Prevenzione, sanità d’iniziativa, paziente esperto: una riflessione

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A Potential Decline in Life Expectancy in the United States

SUMMARY

Forecasts of life expectancy are an important component of public policy that influence age-based entitlement programs such as Social Security and Medicare. Although the Social Security Administration recently raised its estimates of how long Americans are going to live in the 21st century, current trends in obesity in the United States suggest that these estimates may not be accurate. From our analysis of the effect of obesity on longevity, we conclude that the steady rise in life expectancy during the past two centuries may soon come to an end.
USA. Mappa della prevalenza dell’obesità negli Stati (in rosso scuro la prevalenza è uguale o superiore al 30%).
USA. Mappa delle contee in cui la speranza di vita alla nascita mostra uno stop nella crescita o una regressione (punti arancioni e rossi).
Differences In Disease Prevalence As A Source Of The U.S.-European Health Care Spending Gap

Americans are diagnosed with and treated for several chronic illnesses more often than their European counterparts are.

by Kenneth E. Thorpe, David H. Howard, and Katya Galactionova

ABSTRACT: The United States spends more on health care than any European country. Previous studies have sought to explain these differences in terms of system capacity, access to technologies, gross domestic product, and prices. We examine differences in disease prevalence and treatment rates for ten of the most costly conditions between the United States and ten European countries using surveys of the noninstitutionalized population age fifty and older. Disease prevalence and rates of medication treatment are much higher in the United States than in these European countries. Efforts to reduce the U.S. prevalence of chronic illness should remain a key policy goal. [Health Affairs 26, no. 6 (2007): w678–w686 (published online 2 October 2007; 10.1377/hlthaff.26.6.w678)]
Tabella 3. Prevalenza di condizioni morbose e fattori di rischio nei soggetti di 50 aa. e oltre. USA e 10 paesi europei*, 2004

<table>
<thead>
<tr>
<th></th>
<th>USA</th>
<th>Europa</th>
<th>EUROPA</th>
<th>USA/Europa differenza</th>
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<tbody>
<tr>
<td>Malattie cardiache</td>
<td>21,8</td>
<td>11,4</td>
<td>10,4</td>
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<tr>
<td>Ipercolesterolemia</td>
<td>21,7</td>
<td>19,6</td>
<td>2,1</td>
<td></td>
</tr>
<tr>
<td>Ictus/Malattie cerebrovascolari</td>
<td>5,3</td>
<td>3,5</td>
<td>1,8</td>
<td></td>
</tr>
<tr>
<td>Diabete</td>
<td>16,4</td>
<td>10,9</td>
<td>5,5</td>
<td></td>
</tr>
<tr>
<td>Malattie polmonari croniche</td>
<td>9,7</td>
<td>5,4</td>
<td>4,3</td>
<td></td>
</tr>
<tr>
<td>Asma</td>
<td>4,4</td>
<td>4,3</td>
<td>0,1</td>
<td></td>
</tr>
<tr>
<td>Cancro</td>
<td>12,2</td>
<td>5,4</td>
<td>32,5</td>
<td></td>
</tr>
<tr>
<td>Osteoporosi</td>
<td>5,0</td>
<td>7,8</td>
<td>-2,8</td>
<td></td>
</tr>
<tr>
<td>Cancro</td>
<td>12,2</td>
<td>5,4</td>
<td>6,8</td>
<td></td>
</tr>
<tr>
<td>Obesità</td>
<td>33,1</td>
<td>17,1</td>
<td>16,0</td>
<td></td>
</tr>
<tr>
<td>Fumatori</td>
<td>20,9</td>
<td>17,8</td>
<td>3,1</td>
<td></td>
</tr>
<tr>
<td>Ex-Fumatori</td>
<td>31,7</td>
<td>25,2</td>
<td>6,5</td>
<td></td>
</tr>
<tr>
<td>Mai fumato</td>
<td>47,3</td>
<td>57,0</td>
<td>9,7</td>
<td></td>
</tr>
</tbody>
</table>

* Austria, Danimarca, Francia, Germania, Grecia, Italia, Olanda, Spagna, Svezia, Svizzera.

Fonte: Rif. Bibliog. 11
OBESITY BY COUNTRY (OECD)
Sovrappeso e obesità per regione, bambini di 8-9 anni della 3ª primaria. Italia, 2008

* Dati stimati
LA STORIA NATURALE DELLE MALATTIE CRONICHE
Popolazione sana

Gruppi di popolazione esposta a rischi

Pazienti con patologie croniche "semplici"

Pazienti con patologie croniche "complicate"

Pazienti con patologie croniche "complicate e gravi"
Sanità d’iniziativa

Promozione della salute

Popolazione sana

Gruppi di popolazione esposta a rischi

Pazienti con patologie croniche “complicate”

Pazienti con patologie croniche “semplici”

Pazienti con patologie plurime e “grave”
Malattie croniche.
La catena delle cause

Determinanti sociali
- Reddito
- Istruzione
- Classe sociale

Fattori di rischio
- Sedentarietà
- Eccesso di peso
- Fumo
- Alcol

Assistenza sanitaria
- Accessibilità
- Utilizzazione
- Qualità
Improving Primary Care for Patients With Chronic Illness

Thomas Bodenheimer, MD
Edward H. Wagner, MD, MPH
Kevin Grumbach, MD

Mr Sugarman, a 64-year-old patient with diabetes, comes for his 15-minute visit with Dr Madden. After evaluating Mr Sugarman's acutely painful knee and treating his gastroesophageal reflux disease, Dr Madden has 3 minutes left to assess diabetic control. Having fruitlessly searched through Mr Sugarman's medical records to find the last...
Improving Primary Care for Patients With Chronic Illness
The Chronic Care Model, Part 2

Thomas Bodenheimer, MD
Edward H. Wagner, MD, MPH
Kevin Grumbach, MD

A previous article described the chronic care model, a guide to improving the management of chronic illness, particularly within primary care. That article featured several case studies of organizations that have implemented components of the model. This article examines research evidence demonstrating that components of the model can improve quality and reduce costs and examines some barriers to widespread adoption.

This article reviews research evidence showing to what extent the chronic care model can improve the management of chronic conditions (using diabetes as an example) and reduce health care costs. Thirty-two of 39 studies found that interventions based on chronic care model components improved at least 1 process or outcome measure for diabetic patients. Regarding whether chronic care model interventions can reduce costs, 18 of 27 studies concerned with 3 examples of chronic conditions (congestive heart failure, asthma, and diabetes) demonstrated reduced health care costs or lower use of health care services. Even though the chronic care model has the potential to improve care and reduce costs, several obstacles hinder its widespread adoption.

JAMA. 2002;288:1909-1914

www.jama.com
THE CHRONIC CARE MODEL

Community
- Resources and policies

Health System
- Organization of Health Care
  - Self-management support
  - Delivery system design
  - Decision support
  - Clinical information systems

- Informed activated patient
- Productive interactions
- Prepared proactive practice team

Functional and clinical outcomes
Piano Sanitario Regionale
Aggiornamento ai sensi dell’art.18, comma 3, e dell’art.142, comma 3 della L.R. 40/2005

Parte Prima
UN PIANO PER LA SALUTE, UNA SANITÀ D’INIZIATIVA
Evidence On The Chronic Care Model In The New Millennium

Thus far, the evidence on the Chronic Care Model is encouraging, but we need better tools to help practices improve their systems.

by Katie Coleman, Brian T. Austin, Cindy Brach, and Edward H. Wagner

ABSTRACT: Developed more than a decade ago, the Chronic Care Model (CCM) is a widely adopted approach to improving ambulatory care that has guided clinical quality initiatives in the United States and around the world. We examine the evidence of the CCM’s effectiveness by reviewing articles published since 2000 that used one of five key CCM papers as a reference. Accumulated evidence appears to support the CCM as an integrated framework to guide practice redesign. Although work remains to be done in areas such as cost-effectiveness, these studies suggest that redesigning care using the CCM leads to improved patient care and better health outcomes. [Health Affairs 28, no. 1 (2009): 75–85; 10.1377/hlthaff.28.1.75]

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2012</th>
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<tbody>
<tr>
<td>Diabete tipo 1</td>
<td>29.000</td>
<td>156.000</td>
</tr>
<tr>
<td>Diabete tipo 2</td>
<td>1.948.000</td>
<td>3.749.000</td>
</tr>
<tr>
<td>Cancro della mammella</td>
<td>67.000</td>
<td>126.000</td>
</tr>
<tr>
<td>Cardiopatia ischemica</td>
<td>635.000</td>
<td>1.700.000</td>
</tr>
<tr>
<td>Asma</td>
<td>6.000</td>
<td>799.000</td>
</tr>
<tr>
<td>BPCO</td>
<td>8.000</td>
<td>633.000</td>
</tr>
<tr>
<td>Totale</td>
<td>2.693.000</td>
<td>7.163.000</td>
</tr>
</tbody>
</table>
**Mortality And Major Diabetic Complications In Intervention (Enrolled) And Control Groups, German Disease Management Program, 2007**

<table>
<thead>
<tr>
<th>Mortality</th>
<th>Intervention</th>
<th>Percent</th>
<th>Control</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td></td>
<td>Number</td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td>458</td>
<td>2.30</td>
<td>935</td>
<td>4.70</td>
</tr>
<tr>
<td><strong>DIABETIC COMPLICATIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myocardial infarction (ICD: I21, I22)</td>
<td>165</td>
<td>0.83</td>
<td>219</td>
<td>1.10</td>
</tr>
<tr>
<td>Stroke (ICD: I63)</td>
<td>180</td>
<td>0.91</td>
<td>226</td>
<td>1.14</td>
</tr>
<tr>
<td>Chronic renal insufficiency (ICD: N18, N19)</td>
<td>71</td>
<td>0.36</td>
<td>94</td>
<td>0.74</td>
</tr>
<tr>
<td>Amputation of lower leg or foot (OPS: 5-865, 5-864)</td>
<td>95</td>
<td>0.48</td>
<td>152</td>
<td>0.76</td>
</tr>
<tr>
<td>Occurrence of at least one of the four complications</td>
<td>496</td>
<td>2.49</td>
<td>667</td>
<td>3.35</td>
</tr>
</tbody>
</table>

Figura 2. Numero di pazienti per 1000 pazienti partecipanti al programma che sono stati ricoverati almeno una volta con la diagnosi descritta (in confronto con i pazienti non partecipanti). 2006.

Exhibit 3. Number of Patients per 1,000 Enrolled Program Participants Who Were Hospitalized at Least Once with the Described Diagnosis, 2006

Patients per 1,000 insured

Lower extremity, male 0.8 1.9
Foot, male 4.1 6.0
Foot or leg, male 4.5 7.3
Lower extremity, female 0.2 1.4
Foot, female 1.5 2.7
Foot or leg, female 1.6 3.8

Notes: Lower extremity = amputation below the knee; foot = amputation of whole foot or part of foot or toes; foot or leg = not specified.
Various Cost And Health Services Use Indicators In Intervention (Enrolled) And Control Groups, German Disease Management Program, 2003–7

<table>
<thead>
<tr>
<th></th>
<th>Intervention</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall cost difference, 2007-2003</td>
<td>US$1,443.65</td>
<td>US$1,890.40</td>
</tr>
<tr>
<td>Overall costs, 2007</td>
<td>US$5,273.99</td>
<td>US$5,896.54</td>
</tr>
<tr>
<td>Hospital costs, 2007</td>
<td>US$2,664.71</td>
<td>US$3,292.65</td>
</tr>
<tr>
<td>Drug costs, 2007</td>
<td>US$2,609.28</td>
<td>US$2,603.89</td>
</tr>
<tr>
<td>Length of hospitalization per insured, days, 2007 (mean/median)</td>
<td>4.97/0.00</td>
<td>6.41/0.00</td>
</tr>
<tr>
<td>Number of hospital stays per insured, 2007 (mean/median)</td>
<td>0.55/0.00</td>
<td>0.62/0.00</td>
</tr>
</tbody>
</table>

The ten characteristics of the high-performing chronic care system

Chris Ham

Health Economics, Policy and Law / Volume 5 / Issue 01 / January 2010, pp 71 - 90
DOI: 10.1017/S1744133109990120, Published online: 07 September 2009

The Chronic Care Model

The Chronic Care Model developed by Wagner provides a framework for describing the elements needed in a system that aspires to provide high-quality care for people with chronic diseases (Wagner, 1998). The Model was based on a review of available literature about promising strategies for chronic illness management, much of which derived from experience in European health care systems.

The Chronic Care Model has been used in a range of settings to support the reorientation from acute care to chronic care (Singh and Ham, 2006).
The ten characteristics of the high-performing chronic care system
The first and arguably most important characteristic of the high-performing chronic care system is ‘ensuring universal coverage’, for without universal coverage it is difficult to act consistently on the other characteristics. Recent

The second characteristic is the provision of ‘care that is free at the point of use’, or at least care that is provided at a cost that does not act as a major deterrent to sick patients seeking medical help. The RAND study of the Health Care Finance Agency of the Department of Health estimated that 76% of primary care was free or at a low cost. The study concluded that:

The third characteristic is that ‘the delivery system should focus on the prevention of ill health’ and not just the treatment of sickness. Despite progress in a
The fourth characteristic is that ‘priority is given to patients to self manage their conditions with support from carers and families’. The importance of self-

The fifth characteristic is that ‘priority is given to primary health care’. This

The sixth characteristic is that ‘population management is emphasised’ through the use of tools to stratify people with chronic diseases according to their risk and offering support commensurate with this risk.

The seventh characteristic is that ‘care should be integrated to enable primary health care teams to access specialist advice and support when needed’. The
The eighth characteristic, closely linked to the last point, is ‘the need to exploit the potential benefits of information technology in improving chronic care’. Not least, information technology underpins effective population man-

The ninth characteristic is to ensure that ‘care is effectively coordinated’. Coordination is particularly important in the care of people with multiple conditions who are at much greater risk of hospital admission than people with single diseases (Wolff et al., 2002). The role of primary care physicians in providing coordination has been emphasised in a number of studies (Starfield

The tenth characteristic, alluded to in the review of the evidence above, is to ‘link these nine characteristics into a coherent whole as part of a strategic approach to change’. This is important in view of evidence that it is the cumulative effect of different elements that explains the degree of impact of the Chronic Care Model rather than individual components. By extension, the argument of this paper is that
Conclusion

The evidence indicates that a start has been made in reorienting health care systems to meet the challenge of chronic diseases.

Guided by the Chronic Care Model, policy makers and health care leaders are beginning to take the actions required to rise to this challenge.
CCM- Estensione a livello regionale: stato attuale

<table>
<thead>
<tr>
<th>Copertura popolazione &gt; 16</th>
<th>43% (ca. 1.350.000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N. MMG coinvolti</td>
<td>1.098</td>
</tr>
<tr>
<td>N. moduli sanità di iniziativa attivati</td>
<td>137</td>
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</tbody>
</table>

Pazienti in carico PDTA Sanità di iniziativa in Regione Toscana

<table>
<thead>
<tr>
<th></th>
<th>N. assistiti in carico</th>
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<tbody>
<tr>
<td>Diabete</td>
<td>60.750</td>
</tr>
<tr>
<td>Scompenso Cardiaco</td>
<td>13.500</td>
</tr>
<tr>
<td>BPCO</td>
<td>33.750</td>
</tr>
<tr>
<td>Ictus/ TIA</td>
<td>27.000</td>
</tr>
</tbody>
</table>

Si stima che circa il 9,1% degli assistiti di un MMG sia in carico ai PDTA Sanità di Iniziativa.