care professionals is fruitful in both medical and financial way.

Coherent, integrated incentive system is recommended.

GPs real „gate-keeping” function is essential for providing effective and efficient health care.

GP competence increasing – independent life long education required.

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Thank you for your kind attention!

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