Medical and economic issues in managing chronic (long-term) conditions (the French ALD scheme)

As it publishes its first recommendations on chronic conditions, starting with diabetes and hepatitis C, HAS highlights the intricate relationship between the medical and financial objectives of the current chronic condition management system. The implications of this system for the French health service are such that a broad debate on these issues is essential.

Article L.322-3 of the Social Security Code states that chronic conditions are 'conditions requiring long-term care and particularly costly treatment', entitling those affected to exemption from partial payment for their treatment. The health service covers all their treatment costs within the range of items that qualify for reimbursement.

Chronic conditions since 1945

The chronic conditions management scheme dates back to the beginnings of National Health Insurance in 1945. It was created in order to enable the social security system to pay the full cost of the care given to patients suffering from 'conditions requiring long-term care and particularly costly treatment', so that the partial payment requirement (which is laid down in general law) should not become a financial obstacle to healthcare. The scheme became increasingly important in supporting the medical objective of raising standards of care management for these patients. It is clear today, however, that the scheme no longer meets its objectives and is poorly adapted to the current health system. Nonetheless, its aim of providing financial support needs to be preserved in today's context, in which chronic diseases are becoming more common as the population ages, at the same time as medical advances have transformed the outlook for these patients. That means that the issues at stake and the priorities of the system need to be redefined.

A major public health challenge

Over the last 10 years, the number of patients included in the chronic condition management system has been rising at a rate of over 5% per year; they now number almost 8 million, and the care given for such conditions now accounts for nearly 60% of the total expenses reimbursed by National Health Insurance (NHI). This growth is mainly due to better patient care, an improved quality of life and a better prognosis. The increase in life expectancy has resulted in a rise in the proportion of chronic conditions associated with old age, such as cardiovascular diseases, dementia and diabetes.

The reform of the management of chronic conditions, as laid down in the law of 13 August 2004, is therefore a major public health issue in France. It has medical, economic, social and human implications, in that the diseases concerned are serious and the patients affected are among the most vulnerable.
Chronic conditions and the law

The chronic condition management system is governed by Articles D-322-1, L 322-3 and L 324-1 of the Social Security Code. The amount paid by the patient towards the cost of care may be capped or waived completely in the case of chronic conditions, when it is recognised that the beneficiary has one of 30 listed conditions (the list being established by decree) or a disease not on the list but requiring extended care or particularly costly treatment, commonly termed diseases 31 and 32. These two diseases account for roughly 9% of the patients included in the system, or about 100 000 people a year.

While the concepts of cost and duration are associated in the legal texts, only duration is given a regulatory definition: care must be continuous for more than six months before an entitlement to exemption arises. The concept of cost, however, has not been explicitly defined since 1986.

The law of 13 August 2004 based the reform of the NHI scheme around the concepts of the primary care doctor and the care pathway. Within this framework, it made it compulsory to draw up a care protocol for patients with chronic conditions, to be prepared by the patient’s doctor, validated by the NHI medical adviser and signed by the patient or his/her legal representative.

Chronic conditions and HAS’ three-fold remit

The law of 13 August 2004 also sets out HAS’ three missions in relation to chronic conditions. These tasks are consultative and complementary: (i) to issue its opinion on the list of conditions concerned; (ii) to draw up recommendations on the procedures and services required to treat these diseases; and (iii) to draw up recommendations on the medical criteria (which may correspond to disease stages) for a patient to be included in the system.

To address these tasks, HAS has started to re-examine the 30 chronic conditions on the current list. It published its first recommendations (the doctors’ guides and lists of procedures and services required to manage chronic hepatitis C and type 1 and 2 diabetes) on 31 May 2006. It also issued general recommendations on the chronic condition management system.

Chronic conditions: a management system designed to meet two different objectives

HAS has found it necessary to look into the overall consistency of the chronic condition management system.

- It has found discrepancies among chronic conditions as to the medical criteria for admission. For example, in the case of type-2 diabetes, a patient may be admitted at any stage of the disease, whereas patients suffering from chronic respiratory failure or depression are only admitted when the disease has reached an advanced stage. In addition, an assessment of the cost of providing optimal management has shown that cost is not always related to the stage or severity of the disease, as in uncomplicated type-2 diabetes or in untreated or post-treatment hepatitis C.

- Furthermore, the list of items currently qualifying for reimbursement does not include certain medically necessary activities or procedures, such as foot care in the event of diabetic complications, or structured patient education.

- In addition, HAS’ analysis has highlighted the fact that the system has two separate objectives, a medical objective and a financial assistance objective. Historically, the procedure for admission to the chronic condition management system has been a financial mechanism aimed at ensuring that everyone has access to the most expensive care. However, all the stakeholders in the system, patients most of all, now associate admission to the system (with total healthcare cover) with quality of care. The listed
chronic conditions have come to mean coordinated medical care since there is no structured follow-up system that covers all chronic diseases.

Consultation prior to changing the exemption list
Because of this ambiguity and the need to progressively re-examine the full list of chronic conditions, the HAS Board has decided that it is still too early to redefine the medical criteria currently in force for inclusion in the chronic condition management system, particularly as this task is part of a much wider issue, many aspects of which do not fall within its remit.

That is why HAS has recommended launching a public debate among all stakeholders – patients, health professionals, funding bodies and decision-makers. The debate must focus on: (i) the necessary distinction between quality of care and exemption from payment, (ii) defining what constitutes ‘particularly costly’ care, and (iii) society’s role in covering the increased risk. It advocates extending the idea of care pathways and protocols to all chronic diseases and no longer just those that attract exemption. Additionally, it proposes changing the list of items qualifying for reimbursement to cover all procedures and services required in the treatment of chronic conditions.

The first doctors’ guides for diabetes and hepatitis C management
HAS has provided health professionals with new tools to meet the immediate challenge of implementing the new healthcare protocols, with a view to improving the quality of treatment. They consist of two Lists of Procedures and Services required to manage patients with diabetes and with chronic hepatitis C, and four Doctors’ Guides on type-1 diabetes in adults, type-1 diabetes in children and young people, type-2 diabetes, and chronic hepatitis C. These conditions were prioritised because they are common – diabetes is the most frequent chronic condition, with 1.5 million patients affected – serious, and/or expensive to manage, as may be the case with hepatitis C.

The new tools draw on existing clinical practice guidelines but are a highly practical approach to treating patients in a coordinated fashion within an outpatients environment. They describe ideal patient management in detail (initial assessment, treatment and follow-up) as well as the exact care pathway followed by a patient admitted into the chronic condition management system for their disease. They also specify which procedures and services qualify for 100% reimbursement.

These tools will be updated at least every three years, or more often if medical advances so require; they will also be adjusted in accordance with reactions to their use on the ground after their introduction.

Specifically designed tools
A scientific, collaborative approach was used to produce the tools, involving all stakeholders at every stage of the process.

The documents were drawn up taking account of all existing clinical practice guidelines published in France and elsewhere over the last five years, as well as information from the chronic disease monitoring programmes that have been set up in certain countries. All this information, together with expert opinions specifying follow-up methods and timescales, was brought together in the Doctors’ Guides. The procedures and services needed to manage a chronic condition were summarised in the Lists. All the documents were scientifically validated by a working group composed of health professionals (representatives of general and specialist medical associations) and patient representatives. A project manager coordinated the work for each chronic condition.
The operability of the proposals in daily practice was then tested by general practitioners, NHI medical advisers and patients’ associations; their comments were gathered and any difficulties encountered were noted.

Once the proposals had been assessed for their economic impact, the Doctors’ Guide and the List of Procedures and Services for each chronic condition were validated by the Committee for Healthcare Cover for Long-Term Conditions, then by the HAS Board.

The Doctors’ Guides, the Lists of Procedures and Services and the new healthcare protocol

These tools, particularly the List of Procedures and Services, are intended to help in drawing up the care protocol required by law to be agreed on by the doctor, the patient and the NHI medical adviser. The protocol sets out the rights and obligations of the patient. By signing it, the patient becomes a full partner in his/her own medical care. The HAS guidelines make it possible to specify how long that care will last as well as which procedures and services are needed to manage the patient’s condition, as only these will qualify for full reimbursement. The HAS lists do not prevent the protocol from being tailored to the individual. They provide a basic structure, which can then be individually adapted to the patient’s circumstances.

The effective use of these new tools will be an important step forwards. The details of how they will be used in practice are currently being worked out by the stakeholders concerned, including primary care doctors, the health insurance funds and patients’ representatives, in a consultation process involving HAS.

Forthcoming Doctors’ Guides and Lists of Procedures and Services

Further guides and lists will follow at regular intervals, with two to four being published every three months. The next ones will deal with hepatitis B (ALD 6) and with asthma and chronic obstructive pulmonary disease in the context of severe chronic respiratory failure (ALD 14). They will be followed by multiple sclerosis (ALD 25) and, by the end of 2006, cardiovascular diseases in general, including coronary disease, stroke, heart failure, arterial disease of the lower limbs and hypertension (the preparatory work for this has been completed). The aim is to review the current list of 30 chronic conditions by the end of 2007.