PEOPLE-CENTRED POPULATION HEALTH MANAGEMENT IN GERMANY

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Summary: Since 2006 the Gesundes Kinzigtal (GK) model has demonstrated how a people-centred focus on population health management can lead to significant gains in achieving the Triple Aim of better population health, improved experience of care, and reduced per capita costs. Through a strong management organization, a sophisticated data management system, and a trusting relationship between network partners and the communities, the GK model has been able to provide better outcomes for all partners involved.

Keywords: People-Centred Care, Population Health Management, Integrated Care Outcomes, Germany

Background

In Europe, cardiovascular diseases, cancer, diabetes, obesity, and chronic respiratory diseases account for an estimated 77% of the disease burden as measured by disability-adjusted life years. Between 70% and 80% of health care costs in Europe are due to chronic disease management. In monetary terms, this corresponds to €700 billion and this figure is expected to increase substantially in coming years. This represents a major challenge for health systems across Europe and has profound social and economic implications, as patients with chronic conditions often require treatment and care from different practitioners in multiple institutions and settings over time. However fragmented governance and funding mechanisms, misaligned incentives, and vested interests often impede a continuum of care. Not surprisingly, poorly integrated systems are frequently associated with inefficiencies, consumer dissatisfaction, and restricted access to and poor quality of health care services.

Given the evidence and experience of the past 15 years, it is now widely accepted that in order to achieve a safe, effective, patient-centred, timely, efficient, and equitable health care system, we need to overcome the fragmentation of care and strengthen the focus on population health.

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population health management and the Triple Aim approach as the underlying guiding principle.

**Tackling the challenges of the 21st century in Germany**

The German health system is characterized by federalization, whereby the ‘Laender’ (federal state) is in charge of implementing national health policies. Key stakeholders in the operationalization, delivery and design of health services at the regional and local level are the health insurance companies and sickness funds, of which there are non-for profit and private ones, all competing for potential insureds. German citizens have (in principle) free choice between the public, non-profit and private insurances, but they are obliged by law to be insured (i.e., one cannot opt-out of the system). As the birthplace of the Bismarck system, the German health (insurance) system is a highly competitive but also highly regulated system. It is characterized by frequent national health reforms, resulting in constant adjustments but maintaining the key features of a publicly funded health system, including: strong stakeholder organizations and decentralized governance, clear accountability pathways and funding structures.

In tackling the challenges of the 21st century, a decisive stimulant for change came in 2000 and increased in 2004, with the introduction of a national health reform regulating that henceforth health insurances and provider coalitions could offer integrated care options to patients. The initiative also provided seed money for the development and implementation of integrated care projects. One well-researched – and successful – example of an integrated care system is the *Integrierte Versorgung Gesundes Kinzigtal* model, referred to hereafter as the GK model. The model is designed around the Triple Aim approach and based on promoting a governance model that prioritizes strong stakeholder consensus building towards achieving population health. An independent management organization acts as the regional integrator, brings together the stakeholders involved in service provision and systematically monitors the implementation of the GK model. Based on a dynamic and well-developed data management system, the GK model features a continuous learning environment, which also serves to inform further development and innovation of the services and programmes.

The GK model is based on a population health management approach, identifying the patients and the community as key partners in care. Population health management is an integral part of people-centred care, by using the needs of the people as the prerequisite for the planning of services. These then need to be addressed on two levels. First, these person- or patient-centred care services develop individual care plans through shared decision-making. Secondly, strong community engagement and increased health literacy leads to informed choice and co-design of services.

The three targets of the Triple Aim model are: 1) better population health; 2) improved experience of care; and 3) reduced per capita costs. The model was built on substantial evidence from research and practice related to success factors for health care integration.

This accumulated evidence helped identify several necessary components for attaining the Triple Aim. These are: developing a clear (regionally defined) reference population; external policy constraints (such as a total budget limit, assumption of financial responsibility for the population, or the requirement that all groups should be treated equitably); and the presence of a regional integrator to take responsibility for the three aims. The integrator plays a crucial role in establishing partnerships with individuals and families, redesigning health and care services, managing population health, achieving system integration at the management level, and implementing tailored solutions with the involvement of stakeholders.

**Strengthening people and communities to improve population health**

The GK model adopted these key principles and since 2006 has taken up the role of regional integrator for the population of the area. Set up as an accountable care organization between a network of physicians and a management company, GK holds long-term contracts with two German non-profit sickness funds to integrate health and care services for their insured populations in Kinzigtal. Currently, they have enrolled approximately half of the 71,000 inhabitants in their programmes. Since 2006, GK has held ‘virtual accountability’ for the health care budget of this population, and since January 2016, a new contract assigns the GK management company full financial accountability. If the sickness funds spend less on health care for this group than standardized, risk-adjusted costs, GK shares the benefits with the sickness funds and reinvests the savings into the extension and improvement of the model. Thus, a shared health savings account is created.

In order to achieve the Triple Aim, the GK model focussed on improving population health in the region from the very beginning, and targeted programmes for people with chronic illness. Thus, a patient-centred care approach is embedded at three levels: at the structural level by including patients in biannually elected patient-advisory boards, and giving patients opportunities to contribute to identifying and developing new programs; at the level of intervention, by embedding a strong focus on shared-decision making and supported self-management in design and development; and at the level of individual doctor-patient interactions, by providing patients a comprehensive health check (including a self-assessment questionnaire), based on which the appropriate programmes and services are offered. Patients are also given the
opportunity to set health-related goals (i.e., doing more exercise, giving up smoking, reducing alcohol consumption, or losing weight), which are then discussed with the physician and monitored, accompanied by individual support and participation in patient education and self-care programmes on an as-needed basis. Programmes to support families and caregivers complement the services offered to the patients.

On the population level, programmes to strengthen health literacy and primary prevention are offered through the “Healthy Kinzigtal Academy” and lectures on health and self-management for a whole variety of diseases and health issues. A magazine and TV channel, available in 22 GP practices or health centres, inform people about upcoming activities, courses, classes and health improvement programmes on a continuous basis. Health festivals are also held to provide people with a fun and relaxed setting in which they can try out different types of physical activity. Furthermore, GK developed a specific employee health management programme targeting small and medium-sized enterprises, which normally would not have the resources to provide such programmes in-house.

Another success factor lies in a strong network of service providers, many of which do not belong to the health sector. GK has established cooperation with 38 community organizations like local sports clubs, associations for people with disabilities, dancing and hiking clubs, women’s groups, and kids clubs, in addition to closely collaborating with ten local self-help groups. In cooperation with 14 local community councils, GK has designed a wide variety of activities to engage local inhabitants, strengthen local networks, and incentivize people to engage in social activities. GK established two walking trails for memory training, hiking trails for children and their parents, and developed a joint community centre with nurses and housing options in development.

Improving outcomes for all partners involved: demonstrating impact

The impact of all activities is evaluated in terms of implementing the Triple Aim approach has been supported by two independent, scientific evaluation studies. The first involves conducting a biannual random survey with enrollees who set an objective agreement with their physician would recommend becoming a member to their friends or relatives. Participants die 1.4 years later (78.9 vs 77.5 control) 98.9% of enrollees who state that, overall, they have lived a healthier life since joining GK (with 0.4% stating the contrary and 54% stating no change, p>0.001). The second is a quasi-experimental study comparing the intervention population to a matched random sample of around 500,000 insurance members from neighbouring regions.

The financial results have been assessed in relation to the development of the contribution margin described above. Routine data analysis has shown a decrease in the overuse of health services for the prescription of anxiolytics, antibiotics for higher respiratory tract infections, non-steroidal anti-rheumatics, non-recommended prescription for vascular dementia, non-recommended prescription for Alzheimer dementia, and an increase in the prescription of antiplatelet drugs and statin (where appropriate) for patients with chronic coronary heart disease (CHD), prescriptions of statins for patients with an acute myocardial infarct (AMI), cardiology referrals for patients diagnosed with heart insufficiency.

According to routine data, there are still a number of indicators that haven’t yet shown a significant change, perhaps due to insufficient observational time. For two indicators – AMI patients on beta blockers and osteoporosis patients with indicated medication – the analysis suggests a deterioration. Overall, a propensity score matched control group suggests an increase in life expectancy by 1.4 years, and ten years since inception of the project. Overall costs have developed favourably compared to expected costs, with annual savings amounting to €5.5 million in 2013. This difference is expected to further increase in the coming years as some of the health programmes will start paying off years after the initial intervention. The reasons for the observed effects are not yet fully understood and

Figure 1: Achieving the Triple Aim in Gesundes Kinzigtal

(Source: Authors’ own.)

евереду €5.5M surplus improvement for the two sickness funds in the Kinzigtal region in 2013 against €75M norm costs

45.4% stated they now live a healthier life (compared to 0.6% stating the contrary and 54% stating no change, p>0.001). The second is a quasi-experimental study comparing the intervention population to a matched random sample of around 500,000 insurance members from neighbouring regions.

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further, long-term evaluation is needed to assess whether, and to what extent, these results can be further enhanced through improving quality and greater citizen and provider engagement.

Conclusions

The GK model demonstrates that a focus on population health management and providing a continuum of care, including health promotion and primary prevention, can lead to cost-effective solutions, while also strengthening communities and healthier people. The model also underlines the importance of taking an inter-sectoral approach even when working at the local and regional level, since so many determinants outside the health system influence the health and wellbeing of people. Establishing lasting, trusting and respectful relationships with and between health service providers, social and community services, private enterprises and local councils was another factor in developing these successful people-centred services. Finally, long-term and sustainable change can only be achieved with the help of a strong evaluation and monitoring framework in order to understand the impact of the interventions, identify risk factors early on, and design and improve the services based on evidence and predictive modelling. Looking more closely at health inequalities and strengthening patient-related outcomes and experience measures are also essential.

References


Lessons from transforming health services delivery: Compendium of initiatives in the WHO European Region

Copenhagen: WHO Regional Office for Europe, 2016


In order for health services delivery to accelerate gains in health outcomes it must continuously adapt and evolve according to the changing health landscape. At present, the case for change is compelling. In the context of both new challenges and opportunities, initiatives to transform services delivery across the WHO European Region has emerged. This Compendium demonstrates the diversity in activity, describing examples of health services delivery transformations from each Member State in the Region. The initiatives vary greatly in their scope and stages of implementation, from early changes to initiatives at-scale. When taken together, these examples offer unique insights for setting-up, implementing and sustaining transformations. A summary of 10 lessons learned attempts to synthesize key findings and consolidate insights derived from experiences.