



# HEALTH FIRST EUROPE **MODEL FOR COMMUNITY CARE**

*"Delivering positive health outcomes for citizens"*

**“Health equals Wealth” was a phrase coined on 3 October 2003 by former EU Health Commissioner and Health First Europe Patron, David Byrne. Health systems are under tremendous pressure, based on a confluence of factors such as the increased prevalence of chronic disease, changing population demographics, restrained healthcare budgets and institutionalised systems out of date with modern day requirements. These challenges affect the health and well-being of every EU citizen and will lead to the development of new European thinking to meet and overcome these challenges. This will require imaginative thinking and decisive change.**

Community care is about integrating patient care across the continuum of life. It is the missing gap between acute, treatment-driven demand, and normal, healthy living. In some cases, community care will redefine the relationship between different providers of treatment, and in other cases introduce new stakeholders, but essentially it will provide another channel of “healthcare” based on a more patient centric and patient empowered model using innovation to attain long-term benefits that can contribute significantly to improving the well-being of each of us.

The Health First Europe Model for Community Care is a road map of the substantive changes required to release the value and power of the new care model. This road map focuses on six areas of needed reform:

- 1. Community Care Policy:**  
Establishment of a dedicated community care policy and political leadership to implement the policy
- 2. Patient – Centric Care:**  
A system designed in response to citizen health needs
- 3. Innovation and Value:**  
Incentivising innovative solutions involving key actors (citizens, carers, technology) across the health system of value to improve health outcomes for the well-being of citizens and society
- 4. Access and Reimbursement:**  
Flexible funding to increase access to innovative community care solutions including community care products, treatments and services
- 5. Care and Treatment:**  
Creating a mobile and flexible health and social care workforce bound to the citizen, not the system
- 6. Quality Care and Standards:**  
Generating quality of care assurance in the community

Our model is meant not simply to generate debate, but move toward decision in health systems. Decisions will need to be made at the local level which will affect resourcing, work patterns, use of medical technology, delivery of care and patient involvement. Transparency, accountability and partnerships will be tested at all levels of implementation from national to local policymakers (hospitals, primary doctors, carers, nurses, community specialists, social workers, and suppliers).

It should be noted that a model defines a certain structure at a point in time. Pioneers in community care will already recognise the following model in various forms and undoubtedly some jurisdictions will already be developing policy, implementing change, and delivering community care along the spectrum of this model. This model does not presume to be theoretical nor does it assume that certain aspects of the model are not implemented in any Member State or at regional or local levels. The extent to which a jurisdiction has fulfilled the model's demands remains fluid and varied over Europe. Whether the jurisdiction is tax-payer funded model or a self-governing model through sickness funds/insurance many localities, and even countries, have policies which have achieved much of what this model advocates. Annex III to this report will serve as a benchmark on the roll out in EU Member States of the Community Care model.

## Background:

Health First Europe recognises the deep restructuring that will need to occur to EU health systems to ensure sustainability in light of future challenges. It is clear that ageing demographics and the rise of chronic diseases, increased demand and availability of treatment and personalised lifelong care will create such an economic stress on health systems, that the current structure is no longer sustainable in the long term. The current system must be adapted to effectively address the current healthcare needs (predominantly chronic diseases) and this will require an approach that must be built on recognition of the value of the new system, not the cost of the current one.

## Examining the statistics, it is clear that health providers are facing significant challenges and daunting trends:

1. Between 2000 and 2050, the proportion of **the world's population over 60 years will double from about 11% to 22%**. The number of people aged 60 years and over is expected to increase from 605 million to 2 billion over the same period.<sup>i</sup>
2. The **number of people aged 80 and older will quadruple in the period 2000 to 2050.**<sup>ii</sup>
3. The average **life expectancy in the EU shall rise from age 77 (2008) to 85 (2060) for males and from 82 (2008) to 89 (2060) for females.**<sup>iii</sup>
4. The **percentage of growth in the elderly population [+65] in the EU will be 79% by 2060** compared to -15% for working age population [15-64].

5. The **number of older people who are no longer able to look after themselves** in developing countries is **forecast to quadruple by 2050**. Many of the very old will lose their ability to live independently because of limited mobility, frailty or other physical or mental health problems. **Many require long-term care, including home-based nursing, community, residential and hospital-based care.**<sup>iv</sup>
6. **Chronic diseases** kill more than 36 million people globally every year and the WHO estimates chronic diseases will be responsible **for 52 million deaths by 2030 in Europe alone.**<sup>vi</sup> At present in Europe, 80% of patients over the age of 65 already have at least one chronic condition.<sup>vii</sup> **Expenditure rises in correlation with age.** Persons aged 60-64 consume 9.1% of GDP per capita while those aged 90-94 consume 21.9% of GDP per capita.<sup>viii</sup>
7. **70-80% of healthcare costs are spent on chronic diseases**, corresponding to **€700 billion** in the European Union and this number is expected to increase in the coming years.<sup>ix</sup>
8. It is estimated this demographic time bomb will **raise the percentage of GDP spent on healthcare from a 2007 EU average of 5.7% to 8.5% in 2060.**<sup>x</sup>
9. The greatest impact will be felt between 2015 -2040 when the post-war baby boomer generation is aged 60-70. **One half to two thirds of all increased health care between 2007 and 2060 will take place during this time.**<sup>xi</sup>
10. Faced with debt and spending limitations, **Member States will find that they have to make increasingly agonising choices in terms of spending priorities.**

In the absence of a significant, value-enhancing paradigm shift, the result will be a gradual, and then dramatic, drop in healthcare servicing and access through rationing. Eventually, requirements may be needed which will impact universal access and equity in access by measures such as payments for certain services, insufficient availability of capital intensive facilities, and reductions in labour. The longer the EU and Member States wait to slowly evolve institutionalised health care systems, the harder the choices will be when confronted by faster moving demographics and resource limitations. There is therefore a fundamental urgency to tackle the system with revolutionary policy choices – foregoing typical notions of incrementalism. The most significant cost period for health systems will start in less than two years and the rise of chronic diseases will accelerate expenditure to unsustainable levels in the absence of reform.

These issues create an opportunity for Europe to get ahead of its comparators globally by innovating and embracing the future of different types of healthcare provision. Just as the shift to universally provided healthcare did for access to treatment, Europe has all the elements to overcome these challenges – a strong, career oriented work force, an innovative industry, and some genuine forward thinking from academia and policy makers. This is being manifested in experiments and trials at the local level which test the boundaries and limits of today's current care. It is from these worthy efforts that Europe will be able to overcome these challenges, with community care being one of the key approaches to providing the healthcare European citizens' demand.

## What is Community Care

**Community care can take on many forms such as tele-care, care in the home, telemedicine and personal care, amongst other broad identifiers. It also has an element of location and can cut across broader sectors such as social care.**

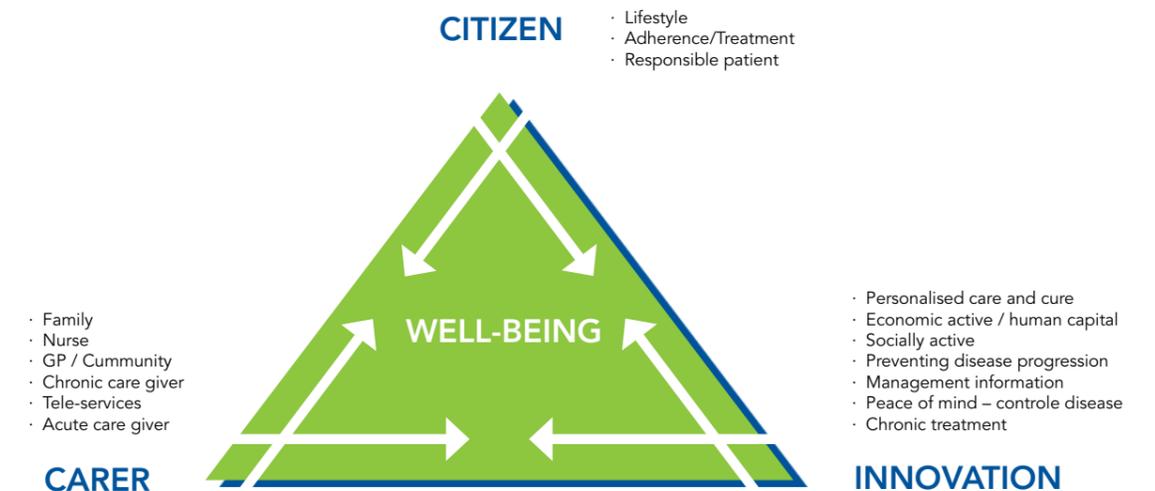
Therefore, it is very difficult to define community care without the risk of discounting certain aspects of the model. For this model, we simply focus on community care as healthcare outside of the hospital. HFE considers community care a geographic definition, not one based on types or length of treatment, or payments. This is not to say that the places of treatment are mutually exclusive, but that integrated care requirements will necessitate a prescribed balance between modes of care. This definition already includes well-established entities such as doctor's offices and out-patient services, but to limit such care to home only for instance would risk undermining the model's reliance on these structures for future delivery. It should also be noted that this definition does not exclude social care but that this is limited to the way both areas - health and social - function and share resources on an operational basis. Social care is a much larger topic and thus is not directly addressed in this model.

Community care, at its essence, relies on delivering care at a local level using advanced technologies/innovations and new forms of health service configuration to facilitate a better, more balanced provision of care within the broader care landscape. It will involve different work patterns, processes and applications required to deliver today's current care. It will also require deep cultural shifts including political will, training and education to bring public opinion along with the changes.

At the heart of this framework is a virtual triangle of citizens – carers – innovation each playing their part to deliver well-being to the citizen and society. Innovation defined here is not limited to a product or service innovation, but also includes in some circumstances, restructuring the process and the validation of innovation of the entire segment chain of community care. This innovation nucleus is an enabler to community care, efficiently allocating care to the most effective treatment point. This enhances the value of innovation beyond the immediate application leading to an improved overall well-being.

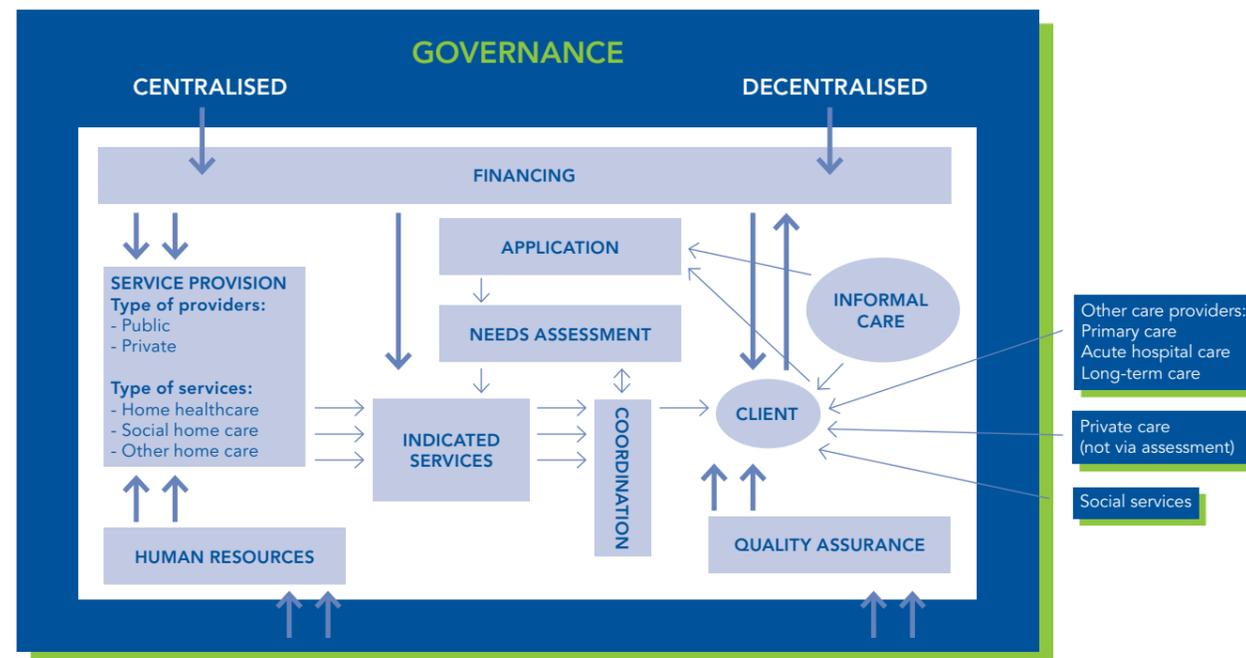
## NEW MODEL FOR COMMUNITY CARE

### KEY ACTORS WORKING TOGETHER TO ACHIEVE WELL-BEING



Today's care consists of a large range of stakeholders to provide patient treatment. Each stakeholder, over time and within the regulations and processes set by governments, regulators and providers, has assumed a certain role in the supply chain of health provision.

The following diagram indicates a generalised framework for healthcare delivery in the EU:



\*Taken from the European Observatory on Health Systems and Policies, Home Care across Europe: Current structure and future challenges. 2012

## Why Community Care?

Community care is not simply a counter to the forces of cost containment and rising patient population, it is an increasingly used form of care delivery which overcomes some of the challenges posed by current systems and can work in tandem with such systems to maximise patient outcomes. It brings together several forces which, cumulatively, create a value – driven, sustainable and patient friendly service. The key principles of community care are:

1. **Patient preference:**  
Studies have proven that patients would prefer to be treated locally and often at home. This has led many Member States to now review and implement "ageing in place" programmes to stimulate and enshrine community care.
2. **Cost effectiveness:**  
It is difficult to ascertain the economic value of community care given the variables involved. However, several studies have proven that specific forms of community care are more cost – effective especially when including the savings from hospital stays and the value-enhancement of improved productivity and recovery time for patients.
3. **Clear pathway of 'lifelong' care:**  
With rising levels of chronic disease, care at hospital-based settings addresses episodic acute problems with patients but does not necessarily lead to a more integrated continuum of care (including prevention and surveillance). Community care and hospitals are crucial in working together on overall patient well-being, especially in the areas of chronic diseases. Community care, in one way, creates pressure on hospitals to adjust the focus of care from acute, product driven responses to overall patient therapy and care, thus bringing community care and hospitals closer as partners in the provision of care.
4. **Access to community care:**  
The Special Barometer study of 2007 showed that citizens believe that the state should provide homecare services (care outside of the hospital) and pay for required care, at least to some extent. This is particularly true in cases where elderly individuals do not have family to help take care of them.

## The time is now

The changing demographics of Europe and the rise in demand for care due to chronic diseases necessitate a revolutionary change to the structure of healthcare to ensure not only the sustainability of systems and access to care for European citizens, but the overall well-being of European citizens. The Health First Europe Model for Community Care outlines the six areas which must be addressed by health authorities in order to encourage and shape national, regional and local community care systems and to share the burden so often left to hospitals to fulfill. These areas include:

1. **Community Care Policy:**  
Establishment of a dedicated community care policy and political leadership to implement the policy
2. **Patient - Centric Care:**  
A system designed in response to citizen health needs
3. **Innovation and Value:**  
Incentivising innovative solutions involving key actors (citizens, carers, technology) across the health system of value to improve health outcomes for the well-being of citizens and society
4. **Access and Reimbursement:**  
Flexible funding to increase access to innovative community care solutions including community care products, treatments and services
5. **Care and Treatment:**  
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## Reform methods

There are two broad methods of introducing this concept – an evolutionary approach which assumes that the institutional drag on legacy systems is too great. In this regard, the key drivers of change are wider reimbursement to drive market uptake, stricter admission requirements for patients and a reasonable acceptance of patient responsibility and empowerment for improving overall health outcomes.

The other view is more revolutionary, which considers a shift of priorities to one that recognises community care as a validated method of treatment on par with other forms of treatment. This segment of change radically overhauls the system from one in which the state minimises its provisions to meet demand, to a system where community care becomes a normal point of treatment based on proper analysis of the patient's condition and clinical prescription. Such changes would dramatically move the centre of decision-making away from the supply side, to the patient themselves.

# THE HEALTH FIRST EUROPE MODEL FOR COMMUNITY CARE

# 1. Community Care Policy

The primary role of the state, recognising the advantages of community care, is to identify, support and push the establishment of a unique community care policy. The policy should have broad political support coupled with detailed policy recommendations, guidance and obligations which positions community care right at the heart of the health treatment system.

This fundamental leadership is essential to any chance for community care to establish its own identity and become part of the lexicon of health treatment. To this extent the model suggests:

- A unique community care policy should be developed, publicised and require a road map for accountability, evaluation and recalibration purposes.
- The community care policy must be cohesive, coordinated with other care sectors and be aimed at effective integration of patients as the cross-over the system.
- The policy must have quantifiable measurements (KPIs) for regular evaluation.
- The policy must have clearly defined goals for accountability.
- The changes require a willingness to accept that initial monetary investment is necessary to achieve long term value by unlocking the tangible benefits of changes in work structures, patient return to productivity, avoidance of progression to more costly disease states and access to quality care.
- The policy must be benchmarked against best practice and other regions or Member States.

Policy choices will take place at all levels of government: EU – National – Regional – Local – Authority. It is increasingly important for the EU level to be part of the persuasive voice on the advantages and frameworks for community care. This increasingly means a call for EU involvement in the areas of:

- Exchange of information so that willing implementers of change can learn from the experiences of others.
- Accelerating the standardisation of sub-components of community care services such as ICT in devices, communication protocols, and medical records. A status report on interoperability progress should be released once a year.
- Framing the design of community care such as quality care guidelines.
- Holding Member States accountable to community care intentions.
- Producing studies and reports, on a regular basis, similar to documents like the European Observatory on Health Systems and Policies study on Homecare.

Member States will remain the force behind serious recalibration of the health system and whose implementation of this model should be held to account. Regional, local and authorities involved are the real laboratories of experimentation with implementing the model. It is here that the constant assessment/reassessment loop takes place to generate real-time information on how the model is tested against real life conditions for patients. Such experimentation should employ the most modern methods of test controls, interactive feedback, improvement cycles and recalibration so to accelerate the learning curve for the implementation of the model locally.

# 2. Patient Centric Care

Today's treatment processes are based on a hierarchy of treatment designed over many years via the supply side and driven by universal access and equity. This means the patient is transferred around a system which is almost factory-like in the differentiation of services. The patient has to fit into the system, not vice versa.

The patient centric system requires a paradigm shift. Rather than solely focused on acute episodes (or "sick care"), the patient centric system uses modern technology to create a patient pathway in which patients, and potential patients (i.e. healthy citizens), are cared for throughout their lives. Patient-centric care is essentially services which are applied to the patient on personalised needs, using modern medical innovation to provide the continuous glue of prediction, screening, diagnosis, prevention, intervention, monitoring, therapy, management, assistive care and service. Essential elements in this patient centric healthcare approach:

- Community care should have a patient pathway road map for all patients, clearly spelled out and indicating where the prevention, treatment and adherence are dependent on the patient.
- Patients shall be fully informed not only of the treatment, but of the alternatives and risks.
- Patient access to medical technology innovation should not be restricted so that a scaleable market develops which drives further innovation.
- A personal health plan should be developed which tracks and traces the entire chain of health for a citizen from birth to death.
- A personal health record should be accessible for each individual and serve as the continuity document between services administered over the life of the patient.
- Patients should be given full access to information in order to provide explicit consent for treatments including alternatives to certain treatments, use of technologies and care.
- Citizens should, during episodes of treatment, be allocated a primary carer who coordinates treatment and professional opinion.
- Prevention and early detection should form part of the evaluation for each potential patient.

## 3. Innovation and Value

Community care relies on innovation and incentivising innovation as the shift requires new tools, procedures and protocols to develop an efficient provision of care. As such, innovation is a key component in the virtual triangle of community care (see diagram page 7).

Innovation as defined in the HFE model is not limited to a product or service innovation but also includes, in some circumstances, restructuring the process and the validation of innovation throughout the entire segment chain of community care. This innovation nucleus is an enabler to community care, efficiently allocating care to the most effective treatment point. This enhances the value of innovation beyond the immediate application leading to an improved overall well-being.

Innovation is driven by many factors but like any under-exploited area it requires primers to accelerate its implementation. Community care is no different. There are 5 variables which impact on the value of innovation for community care:

1. The recognition of the full value of innovation in approval processes for products, services and work place innovation. Too often pure clinical valuations fail to recognise the overall value of community care for society. A prime example is productivity and social activity of the patient and time to fully recover of interventions. The advance of health technology assessments provide a good example of where the calculation of value can be validated from new variables outside a pure clinical basis. Monitoring of medical data, for survey or decision-making, can also show efficiency gains by limiting medical consumption.
2. Dedicated financing schemes for innovation.
3. Patient acceptance and choice which would drive demand for community care treatment.
4. Innovative financing paradigms which open up options for provision such as top-up and cost + schemes.
5. A long term view on community care value, evaluating the benefits over a longer period of time using recognised benchmarks.

All of these incentives are often muted in traditional hospital environments. However, community care provides the ideal change point to experiment and recalibrate the methodology of innovation by:

- Defining a model of valuing community care products and services.
- Eliminating discrimination between usage settings.
- Reconsidering financing options aimed at creating markets for innovation in community care.
- Allowing local and regional experimentation on ways to encourage innovation.

## 4. Access and Reimbursement

Resources for care tend to emanate from the acute centre outwards towards patients. The concentration of expenditure in acute settings (work force, capital equipment, buildings) moves horizontally into GP settings, but dwindles rapidly after the last stage. Typically community care innovations used are paid in full in acute and GP settings but suffer from partial or no reimbursement outside of these health settings.

There are essentially three different types of financing in the EU health system – state taxation based, social insurance based, or a mix of both. In a state based system, demands fight for resources and policy priorities indicate the point at which demand can no longer be met and rationing begins. In a social insurance system, the gatekeepers are the insurers themselves, with interference from the state on access and equity. This model does not recommend any form of financing healthcare expenditure, leaving it to providers to determine their best approach to demands on financing.

Community care suffers from a mix of reimbursement policies, depending on the criticality of care. There is essentially a waterfall of access limitations impacting wide range of technologies in community care.

Starting with:

- Full reimbursement for all products in a class.
- Reimbursement for community care products and services that would otherwise be reimbursed in hospital settings.
- Full reimbursement for certain products in a class, differentiating between base and more innovative products.
- Full reimbursement of base products with top-up payment for more innovative products not benefiting from full reimbursement.
- Co-payments against reimbursable products and services (a "top down" payment).
- Reimbursement largely focused solely on consumer products.
- Partial reimbursement for whole service around a product, or reimbursement for a product, but not for eHealth or ICT support or carer intervention.
- No reimbursement.

## 4. Access and Reimbursement

## 5. Care and Treatment

### COMMUNITY CARE – SCOPE OF TECHNOLOGIES

PREVENTIVE	DIAGNOSTICS / MONITORING		INTERVENTIONS		THERAPEUTIC		ASSISTIVE		
To prevent disease, injury or other conditions. Used by citizens and healthcare professionals.	To diagnose conditions and monitor health. Used by citizens and healthcare professionals.		Often used outside of hospital. Used by healthcare professionals.		To treat patients in the home or after hospital stay. Require support from healthcare professionals. Used by patients and carers.		To manage or restore bodily function. After initial fitting patients and carers take over the care.		
CONTRACEPTIVE DEVICES	FRACTURE PROTECTORS	DIABETES TEST	BLOOD PRESSURE MEASURING DEVICES	CATARACT SURGERY	BOIL & WART EXCISION	WOUND DRESSINGS	HOME RESPIRATORY EQUIPMENT	OSTOMY SUPPLIES	CUSTOM PROSTHETICS, WHEELCHAIRS, WALKERS
COMPRESSION HOSIERY	PNEUMATIC COMPRESSION DEVICES	THERMOMETER	PREGNANCY TEST	DENTAL TREATMENTS	CHIROPODY	FEEDING PUMPS	HOME DIALYSIS	EYEGASSES, CONTACT LENSES	INCONTINENCE CARE

\*diagram courtesy of HFE member, Eucomed

Community care resources flow from more centralised funds – either local or state taxation based funds or social/health insurance. Funds are rarely dedicated to community care except in the more established areas of community care such as palliative care.

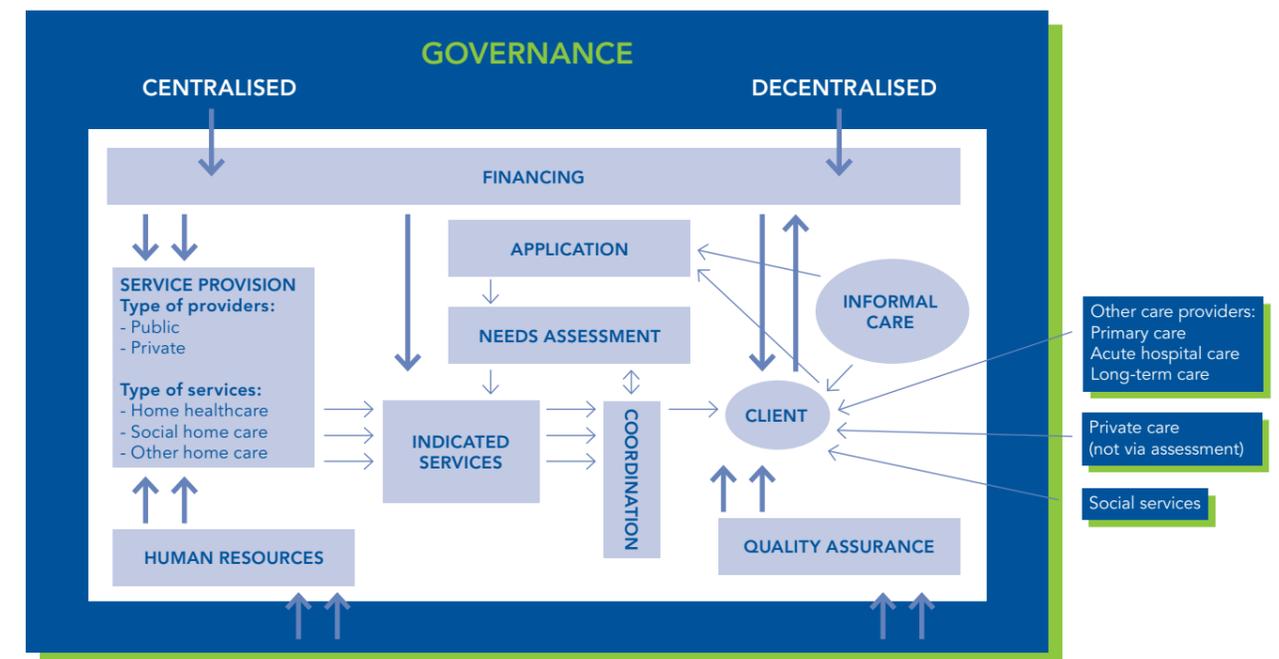
One of the main problems with the current system is that silo budgeting favours reimbursement through the hospital system but does not affect similar policies for the same product used in the community setting. A sample of medical technology used in non-hospital settings indicates this lack of a location-neutral policy.

This model ascribes a new set of funding priorities in order to facilitate change in the coordination of actors and to accelerate the shift to community care. This model advocates:

- Community care should have a claim on budgets without discrimination against other forms of health delivery.
- Social and healthcare budgets should be merged to reflect the blurring of lines between social and health community care. This applies as well to silo budgeting between segments in health and social care and within healthcare budgets.
- Any product or service which is reimbursed in acute or GP settings should automatically be reimbursed for community care settings except where technical limits or costs, arising from the basis of it being supplied in the community, make it unfeasible – there should be, in principle, no care setting discrimination.
- Patients' choice of treatment should not be prejudiced by public policy decisions on reimbursable products. To this extent patients should be able to "top-up" to increase access to new products and services.
- In exchange for patients possibly requiring a financial contribution for their care, the range of products and services that are reimbursable should be extended to those currently valued by patient and society but not reimbursed.

The shift to community care will require a cultural re-think for healthcare workers, carers and citizens. Currently community care is a mix of social worker assistance, informal carers (often family members), residential and nursing home care and healthcare worker visits.

Today's care consists of a large range of stakeholders to provide patient treatment. Each stakeholder, over time and within the regulations and processes set by governments, regulators and providers, has assumed a certain role in the supply chain of health provision. The following diagram, as aforementioned on page 7, indicates a generalised framework for current healthcare delivery in the EU:



\*Taken from the European Observatory on Health Systems and Policies, Home Care across Europe: Current structure and future challenges. 2012

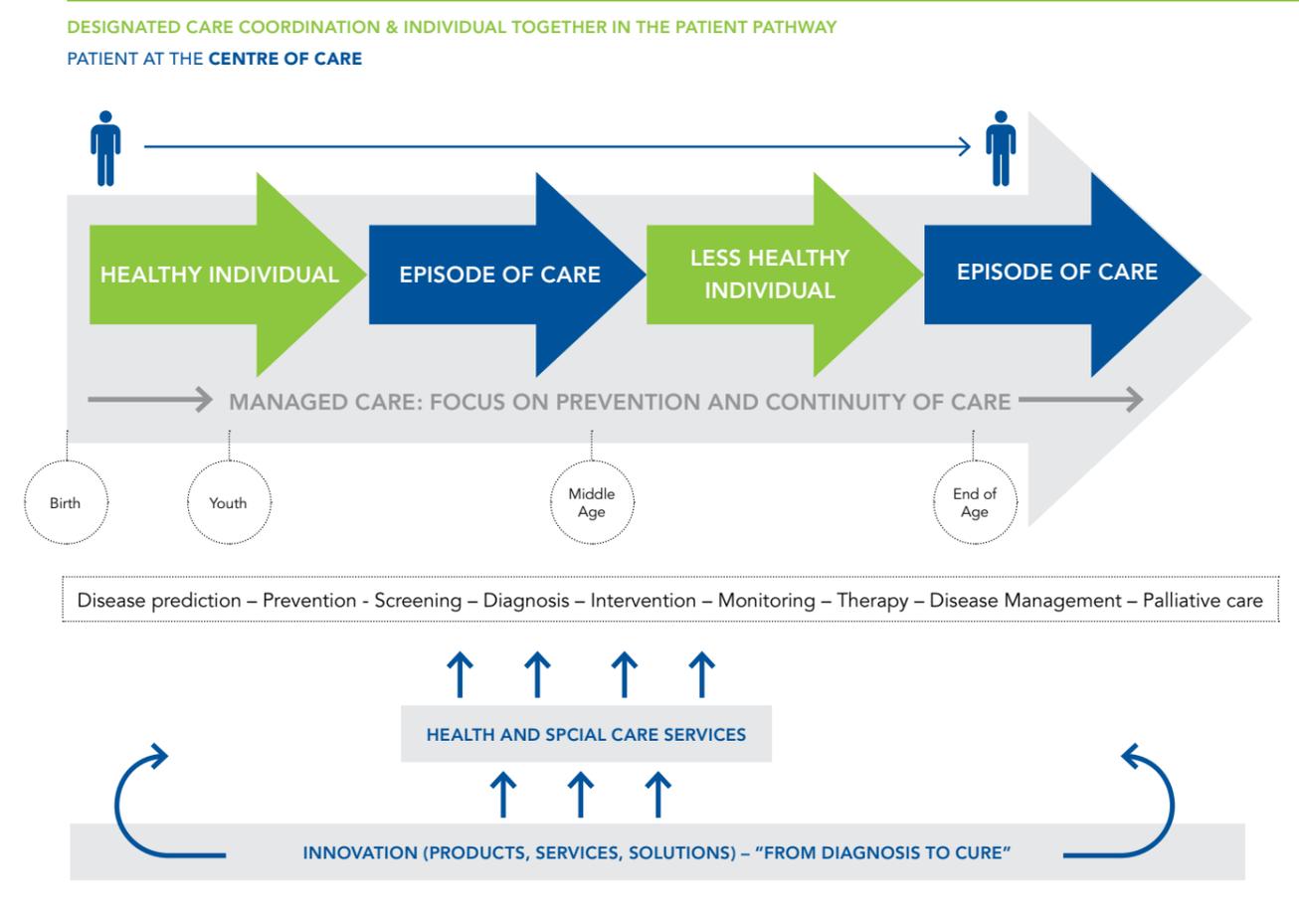
The main message for healthcare workers will be mobility. This phenomenon will require new skills, processes and accountability for professional healthcare workers. It will also open up new opportunities for healthcare professionals, for specialists, GPs, and nurses in particular.

In most Member States there are two types of delivery methods which cross over:

- A. **Ownership models:**  
State provided and funded, state commissioned care and personal or informal care
- B. **Delivery:**  
Single organisation, coordinating role or voluntary

The state as owner, organiser and funder, is prevalent in some systems where the state has typically exercised a large role as the guarantor of equity and access. Under this single organisation system, the state uses its own resources and assets to provide care all within the state system. However, due to funding constraints in recent years, more state funded systems are commissioning care from a number of providers and acting like health insurance gatekeepers – controlling costs and care options. Providers thus become coordinators of care, commissioning treatment and care as and when needed by the patient. In some Member States the evolution of homecare has meant new teams aimed solely at the provision of care. Other coordinating agents are GP offices, hospitals and nursing homes.

The new model of healthcare delivery will require greater coordination due to the fragmentation of patients across the community as well as the demand driven, patient-centric model which cannot easily be regimented (like scheduled hospital visits). Patient demand may arise at anytime and thus there will be challenges to continuity of care. Critical to this will be a care coordinator, a function typically provided by the family doctor but could easily be provided by a designated carer (e.g. nurse) or by the patient themselves. For many patients, managing their care is a difficult process, often felt shuffled between appointments with no continuity of overall care. Each acute episode is treated in isolation, but this breaks down with constant care for chronic conditions and requirements for prevention. Ideally each citizen will have someone who manages their care on a continual basis – someone they get to know and can rely on for managing their health requirements. Over time, this person may “train” such patients to become self-managed by having them take on responsibilities normally managed by healthcare institutions.



\*Pathway – the pathway is defined here as a plan and not intended to suggest a sequential approach nor a prescription on the way the pathway is designed

This model requires the following items to insure a successful delivery of care:

- The professional healthcare worker labour force needs greater training on community care services such as ICT (remote telecare, telemedicine, etc.), commissioning responsibilities, and servicing of patient needs.
- Greater emphasis must be made to create a more mobile, healthcare workforce who is connected to resources and professional opinion via new ICT technologies.
- Due to the use of modern technology in a home setting, healthcare professionals are going to need to be up to date on using and maintaining medical technology, even if on a basic level. This should include accreditation and audit schemes for health professionals.

## 5. Care and Treatment

- A healthcare worker should be assigned to each community care patient except where these patients require more expert and differentiated care.
- GP offices should be more geared towards managing out-patients rather than acute treatment of in-patients. This means using the hub of the local GP as the managing agent of care and acting more like a distribution hub than a treatment centre.
- Healthcare workers in community care should achieve a certified level of training and education, setting community care on a path of specialised qualifications and acceptance of community care workers as a career option.
- There should be a clear line of accountability for the healthcare worker to ensure the best treatment of the patient.

### Work Force Opportunities

Any section on care and treatment cannot ignore the fundamental and critical role that healthcare workers will play in community care. Any change required for community care to succeed needs to recognise the following elements:

- Any change requires healthcare workers support and therefore all consulting, discussion and decision-making should include this vital segment of healthcare delivery.
- Choosing community care as a method of treatment should further increase the skill set of the profession and thus advance career prospects for healthcare workers. Learning curves on ICT, social care and other elements not necessarily found in other settings will need to be overcome and enhance the skill set of workers.
- Healthcare workers – and in particular nursing – will require new roles as they move from disbursing care on function to managing care by patient. This will require more horizontal care skills. Such skill development will make such workers more indispensable to the provision of community care and thus enhance their health career prospects.
- Community care should empower healthcare workers by requiring them to take decisions “in the field”. This will further enhance their skill set and value in maximising patient outcomes.
- There will need to be a set of standards for community care treatment and healthcare workers are the best guarantor of those standards. Systems will need to be designed to encourage and, where necessary, mandate the upholding of such standards by healthcare workers.
- Healthcare workers will be required to empower their own patients as well to ensure that demands on the workforce can be managed efficiently.
- The healthcare work force will also be a critical provider of prevention, ensuring correct diagnosis and prescribing prevention as part of the continuing of care.
- Training programmes will need to be put in place to help achieve the aforementioned requirements so that community care can fulfil its promise.

## 6. Quality Care and Standards

The diffusion of care into the community will affect the efficiency of care although this is not directly correlated with the value of such care. It will be incumbent upon health services to assure patients of a quality of care commensurate with the treatment needed. To do this community care will have to determine the following:

- An identification and assessment of health needs.
- A determination of the ability to provide against these needs in a community setting.
- A flexible approach which allows patients to, at a minimum, be informed of their choices and, over time, to input into the choice itself always subject to a professional's opinion.
- Administration of treatment to standards or guidelines.
- A reinforcement mechanism which validates that such standards have been met such as adverse incident reporting obligations, patient feedback requirements and third party quality care supervision.
- A constant monitor of quality of care status and trends in care that is transparent to the public.

These concepts are the parameters for assuring quality care from a dynamic patient choice – regulatory surveillance perspective. Over time patient choice will dictate the demand for quality care with regulatory and legal assurance through standards, supervision and enforcement, to protect against uninformed choice of treatments.

The diffusion of patients into the community should not take a minimisation approach. The rapid movement of patients into community care will create tensions with regards to care for people outside of the hospital system, nursing care homes, etc. This means not only from a communications perspective, but a cost one as well. Studies have shown that creating standards leads to efficiencies in treatment as learning curve aspects and economies of scale are absorbed into the system. However, standards are difficult to apply when each case requires a degree of personalisation. Therefore, standards should be set high but allowing for a degree of personalisation. Guidelines should be brought into to handle non-homogenised treatments. Quality of care systems should follow by raising the standards as guideline treatments become more standardised.

The iterative process of a minimum benchmark of standardised care as well as the force to raise levels of patient choice and new technologies should continue to raise the standard of care. The advantage is that innovation is spurred by the constant re-evaluation of treatments as they move from personalised, guideline rated to new standards of care. Standards should be set up with the clear objective to improve health outcomes that will lead to the well-being of citizens and society.

The above model is not a silver bullet of reform. It is but one section of the overall health-care mix, but one that deserves a new prioritisation and recognition. It requires hard choices, trade-offs and will result in problems, both at the outset and over time. In particular, the institutionalised resistance to change will be an overarching barrier felt most across all stakeholders of the current system. This requires intervention of responsible authorities and broad political support on a push and pull basis with legislation determining a destination, but with in-built incentives for stakeholders to maintain flexibility and motivation to move towards community care providing positive health outcomes for the well-being of citizens and society.

Health First Europe believes that this model adds to the debate on the consideration for the patient. The model reflects the trends in care, driven by exigencies like patient safety problems in acute treatment settings, and the model is meant to simply accelerate the potential redesign and configuration of health system.

The barriers aforementioned are simply challenges, ones that must be overcome if citizens and society well-being is to be assured in the future. The clarity of focus on health care reform, following the financial crisis, has given new hope to innovation and long term restructuring of the system.

Europe is well placed to rise to these challenges with a dynamic healthcare work force, a culture of health innovation and a shifting political mindset that the current system needs reform. The future is not pre-ordained by the statistics but determined by the actions taken by all stakeholders. Community care deserves its place at this discussion and this model is HFE's contribution to the challenge ahead.

## Key factors for chronic disease patients

1. Chronic diseases kill more than 36 million people globally every year, with 9 million deaths occurring before the age of 60.<sup>xviii</sup>
2. The WHO estimates that chronic diseases will be responsible for 52 million deaths by 2030 in Europe alone.<sup>xix</sup>
3. At present in Europe, 80% of patients over the age of 65 already have at least one chronic condition.<sup>xxi</sup>
4. 70-80% of healthcare costs are spent on chronic diseases, corresponding to €700 billion in the European Union and this number is expected to increase in the coming years.<sup>xxii</sup>

It is the area of chronic disease where the greatest benefit lies in developing a community care model. Chronic disease fits all the criteria for a condition treatable in the community. It requires a partial life or lifelong healthcare pathway, can often be treated at the home or out of hospital, requires patient responsibility and input and is most adaptable or ready for service and medical technology innovations chronic disease patients often are multi-morbid, which requires care from a variety of experts, but which also can provide that care without constant hospital surveillance. The Community Care Model would provide a system which puts these patients at the centre of care, with designated care coordination for treatment from a range of carers, with patient choice for products and treatment which can be accessed outside of an acute setting (often in the home).

One such model has already been developed in Germany where multidisciplinary teams of professionals and carers are part of a standardised, cross-sector care pathway which reflects a framework of a medical guideline and incorporates medical and nursing parameters as well as other therapies.<sup>xxiii</sup>

The critical demands of a chronic disease management model:

- **Continuity of care:**  
It is essential that patients have a single continuum of care. This may take the form of prevention one day, treatment the next and rehabilitation at another time.
- **Accountability:**  
There needs to be a clear line of accountability which will require that the responsible person/carer avoids a geographical or location based treatment approach. Someone must be responsible, with clear negative consequences, if the continuum of care is ignored or violated. The citizen will also have clear accountability in this model.

- **Simplicity:**  
To get patients empowered for their roles in the continuum of care, the health care plan must be simple in its design at patient level. Charting sugar levels, changing of products or other patient applied functions must be reasonably adapted to the community care setting.
- **Choice:**  
Any system that does not apply choice denies the system of competing interests which in turn drives innovation. Choice must be crystallised in policy so there are means by which to exercise choice. This could be through financing, revised prospective payment schemes, or other means to allow patient influence on treatment options.
- **Standards:**  
Fragmentation will inevitably be a consequence of choice so the chosen treatment should revolve around a standard of care. This standardisation will extract efficiencies in application and cater to parameters of simplicity. This is not to imply that personalised treatment is not standardised, but that standards can be dictated around approach as opposed to products or processes.
- **Transparent information:**  
No system works without minimum levels of information for rational decision-making. Information on pricing, treatment options and service quality are critical in empowering consumers to take responsibility in the continuum of care.
- **Codification and health records:**  
Any system, where many independent individuals are being treated in a multitude of settings on any given day necessitates connectivity for the patient to flow from one setting to another. Standardised and available records must be available to every health professional on an open or circular view (not pass along or sequential) with the primary carer informed at each stage.

## Recommendations for a model for community care

### 1. Community Care Policy:

- A unique community care policy should be developed, publicised and require a road map for accountability, evaluation and recalibration purposes.<sup>xxiv</sup>
- The community care policy must be cohesive, coordinated with other care sectors and be aimed at effective integration of patients as the cross-over the system.<sup>xxv</sup>
- The policy must have quantifiable measurements (KPIs) for regular evaluation.
- The policy must have clearly defined goals for accountability.
- The changes require a willingness to accept that initial monetary investment is necessary to achieve long term value by unlocking the tangible benefits of changes in work structures, patient return to productivity and access to quality care.
- The policy must be benchmarked against best practice and other regions or Member States.

### 2. Patient Centric Care:

- Community care should have a patient pathway road map for all patients, clearly spelled out and indicating where the prevention, treatment and adherence are dependent on the patient.
- Patients shall be fully informed not only of the treatment, but of the alternatives and risks.
- Patient access to medical technology innovation should not be restricted so that a scaleable market develops which drives further innovation.
- A personal health plan should be developed which tracks and traces the entire chain of health for a citizen from birth to death.
- A personal health record should be accessible for each individual and serve as the continuity document between services administered over the life of the patient.
- Patients should be given full access to information in order to provide explicit consent for treatments including alternatives to certain treatments, use of technologies and care.
- Citizens should, during episodes of treatment, be allocated a primary carer who coordinates treatment and professional opinion.
- Prevention and early detection should form part of the evaluation for each potential patient.

### 3. Innovation and Value:

- Defining a model of valuing community care products and services.
- Eliminating discrimination between usage settings.
- Reconsidering financing options aimed at creating markets for innovation in community care.
- Allowing local and regional experimentation on ways to encourage innovation.

#### 4. Access and Reimbursement:

- Community care should have a claim on budgets without discrimination against other forms of health delivery.
- Social and healthcare budgets should be merged to reflect the blurring of lines between social and health community care. This applies as well to silo budgeting between segments in health and social care and within healthcare budgets.
- Any product or service which is reimbursed in acute or GP settings should automatically be assumed as being reimbursed for community care settings except where technical limits or costs, arising from the basis of it being supplied in the community, make it unfeasible – there should be, in principle, no care setting discrimination.
- Patients' choice of treatment should not be prejudiced by public policy decisions on reimbursable products. To this extent patients should be able to "top-up" to increase access to new products and services.
- In exchange for patients possibly requiring a financial contribution for their care, the range of products and services that are reimbursable should be extended to those currently valued by patient and society but not reimbursed.

#### 5. Care and treatment:

- The professional healthcare worker labour force needs greater training on community care services such as ICT (remote telecare, telemedicine, etc), commissioning responsibilities, and servicing of patient needs.<sup>xxvi</sup>
- Greater emphasis must be made to create a more mobile, healthcare workforce who is connected to resources and professional opinion via new ICT technologies.
- Due to the use of modern technology in a home setting, healthcare professionals are going to need to be up to date on using and maintaining medical technology, even if on a basic level. This should include accreditation and audit schemes for health professionals.
- A healthcare worker should be assigned to each community care patient except where these patients require more expert and differentiated care.
- GP offices should be more geared towards managing out-patients rather than acute treatment of in-patients. This means using the hub of the local GP as the managing agent of care and acting more like a distribution hub than a treatment centre.
- Healthcare workers in community care should achieve a certified level of training and education, setting community care on a path of specialised qualifications and acceptance of community care workers as a career option.
- There should be a clear line of accountability for the healthcare worker to ensure the best treatment of the patient.

#### 6. Quality Care and Standards:

- An identification and assessment of health needs
- A determination of the ability to provide against these needs in a community setting.
- A flexible approach which allows patients to, at a minimum, be informed of their choices and, over time, to input into the choice itself always subject to a professional's opinion.
- Administration of treatment to standards or guidelines.
- A reinforcement mechanism which validates that such standards have been met such as adverse incident reporting obligations, patient feedback requirements and third party quality care supervision.
- A constant monitor of quality of care status and trends in care that is transparent to the public.



CARE AND TREATMENT		Professional healthcare worker labour force receives training on community care services such as ICT (remote telecare, telemedicine, etc), commissioning responsibilities, and servicing of patient need	Healthcare workforce is mobile and connected to resources and professional opinion via new ICT technologies	Healthcare professionals are to date on using and maintaining medical technology and accreditation and audit schemes exist for training on use of modern technology in a home setting	Healthcare worker is assigned to each community care patient (except where these patients require more expert and differentiated care)	GP offices are geared towards managing out-patients rather than acute treatment of in-patients.	Healthcare workers in community care can achieve a certified level of training and education	Clear line of accountability exists for the healthcare workers to ensure the best treatment of the patient
	Austria							
	Belgium							
	Bulgaria							
	Cyprus							
	Croatia							
	Czech Republic							
	Denmark							
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	Finland							
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	Poland							
	Portugal							
	Romania							
	Slovakia							
	Slovenia							
	Spain							
	Sweden							
	United Kingdom							

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Health First Europe was established in 2004 as a non-profit, non-commercial alliance of patients, healthcare workers, academics, and healthcare experts and the medical technology industry. We aim to ensure patient access to modern, innovative and reliable medical technology is regarded as a vital investment in the future of Europe. We call for truly patient centred healthcare and believe that every European should benefit from the best medical treatments available.

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