

AIM
Association Internationale de la
Mutualité



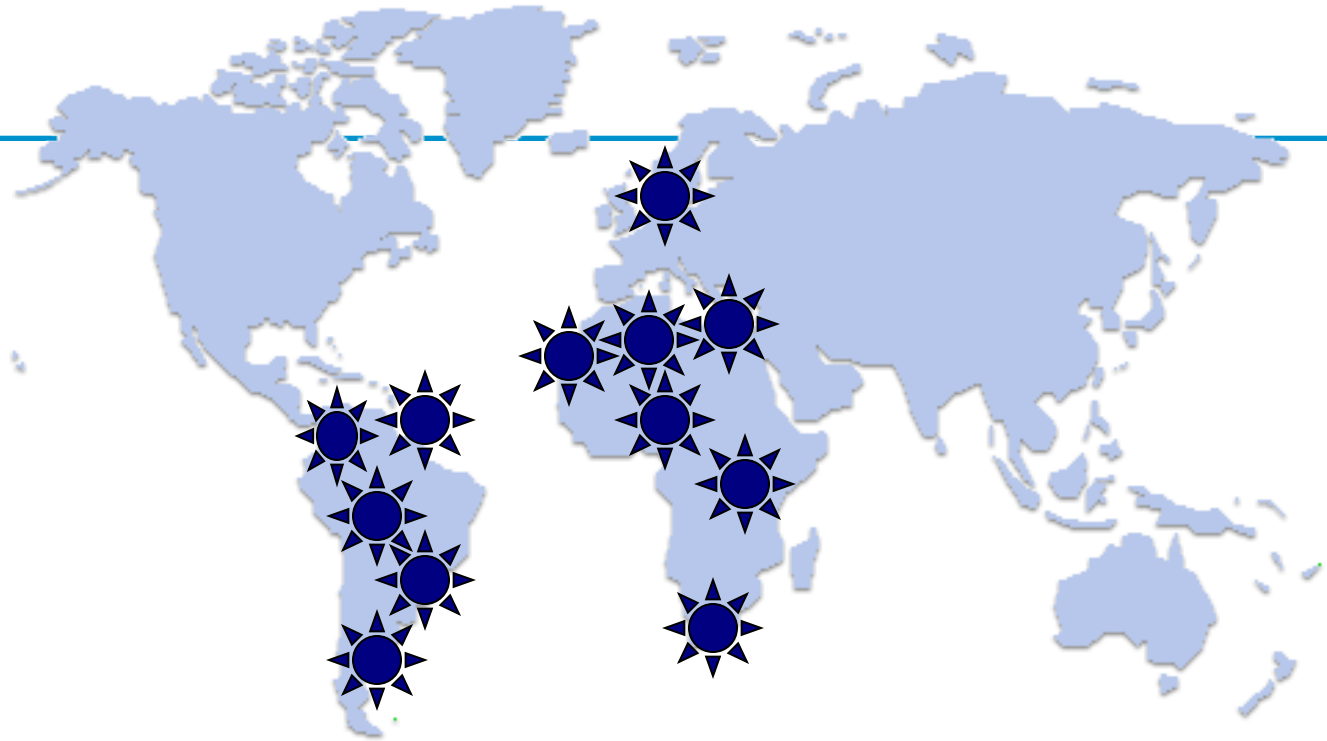
Innovation is a duty
The Health Insurance perspective

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Introduction

- ⑩ Context
- ⑩ What to do?
- ⑩ Prevention model
- ⑩ Chronic Care model
- ⑩ MLOZ launches

Introduction : AIM : international association



***An international association
for universal principles***

AIM

Membership

47 national federations
32 countries worldwide
Europe, Middle-East,
Africa, Latin-America

Values and principles

Health and well-being
Autonomous management
Not-for-profit orientation
Solidarity

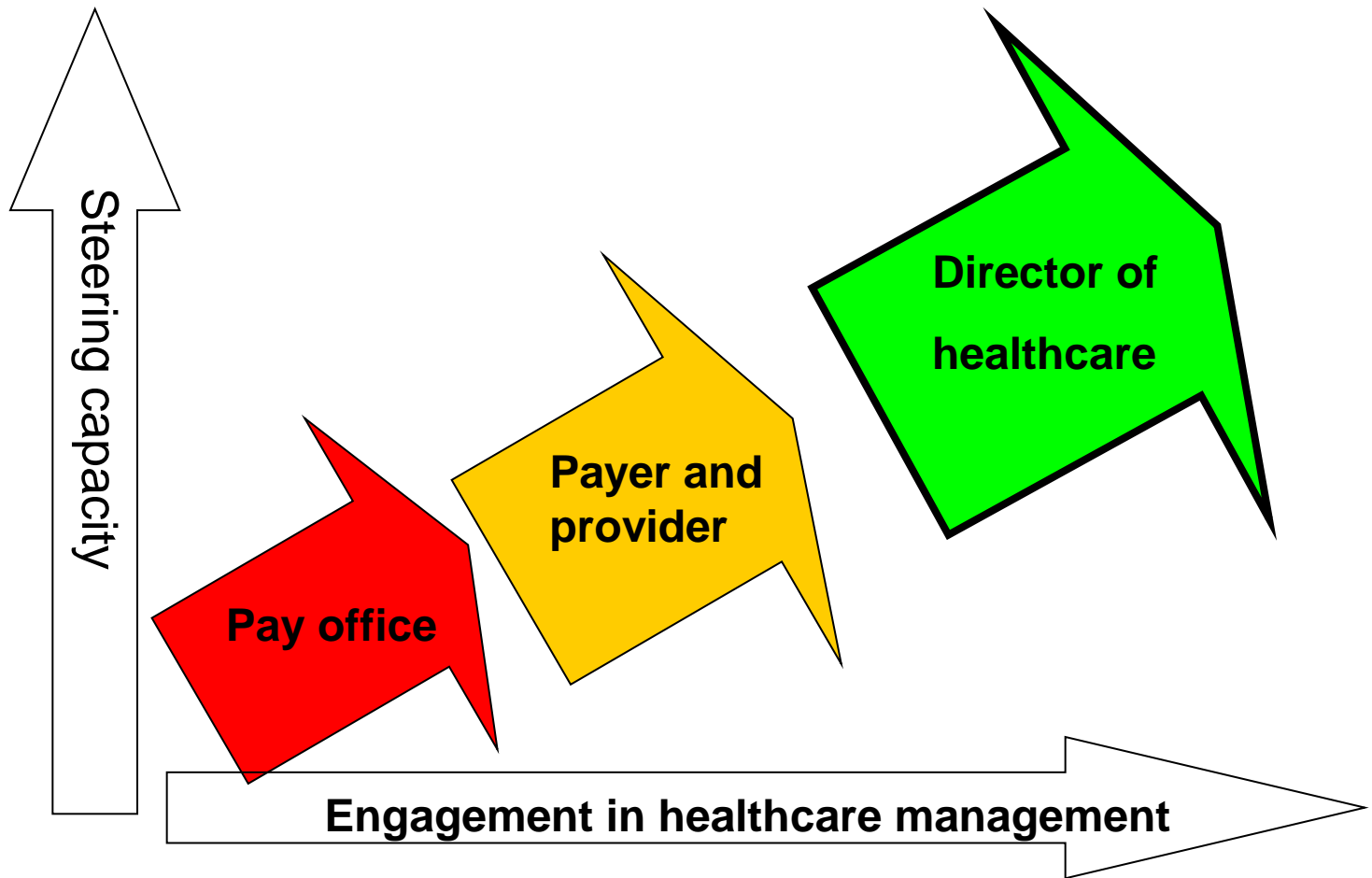
Activities

Healthcare financing
Healthcare provision
Social services, pensions
For 240 mln citizens

Objectives

Interest representation
Knowledge exchange
Lobbying
Promotion

The New Role of Healthcare Mutuals



Reimbursement principles

Criteria of choice:

- ⑩ the quality of care
 - safety/risk management (risk of malpractice)
 - collaborative health care processes
 - improved time/healthcare
- ⑩ the access to care
- ⑩ the economic efficiency of care.

1. Context 2011 : challenges

- Chronic conditions leading cause of mortality not well « managed » : new care model
- Long Term care due to ageing: budget and workforce
- Labor shortage : need for efficiency
- Budget restrictions – need for efficiency
- Quality and safety : need validation system
- Lack of management and coordination
- IT is a catastrophe
- Expectations: Integrated customised care

Analytic framework : Health care system

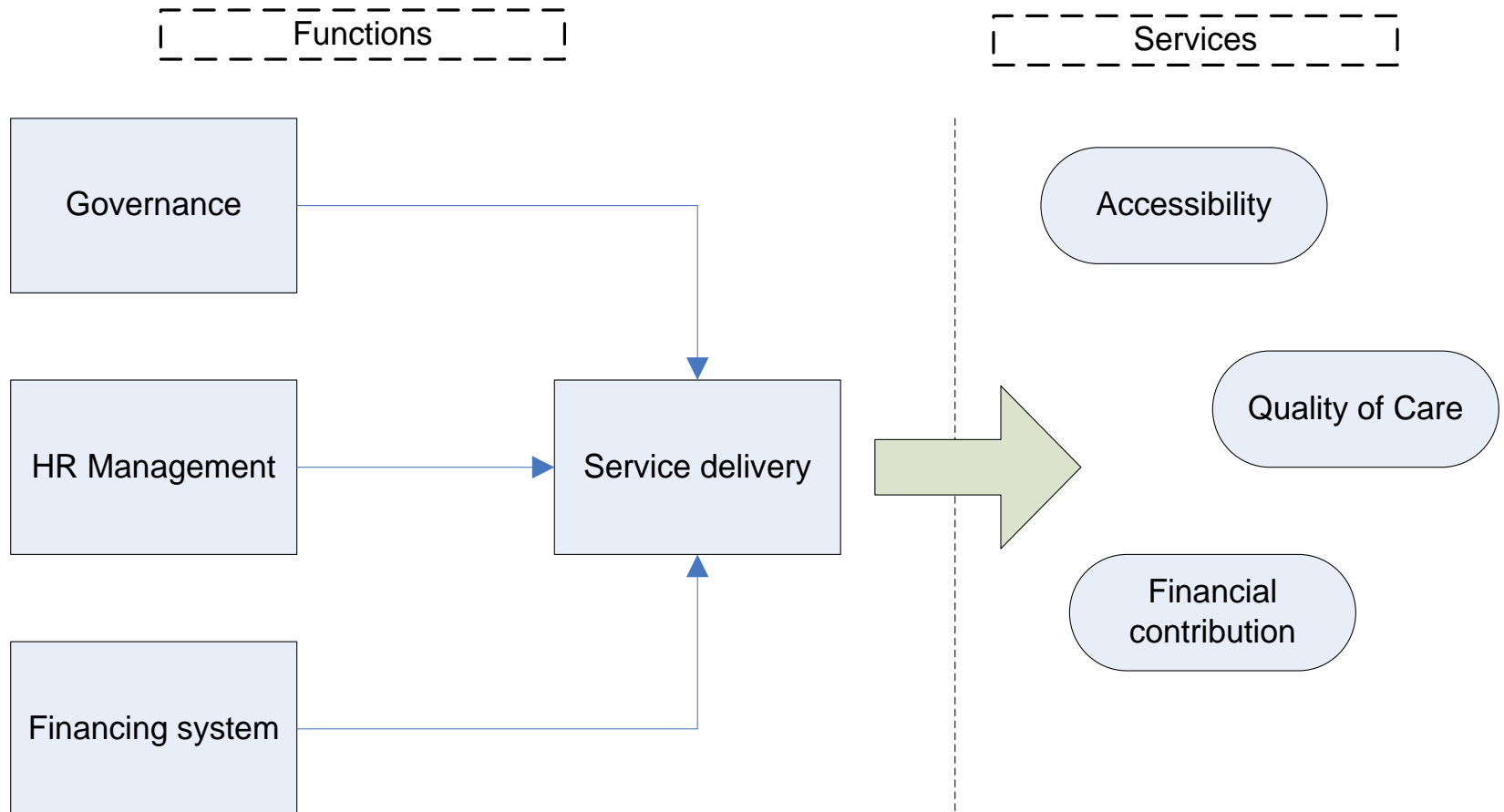
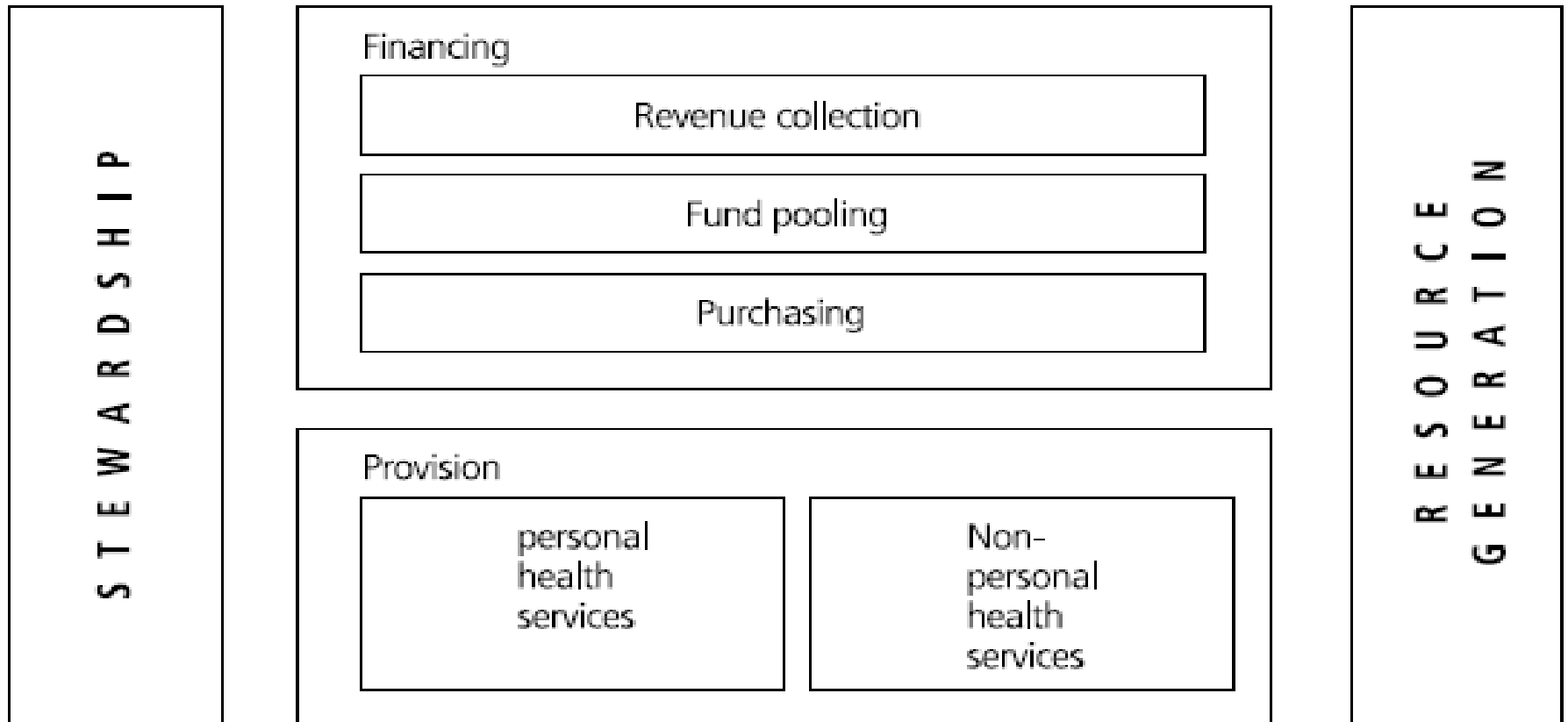
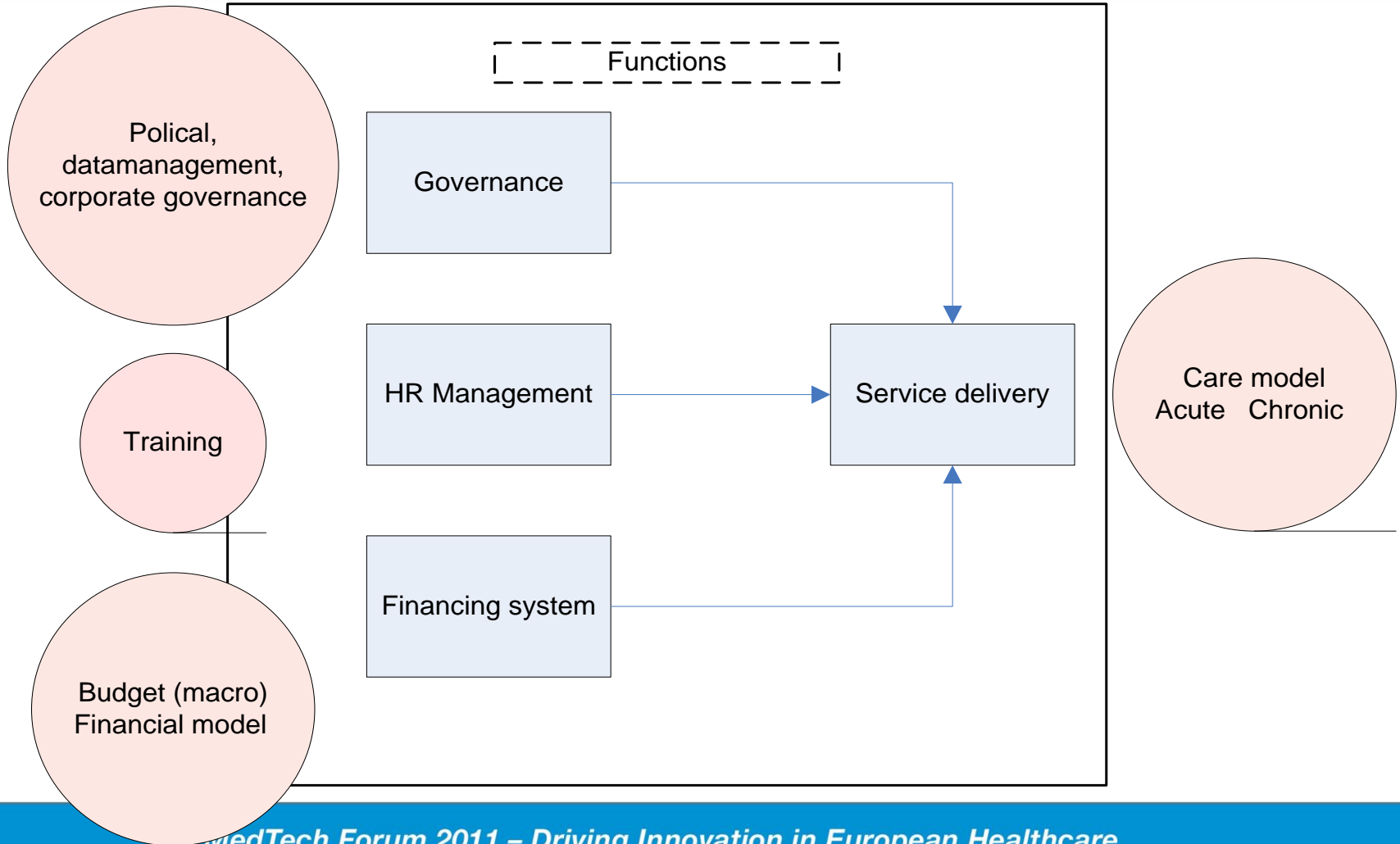


Fig. 4. Functions of health systems



Stewardship concerns financing, provision and resource generation.
Resource generation concerns financing, provision and stewardship.

Problem allocation in system



Vision AIM - MLOZ

Integrated Customised Care

Paradigm shift: new medical model and financial model

Role and functions of stakeholders in change

Partnerships

Risk Management, Disease Management, Case Management

2. What to do : Governance ?

- Create political integration of prevention, cure, care,
- Create cultural willingness to change
- Set up data management system
- Evolve towards Corporate governance
- Innovative public health initiative for elderly people
- Validation (at EU level) of programs for Risk management, Disease management, case management

What to do : Service delivery

- **Standards of care**
- **New model for prevention**
- **New model for chronic care**

What to do ?

Human Resources

- Changing function discussion national and EU
- Training

Financial model

- Macro: new budget allocation for chronic diseases (risk management, DM, Case management)
- Microlevel : new rewarding system for health care provider, for patient and for insurance
- Incentives for innovation

3. New care model prevention

Patient side:

- **Awareness : information – advantages? C/B?**
- **Knowledge : information (content – format)**
- **Access: financial, physical,**
- **Incentives : obligatory, financial, ban, other**
- **Tools of empowerment : self diagnosis, selfcare, selfmanagement, PHR**

New prevention model

At the HC system side : Governance

- **Competencies : consistency**
- **Datamining: Predictive medicine – stratification**
- **“Risk Management” instead of “Risk Insurance”**
- **Outcome measurement**
- **Accountability of partners (HIF)**
- **EU level : validation board**

New prevention model

- **Service delivery model :**
 - **“Public health” initiative for elderly people. Conducted by GP (vaccinations, screening, fall preventie, integrated care, personal and environmental tools**
 - **New model chronic care : enrolment, medical support, information, education, coaching, self monitoring, telemonitoring**

New prevention model

- **Professionals : training and agreement**
 - New role nurses, GP, specialist, hospitals, pharmacists
 - New training modules (information, education, coaching, monitoring, screening)

- **Financing system**
 - New financing model public health initiative and chronic care
 - HTA in prevention: CE ratios

4. New chronic care model : management

Risk management, disease management, case management with as Services :

- Detection, stratification, enrolment,**
- Medical management plan and follow-up**
- Patient empowerment**
- IT support**
- Assessment : medical, economic, patient satisfaction**

Introducing Care Management : RM, DM and CM?

Care management is a system of coordinated and standardised health care interventions and communications for populations with conditions in which patient self-care efforts are significant.

Care management:

- Supports the physician or practitioner/patient relationship and plan of care;
- Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and
- Evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health.

What is RM, DM and CM? (DM in common)

= A management system for the whole period of a chronic condition (from risk factor to complicated multimorbidity).

The system is activated by executing specific programs (diabetes, COPD, hart failure, depression, schizofrenia...) offering services to patients and health care providers.

These services are standardised and coordinated and focus on improving the quality of life of the patient and on cost reduction by preventing hospitalisations and complications.

5. MLOZ launches

Coaching program for chronic diseases

- **Motivational interviewing**
- **Telecoach (telephone)**
- **Targets : biomedical, lifestyle, compliance**

Personal health record including prevention, chronic care, administration

Hurdles and success factors

Hurdles

- Political integration
- Endorsing the concept by “decision fora”
- Financial environment – incentives for all
- Implementation roadmap for concrete services

Success factors

- Driver
- Critical mass
- Support by National Social Security
- International support