Global Burden of Chronic Mental and Behavioural Disorders

Years lived with disability (YLDs), 2017

Number of total YLDs, global, both sexes, by age group and cause, 2017

Socioeconomic impact of CM&BDs
High Cost to Economies, Health Systems, Households and Individuals

Key drivers:

- **Economies**
  - Reduced labor supply
  - Reduced labor output (e.g., cost of absenteeism)
  - Additional costs to employers (e.g., productivity, insurance)
  - Lower returns on human capital investments
  - Lower tax revenues
  - Increased public health and social welfare expenditures

- **Health systems**
  - Increased consumption of NCD-related healthcare
  - High medical treatment costs (per episode and over time)
  - Demand for more effective treatments (e.g., cost of technologies and innovations)
  - Health system adaptation (e.g., organization, service delivery, financing) and adaptation costs

- **Households and individuals**
  - Reduced well-being
  - Increased disabilities
  - Premature deaths
  - Household income decrease, loss, or impact (debt)
  - Higher health expenditures, including catastrophic spending
  - Savings and asset loss
  - Reduced opportunities

Example impact areas:

- Country productivity and competitiveness
- Fiscal pressures
- Health outcomes
- Poverty, inequality, and opportunity loss


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INTEGRATED CARE

COMMUNITY

- Supportive environment
  - Public health
  - Community action

HEALTH SYSTEMS

- Self-management
  - Delivery system
  - Information system
  - Decision support

PRODUCTIVE

- Informed, activated patient
- Prepared, proactive practices team
- Support partners

Improved outcomes

- Education + empowerment + involvement of patient + process
- Patient-centred
- Multidisciplinary
- Integrated disease management
- Consumer + public health + social + research
- Affected policies
Is the CCM / IC implemented?

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<th>Organisation of healthcare</th>
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<th>Clinical information systems</th>
<th>Community and policies</th>
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Notes: X Implemented Systematic steps towards implementation Not implemented

Source: Epposi White Paper 2012

Who we are?

9 Health and Social Care Authorities:
- Flanders Agency for Health and Care, Belgium
- Optimedis, Germany
- AReSS Puglia, Italy
- Vilnius University Hospital, Latvia
- National Health Fund, Poland
- TEC Division, Scottish Government (Coordinator)
- Pavol Jozef Safarik University, Slovakia
- Social Protection Institute of the Republic of Slovenia
- Osakidetza, Basque Country, Spain

3 Universities and Competence Centers
- University of Edinburgh, Scotland
- University of Valencia, Spain
- Kronkgune, Basque Country, Spain

2 Membership Organisations
- EHTEL (European Health Telematics Association), Belgium
- AER (Assembly of European Regions), France

Budget: €2,649,587
Start: 1 January 2019
Aim of SCIROCCO Exchange

“To support the readiness and capacity of health and social care authorities for the adoption and scaling up of integrated care by facilitating their access to tailored, evidence-based assets on integrated care and supporting personalised knowledge transfer and improvement planning.”

Why Integrated Care?

The evidence suggests that developing more integrated person-centred care has the potential to generate significant improvements in the health and care of all citizens, including better access to care, health and clinical outcomes, health literacy and self-care; increased satisfaction with care; and improved job satisfaction for health and care professionals, efficiency of services and reduced overall costs.

crosscutting, connecting & engaging stakeholders across sectors, from private & public sector

The King’s Fund, 2014
What conditions enable the successful adoption and scaling-up of integrated care?

How to change existing boundaries and behaviours to work differently; in more co-ordinated and integrated way?

How to support leaders and all stakeholders involved to adopt a long journey of change towards the transformation and succeed in their efforts?

How to share learning more widely to build sustainable integrated care systems?

Maturity Model for Integrated Care

Local context matters!

B3 Maturity Model for Integrated Care

Qualitative assessment based on interviews and desk research

Phase 1: Interviews with 6 regions involved in EIP AHA (Feb – April 2014)
Athens; Basque Country; Catalonia; Galicia; N Ireland; Saxony

Phase 2 Interviews with 6 regions involved in EIP AHA (Jan– March 2015)
S Denmark; Skane; Scotland; Puglia; Delft; Olomouc

European Innovation Partnership on Active and Healthy Ageing
SCIROCCO Tool for Integrated Care
https://scirocco-exchange-tool.inf.ed.ac.uk

Online self-assessment tool to address the challenge of adoption and scaling-up of integrated care

Validated and tested in over 65 regions/organisations

If the existing systems of care need to be re-designed to provide a more integrated set of services, this will require change across many levels, the creation of new roles, processes and working practices, and new systems to support information sharing and collaboration across care teams. This will be disruptive and may be viewed negatively by workers, press and public, so a clear case needs to be made for those changes, including a justification, a strategic plan, and a vision of better care.

Assessment scale

0– No acknowledgment of compelling need to change
1– Compelling need is recognised, but no clear vision or strategic plan
2– Dialogue and consensus-building underway; plan being developed
3– Vision or plan embedded in policy; leaders and champions emerging
4– Leadership, vision and plan clear to the general public; pressure for change
5– Political consensus; public support; visible stakeholder engagement
Using the SCIROCCO Tool
https://scirocco-exchange-tool.inf.ed.ac.uk

Are we ready for integrated care?

Strengths

Weaknesses

05/09/2019
Are all stakeholders involved?

Can we agree on common priorities?
Can we learn from others?

Knowledge transfer as an enabler of capacity-building support

“Knowledge transfer is a “contact sport”; it works better when people meet to exchange ideas and spot new opportunities” – Tim Minshall

1. Maturity assessment for integrated care
2. Capacity-building assets
3. Knowledge transfer
4. Improvement Plans
Disclaimer

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