Hacia una financiación de la Atención Integrada basada en Valor

Roberto Nuño-Solinís
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Barcelona, 7 de Noviembre de 2023

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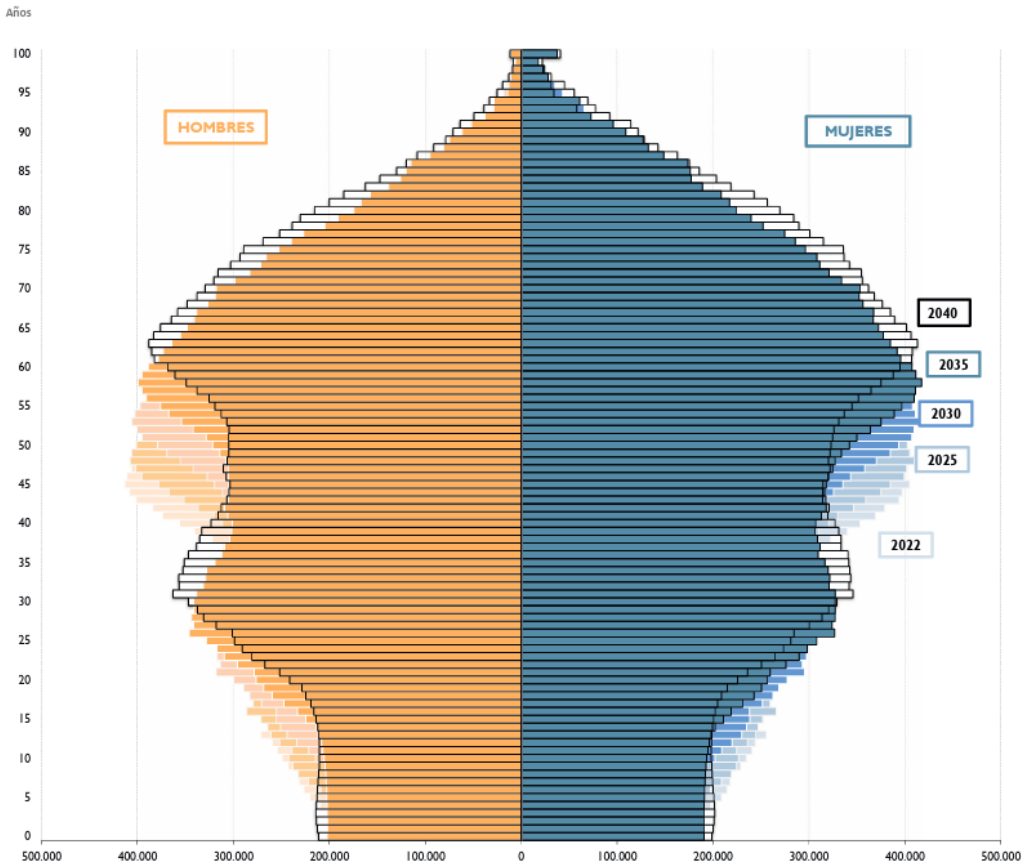
3. Pago por Valor: ¿dónde estamos?
4. El caso SAIATU

1.- Historia de dos tsunamis

El tsunami demográfico en España



Fuente: Instituto Nacional de Estadística (INE). Estadística del Padrón continuo (2022) y Proyecciones de población (2023-2040). Consulta en mayo de 2023.


平安好医生
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PUSH

2.- La Atención Integrada basada en Valor

International Journal of Integrated Care

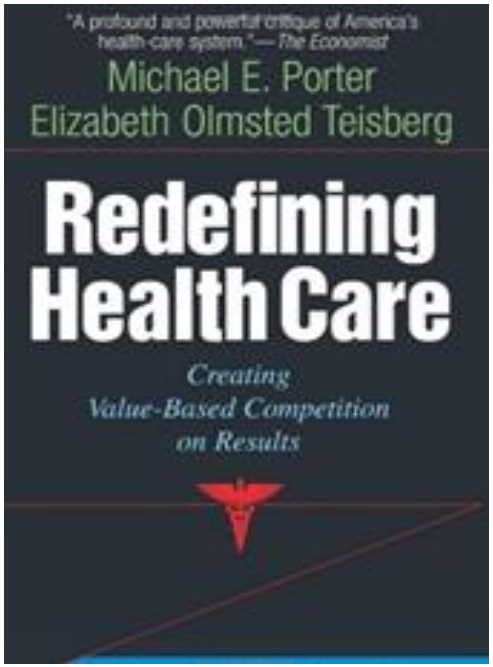
Nuño-Solinís, R. Advancing Towards Value-Based Integrated Care for Individuals and Populations. *International Journal of Integrated Care*, 2019; 19(4): 8, 1–3. DOI: https://doi.org/10.5334/ijic.5450

EDITORIAL

Advancing Towards Value-Based Integrated Care for Individuals and Populations

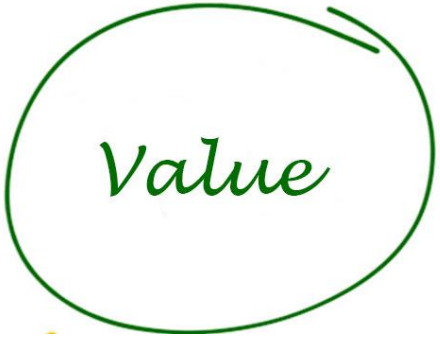
Roberto Nuño-Solinís

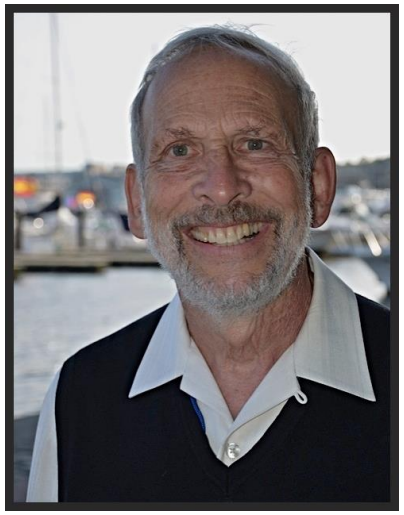
Keywords: value-based health care; integrated care; outcomes measurement



Medición de la creación de Valor en Salud para Individuos y Poblaciones

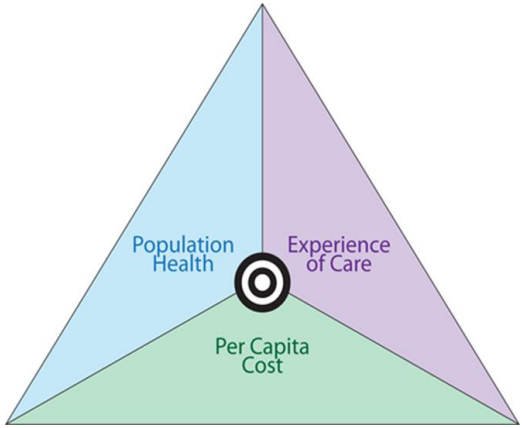
Michael Porter

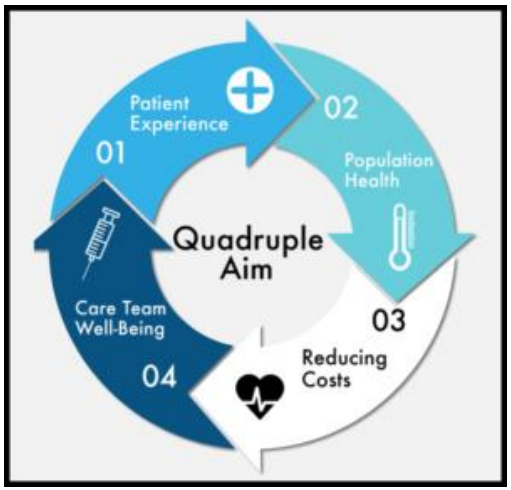


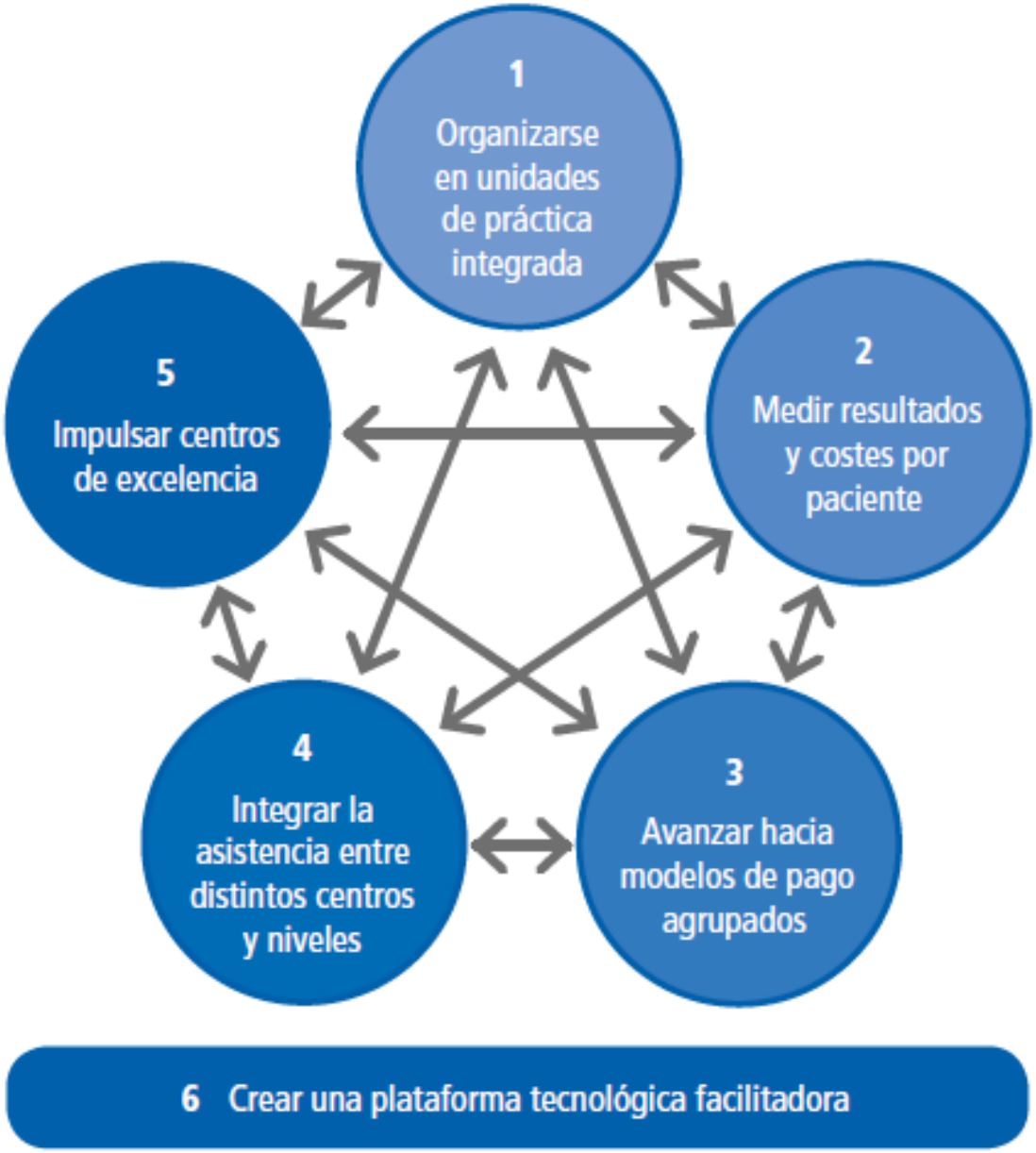


Thomas Bodenheimer

Don Berwick







Fuente: Modificado a partir de M.E. Porter, et al. The strategy that will fix health care. Harvard Business Review 2013.

Experiences in translating and culturally adapting the ASCOT SCT4 to the Spanish context: ***The Spanish-ASCOT***

Bruno Casal[1], Eva Rodríguez-Miguez[2]

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PSSRU
Personal Social Services Research Unit

ASCOT
adult social care outcomes toolkit

University of Kent

UNIVERSIDADE DA CORUÑA

NEJM Catalyst | Innovations in Care Delivery

IN DEPTH

The Economic Case for Vertical Integration in Health Care

Peter Orszag, PhD, Rahul Rekhi, MS

Vol. 1 No. 3 | April 15, 2020

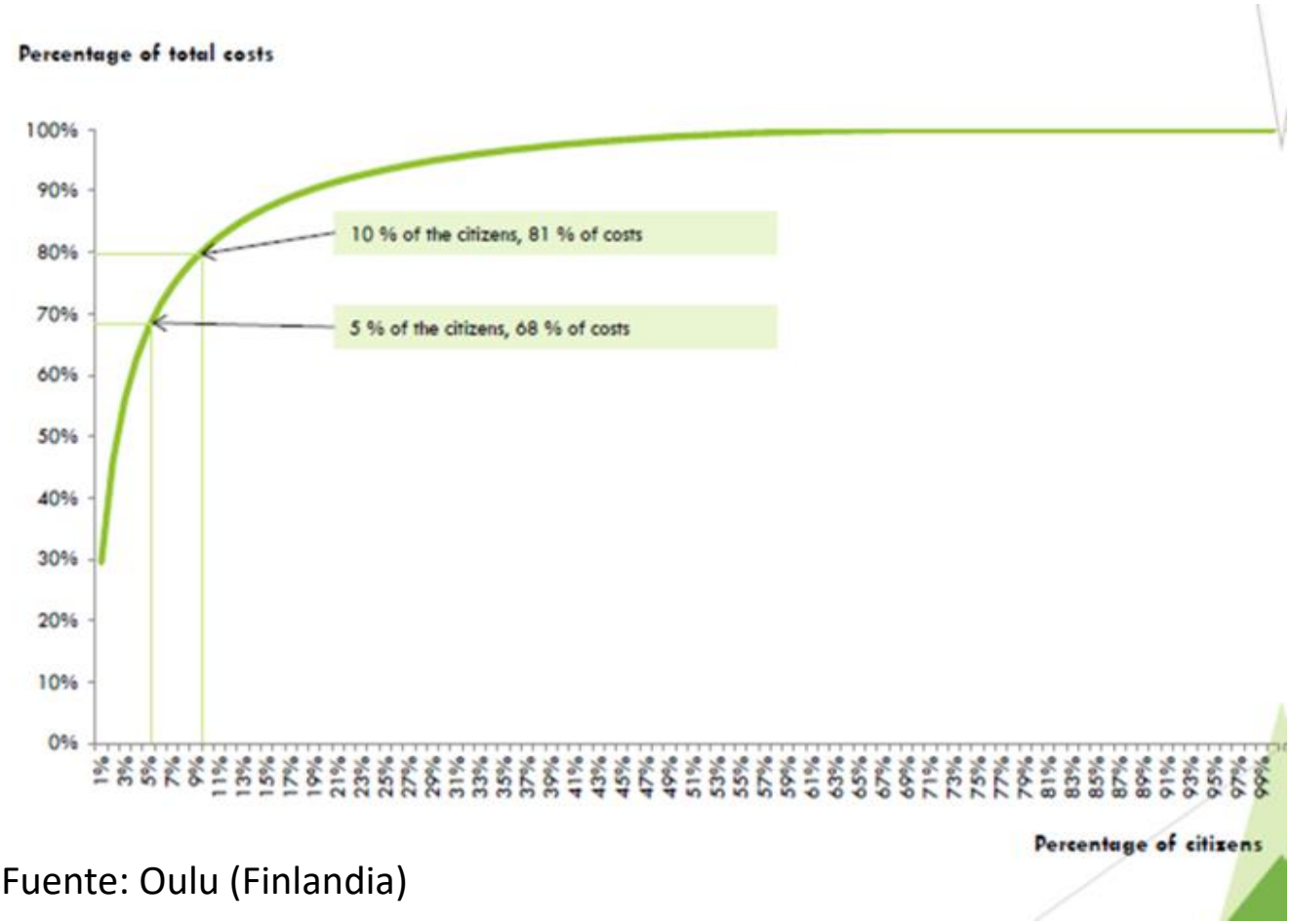
DOI: 10.1056/CAT.20.0119

Table 1. Illustrative Medical Cost-Savings Estimates from Models of Owning the Whole Patient

Category	Description	Type	Reference	Study Type	Central Finding on Cost Savings
Contractual	Medicare Shared Savings Program	Contractual	MedPAC, 2019[T-1]	Report	Approximately 1% to 2% reduction
	Aetna ACOs	Contractual	Stockton, 2017[T-2]	Market Data	12.4% reduction (observational)
	UnitedHealthcare ACOs	Contractual	UnitedHealthcare, 2018[T-3]	Market Data	7% reduction
	Vermont Medicaid ACO	Contractual	RTI International, 2018[T-4]	Report	8.4% reduction
	Camden Coalition Medicaid ACO (NJ)	Contractual	Truchil, et al., 2018[T-5]	Peer-Reviewed	0.4% to 5.3% reduction
	BCBS AZ ACO	Contractual	Daly, 2018[T-6]	Market Data	Approximately 3.7% reduction
	BCBS MA Alternative Quality Contract (AQC)	Contractual	Kaufman, et al., 2019[T-7]	Peer-Reviewed	11.7% savings (relative to control states)
Partial Integration	BCBS of Western NY and Kaleida	Partnership	Kaleida Health, 2013[T-8]	Market Data	Expected 6% to 10% reduction
	ElevateHealth: Harvard Pilgrim, Elliot Health, and Dartmouth-Hitchcock	Joint Venture	Palermo, 2013[T-9]	Market Data	Expected 10% reduction (Note: other reports of 15% to 20% savings from performance data)
	Aetna-Inova	Joint Venture	Morse, 2016[T-10]	Market Data	Approximately 8% reduction
	Aetna-Banner	Joint Venture	Nettesheim, 2017[T-11]	Market Data	11.5% reduction
Full Integration	Provider-Led ACA Exchange Plans	Vertically Integrated	La Forgia, et al., 2017[T-12]	Peer-Reviewed	6% to 9% reduction in premiums relative to Blues, regional, and national insurers
	Provider-Led MA Plans	Vertically Integrated	Frakt, et al., 2013[T-13]	Peer-Reviewed	Mixed impact; integrated plans charge higher premiums but markets with more integrated entities associated with lower premiums
	Staff-Model HMOs	Vertically Integrated (includes group-model HMO)	Staines, 1993[T-14]	Peer-Reviewed	Modeled 10% reduction
	Kaiser Permanente	Vertically Integrated	Pearl R, Madvig P. 2020[T-15]	Report	10% to 15% reduction
	Group Health Cooperative	Vertically Integrated	Manning, et al., 1985[T-16]	Report	25% reduction

Cronicidad y Gasto Sociosanitario

"10% usuarios → 81% gasto sanitario y social"



Fuente: Oulu (Finlandia)

3.- Pago por Valor: ¿dónde estamos?

Consideraciones previas:

- ¿Qué servicios? Globales o parciales
- ¿A quiénes?: responsabilidad individual o poblacional
- ¿Qué fuentes de financiación?, ¿hay copagos?
- ¿Quién paga?, ¿hay separación de funciones?
- ¿Quién asume riesgos?
- ¿Hay equidad en la asignación? y ¿en las reglas del juego?
- ¿Qué queremos incentivar?

PRECIO PLAZAS CONCERTADAS COMUNIDADES AUTÓNOMAS

COMUNIDAD	PRECIO 2022	PRECIO 2023	OBSERVACIONES
GIPUZCOA (P.Vasco)	108,64€	112,98€	Regulado por Decreto subida anual de al menos 4%. Precios concertados especiales para las ENLs. Se negocia pago extraordinario de extra gastos suministros
VISCAYA (P.Vasco)	95,37€	95,37€	Se negocia subida para 2023. Se negocia pago extraordinario de extra gastos suministros
NAVARRA	79,79€	79,79€	Se negocia subida del IPC.
ALAVA (P.Vasco)	69,93€	73,42€	Regulado por decreto subida anual del 5%.
COMUNIDAD DE MADRID	72,00€	72,00€.	No se espera subida alguna. Renovación de precios al alza con el nuevo decreto de 2025.
ISLAS BALEARES	71,22€ (GIII) 67,22€ (GII)	71,22€ (GIII) 67,22€ (GII)	Se negocia subida para 2023.
COMUNIDAD VALENCIANA	67,17€	70,75€	Regulado por decreto subida anual del 5% (Conlleva igualmente subida de ratios y convenio colectivo. Intención de unir en 2026 los salarios de los centros residenciales con los de la administración pública) Se negocia pago extraordinario de extra gastos suministros
LA RIOJA	68,72€	68,72€	Se negocia con el gobierno la subida del IPC
CATALUÑA	65,00€	67,42	Subida anual del 4,5% Se negocia pago extraordinario de extra gastos suministros
CASTILLA y LEÓN	62,90€ (GIII) 55,10€ (GII)	66,36€ (GIII) 58,13€ (GII)	Subida anual entre el 5% y 6%. Compromiso con el gobierno regional de subir todos los años 3 puntos por encima del IPC.
CANARIAS	64,50€ (GIII) 57,50€ (GII)	64,50€ (GIII) 57,50€ (GII)	Mismos precios desde el año 2020. Se negocia una subida para 2023 del 6%.
CANTABRIA	62,57€	64,45€	Acuerdo de las entidades con el gobierno regional de subida anual igual al % que suba el convenio estatal. Previsto 2023-2025: 3%.
EXTREMADURA	62,16€	64,02€	Compromiso con el gobierno regional de subida anual de al menos el 3%.
COMUNIDAD DE MURCIA	61,12€	63,26€	Regulada la subida por trienios. Año 2024: 4,25%.
GALICIA	60,00€	60,00€	Precio de 2023 pendiente de licitación. Se espera subida de al menos 5%.
ARAGÓN	56,84€	59,68€	Compromiso con el gobierno regional de subir todos los años un 5%.
ANDALUCÍA	55,79€	58,30€	
CASTILLA LA MANCHA	52,88€ (GIII) 51,92€ (GII)	52,88€ (GIII) 51,92€ (GII)	Se negocia subida del 5,5%.
ASTURIAS	43,00€	43,00€	A la espera de subida sustancial del mismo.
MEDIA DE ESPAÑA	***60,65€***	***68,84€***	

Fuente: *AGO – Servicios a entidades sociales y solidarias.*

	Unit of Payment	Common term (*integration-specific term*)
1	Per time period	Budget and salary
2	Per beneficiary	Capitation
3	Per recipient	Contact capitation
4	Per episode	Case rates, payment per stay, and **bundled payments**
5	Per day	Per diem and per visit
6	Per service	Fee-for-service, ***pay-for-performance***[a], ***pay-for-coordination***
7	Per dollar of cost	Cost reimbursement
8	Per dollar of charges	Percentage of charges

OECD Health Working Papers No. 154

Innovative providers' payment models for promoting value-based health systems: Start small, prove value, and scale up

Luca Lindner,

Luca Lorenzoni

https://dx.doi.org/10.1787/627fe490-en

Table 4.1. Impact of episode-based bundled payment models on spending, quality of care and patient experience with care

Country	Programme	Spending	Quality of care	Patient experience	Source
United States	BPCI	-/+*	=		(Centers for Medicare & Medicaid Services, 2022[51])
	BPCI-Advanced	-/+**	+/=		(Lewin Group, 2022[58])
	CJR	+	+/=		(Lewin Group, 2020[67]; Haas et al., 2019[61])
Netherlands	Integrated Maternity Care Organization (IMCO)	+	=		(Struijs et al., 2020[68])
Canada	Integrated Funding Model (IFM), six pilot projects	+	+	+	(Walker, Hall and Wodchis, 2019[69])

Table 4.2. Impact of bundled payments for chronic disease management models on spending, quality of care and patient experience with care

Country	Programme	Spending	Quality of care	Patient experience	Source
United States	Oncology Care Model	-	=	=	(Centers for Medicare & Medicaid Services, 2022[51])
Netherlands	Ketenzorg	-			(Karimi et al., 2021[36])
Australia	Australian Health Care Home Trial	-	=	=	(Health Policy Analysis, 2022[72])

Table 4.3. Impact of comprehensive capitation payment models on spending, quality of care and patient experience with care

Country	Programme	Spending	Quality of care	Patient experience	Source
United States	ACOs	+/=	+/=	=	(Wilson et al., 2020[75]; Kaufman et al., 2019[74])
	PACE	=/-	+/=		(Arku et al., 2022[81]; Foster et al., 2007[82])
Germany	Healthy Kinzigtal	+	=	=	(Schubert et al., 2016[84]; Schubert et al., 2021[89]; Hildebrandt et al., 2015[86]; Siegel et al., 2016[90])
Netherlands	Menzis Shared Savings Model	+	=	=	(Hayen et al., 2021[48])

Value-Based Payment As A Tool To

other factors.

DECEMBER 1, 2022 10.1377/hpb20221014.52654

Top Findings From The Literature

- More than half of health care payments in the US are still based on fee-for-service.
- Savings attributable to Accountable Care Organizations range from just under 1 percent to just over 6 percent of per person spending.
- The effects of bundled payments vary across procedures and patient populations.
- Research on savings from capitation is limited.

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
Fee-for-service: no link to quality and value	**Fee-for-service: link to quality and value**	**APMs built on fee-for-service architecture**	**Population-based payment**
	2A **Foundational payments for infrastructure and operations** For example, care coordination fees and payments for health information technology investments	**3A** **APMs with shared savings** For example, shared savings with upside risk only	**4A** **Condition-specific population-based payment** For example, per member per month payments or payments for specialty services, such as oncology or mental health
	2B **Pay-for-reporting** For example, bonuses for reporting data or penalties for not reporting data	**3B** **APMs with shared savings and downside risk** For example, episode-based payments for procedures and comprehensive payments with upside and downside risk	**4B** **Comprehensive population-based payment** For example, global budgets or the full or a percent of premium payments
	2C **Pay-for-performance** For example, bonuses for quality performance		**4C** **Integrated finance and delivery systems** For example, global budgets or the full or a percent of premium payments in integrated systems
		3N Risk-based payments not linked to quality	**4N** Capitated payments not linked to quality

J Health Econ. 2018 Mar:58:43-66. doi: 10.1016/j.jhealeco.2018.01.002. Epub 2018 Jan 31.

Does long-term care subsidization reduce hospital admissions and utilization?

Joan Costa-Font [1], Sergi Jimenez-Martin [2], Cristina Vilaplana [3]

Affiliations + expand

PMID: 29408154 DOI: 10.1016/j.jhealeco.2018.01.002

Abstract

We use quasi-experimental evidence on the expansion of the public subsidization of long-term care to examine the causal effect of a change in caregiving affordability on the delivery of hospital care. More specifically, we examine a reform that both introduced a new caregiving allowance and expanded the availability of publicly funded home care services, on both hospital admissions (both on the internal and external margin) and length of stay. We find robust evidence of a reduction in both hospital admissions and utilization among both those receiving a caregiving allowance and, albeit less intensely, among beneficiaries of publicly funded home care, which amounts to 11% of total healthcare costs. These effects were stronger when regions had an operative regional health and social care coordination plan in place. Consistently, a subsequent reduction in the subsidy, five years after its implementation, is found to significantly attenuate such effects. We investigate a number of potential mechanisms, and show a number of falsification and robustness checks.

Keywords: Bed-blocking; Hospital admissions; Hospital utilization; Long-term care reform; Poisson hurdle model; Spain.

Integración social y sanitaria

> Empir Econ. 2023;64(1):1-30. doi: 10.1007/s00181-022-02246-0. Epub 2022 May 27.

'Investing' in care for old age? An examination of long-term care expenditure dynamics and its spillovers

Joan Costa-Font [1], Cristina Vilaplana-Prieto [2]

Affiliations + expand

PMID: 35668842 PMCID: PMC9137442 DOI: 10.1007/s00181-022-02246-0

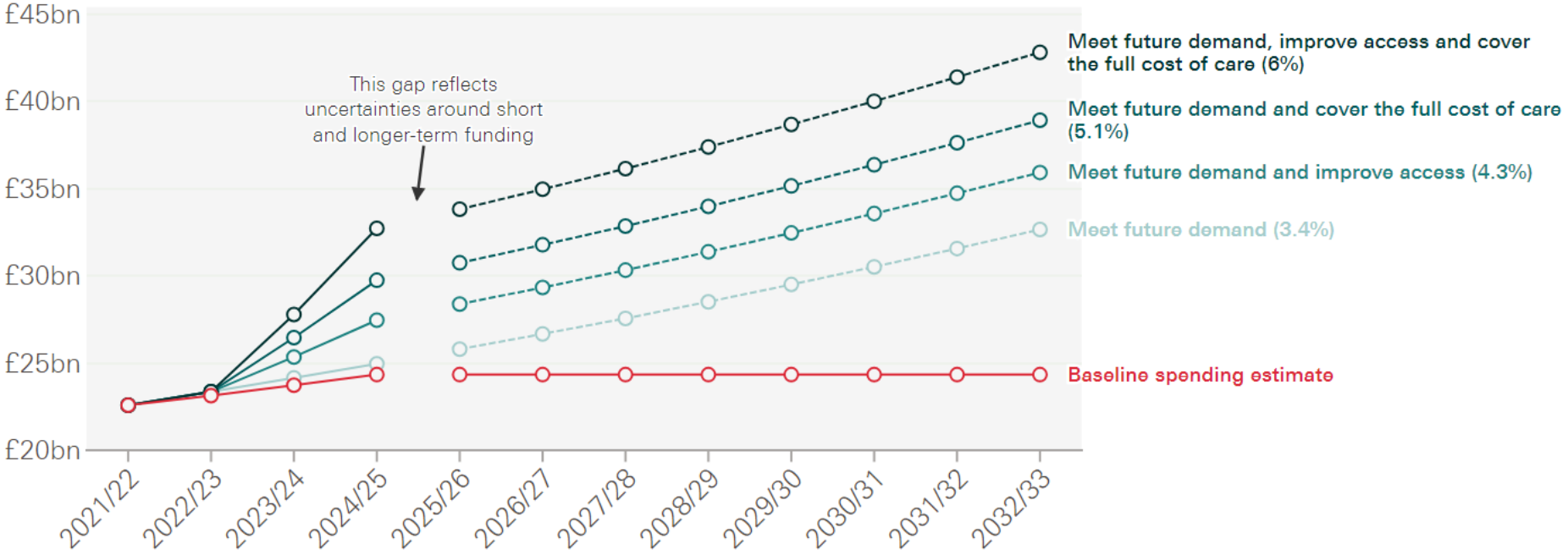
Free PMC article

Abstract

We study the dynamic drivers of expenditure on long-term care (LTC) programmes, and more specifically, the effects of labour market participation of traditional unpaid caregivers (women aged 40 and older) on LTC spending, alongside the spillover effects of a rise in LTC expenditure on health care expenditures (HCE) and the economy (per capita GDP). Our estimates draw from a panel of more than a decade worth of expenditure data from a sample of OECD countries. We use a panel vector auto-regressive (panel-VAR) system that considers the dynamics between the dependent variables. We find that LTC expenditure increases with the rise of the labour market participation of the traditional unpaid caregiver (women over 40 years of age), and that such expenditures rise exerts large spillover effects on health spending and the economy. We find that a 1% increase in female labour participation gives rise to a 1.48% increase in LTC expenditure and a 0.88% reduction in HCE. The effect of LTC spending over HCE is mainly driven by a reduction in inpatient and medicine expenditures, exhibiting large country heterogeneity. Finally, we document significant spillover effects of LTC expenditures on per capita GDP.

Meeting future demand for social care would require an additional £8.3bn per year by 2032/33

Short and long-term funding estimates in social care expenditure



Arguments made for merging of the NHS and social care	Arguments made against merging of the NHS and social care
• A single health and social care system with a ring-fenced singly commissioned budget would align the disparate funding streams that currently exist. There is little logical division between what is means tested under social care and what is free at the point of use NHS care. Existing divides – artificial and historical – between health and social care would largely be done away with, and entitlements would be more closely aligned. • A single budget and single commissioner would offer the opportunity to provide many more integrated services, working out what individuals' needs and preferences are and making it easier over time to provide services in the place where they produce the best results – whether that is at home, in residential and other settings, or in hospital.	• There is little to no evidence it would save money or boost productivity – there is limited evidence from any country that pooled budgets and other forms of integrated finances have increased cost savings or productivity. • For many working-age people who use social care, the NHS is not the main partner, in fact it is housing and employment support services, so it does not address the fundamental silos between services that impact on people's care. • It would not make health and social care funding more sustainable – although it may remove some of the frictions between the two services, but that has marginal impact on the overall cost of both.

The NHS in crisis – evaluating the radical alternatives

4.- El caso SAIATU

"To allow people the deaths they want, end of life care must be radically transformed…"

DYING FOR CHANGE

Charles Leadbeater
Jake Garber

"The inclusion of social services in the provision of palliative care is the natural way to expand".

Nick Bosanquet

Descripción del programa SAIATU

Definición de la población diana

- Pacientes oncológicos
- Pacientes con enfermedades crónicas avanzadas

Cartera de servicios

Pacientes

- Información
- ABVD
- Acompañamiento
- Comunicación
- Cuidados especiales
- Control de síntomas
- Respiro familiar
- Apoyo en los cuidados
- Atención al duelo
- 24x7x365

Familiares

Protocolos de atención

HIPÓTESIS

- EFECTOS: El acompañamiento social profesional de pacientes y familias en situación de final de vida en su domicilio, y el conocimiento sobre diagnóstico y pronóstico de la enfermedad por parte del paciente y la familia, se asocian con la probabilidad de morir en el lugar deseado por el paciente.
- COSTE: El acompañamiento social profesional de pacientes y familias en situación de final de vida en su domicilio reduce la utilización de recursos sanitarios.

Lugar de fallecimiento según voluntades expresadas			Muerte en domicilio	Muerte en hospital	P-valor
Voluntades previas		NO	4 (8%)	4 (20%)	0,156
		SI	46 (92%)	16 (80%)	
Coincidencia con voluntades previas	NO		0 (0%)	13 (65%)	0,000
		Mal control síntomas	-	9 (45%)	
		Claudicación familiar			
	SI				
	SIN VOLUNTADES				

79% fallecieron donde habían elegido

Comparative Analysis of Costs related to the Intensity of Healthcare

	SAIATU	PC+SC	p[1]	PC+SC+HaH	p[2]
Cost per activity	6.719 [4.082-9.356]	15.326 [12.224-18.428]	<0.001 *		
Cost per activity + days on programmes	18.709 [13.177-24.241]			23.431 [18.247-28.617]	0.343

Note: * values for the SAIATU group were significantly lower by one-tailed Mann-Whitney U test
+ Mean & 95% confidence interval

The mean cost per activity was significantly lower for the SAIATU than for the PC+SC group ($p<0.001$).

The difference between the costs related to the SAIATU with HaH group & the PC+SC+HaH group was not statistically significant ($p=0.343$).

Community Based Participatory Research For The Development of a Compassionate Community: The Case of Getxo Zurekin

International Journal of Integrated Care

INTEGRATED CARE CASES

]u[ubiquity press

NAOMI HASSON
MAIDER URTARAN-LARESGOITI
ROBERTO NUÑO-SOLINÍS
ITZIAR MORENO
GORKA ESPIAU
MAIDER GRAJALES
JANIRE FONSECA

Value Based Health and Care

Action Plan

NHS SCOTLAND

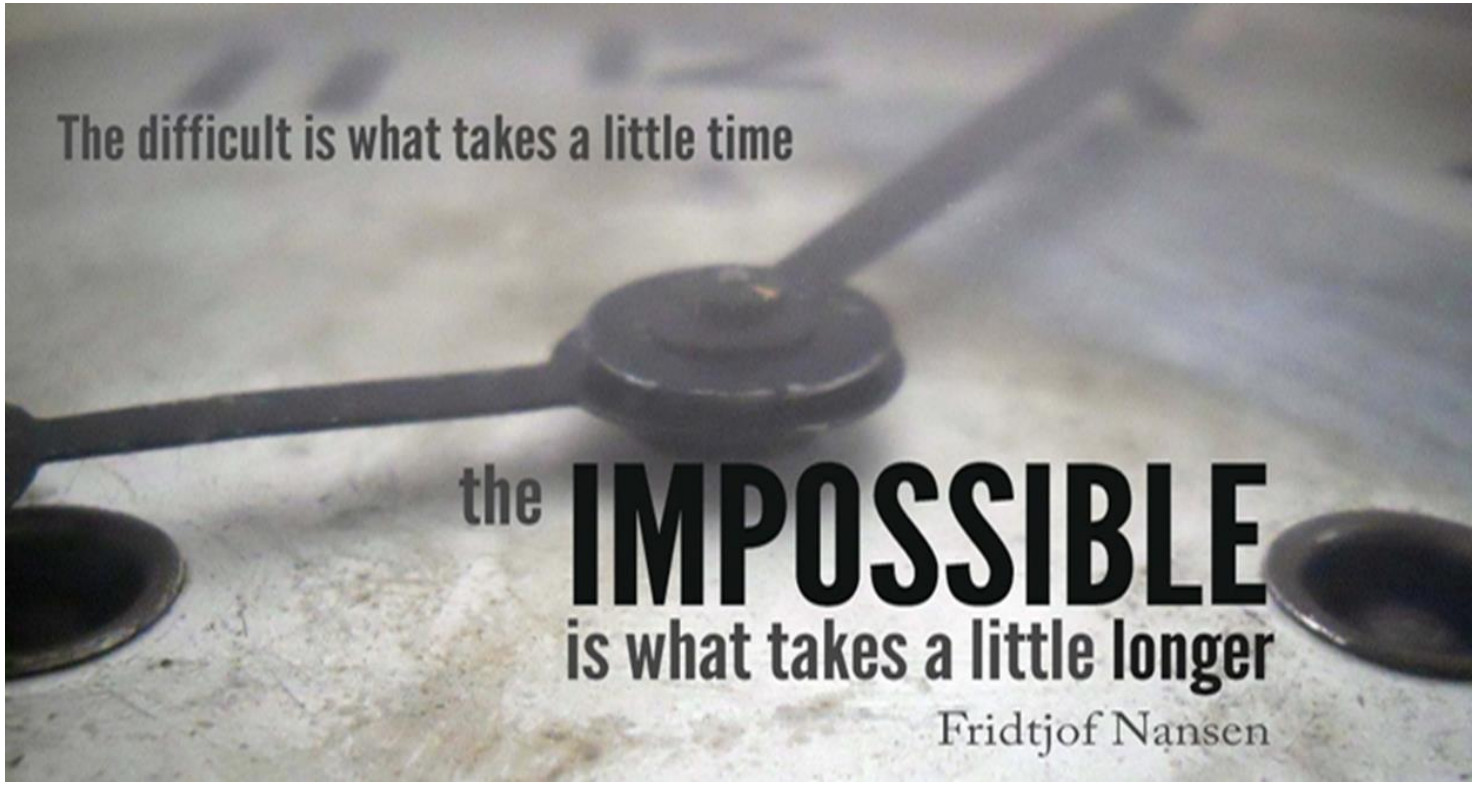
REALISTIC MEDICINE

Scottish Government
Riaghaltas na h-Alba

Conclusiones

- La sostenibilidad del Estado de Bienestar requiere dar respuesta a los retos del envejecimiento, la cronicidad y la disrupción tecnológica.
- Existen avances relevantes en torno al concepto de valor en salud, a su medición y a su mejora.
- Determinar el valor del cuidado plantea importantes retos, pero ya se dispone de herramientas muy prometedoras.
- Financiar modelos de atención integrada por valor requiere reconocer y analizar la eficiencia/equidad de los distintos subsistemas, que presentan claros vasos comunicantes.
- Los esquemas de pago por valor presentan resultados diversos, son muy contextuales y dependientes de detalles en su implementación.

Muchas gracias



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