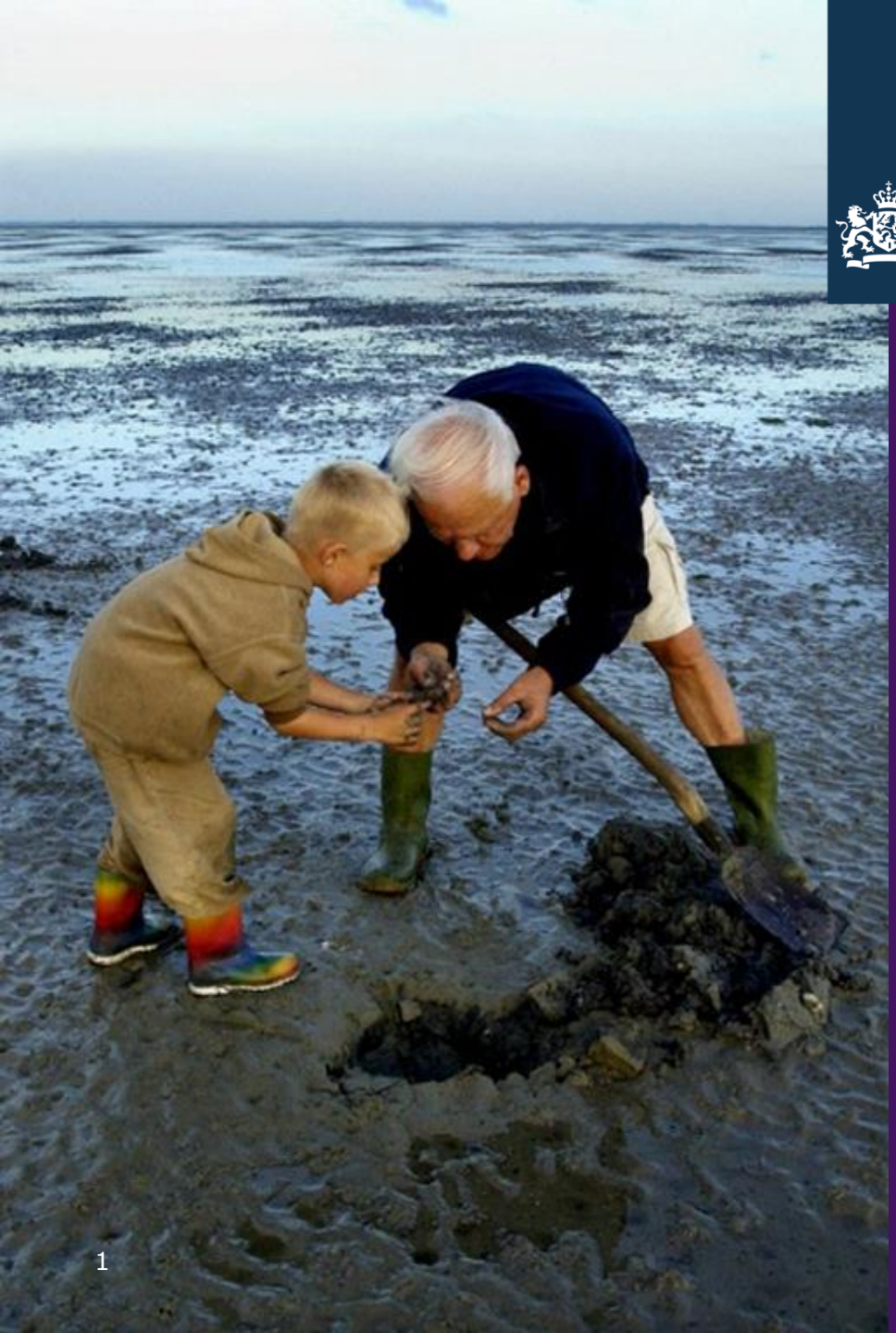

Rijksinstituut voor Volksgezondheid
en Milieu
*Ministerie van Volksgezondheid,
Welzijn en Sport*

Integrating care by bundled payments in the Netherlands

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Content lectures

- **Lecture 1: Integrating care by bundled payments**

  – Introduction Dutch health care system (in a nutshell)

  – Bundled payment:
    › Basic premises
    › Results (health care delivery process, quality and spending)

  - Population management
    - Pioneer sites
    - Early results (organization and early experiences)

Content lectures (II)

- **Lecture 2: Cross-nation comparison of payment reforms**
  - US:
    - Medicare Shared Savings Program
    - Alternative Quality Contract
  - England
    - Clinical Commissioning Groups
  - The Netherlands
    - Bundled Payments

  → Basic features, design and early results

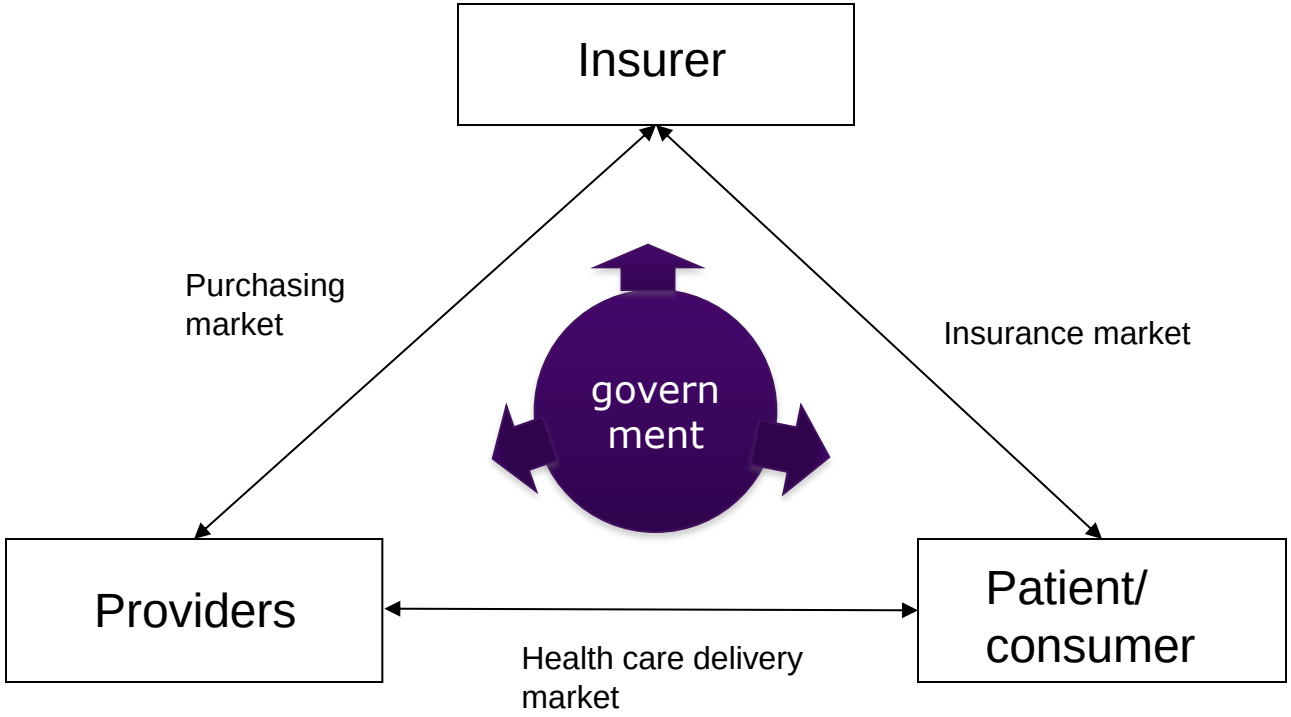
Introduction

DUTCH HEALTH CARE SYSTEM

Background of Dutch health care system

- Health care insurance is mandatory (about 0.2% uninsured)
- Broad basic benefit package
- 4 insurers have 90% of the market
- Advanced risk adjustment system
- Mandatory deductible: 375 euro in 2014
- Health care cost: 12% of GDP (2nd highest in the world after the US)
- High public spending on long term care (3.8% of GDP)
- Strong primary care system

Dutch managed competition model



Primary care system, some key facts

- GP: in principle mandatory
  - No copayments (visit to hospital without consulting GP: 50 euro)
  - in principle free to choose your own GP
- GPs are paid by mixed payment system
  - Fixed capitation fee per enrollee: 57 euro
  - Small additional fee for each consult: 9 euros
  - on average 2500 enrollee per GP
  - 60% of inhabitants: longer than 10 years enrolled

Introduction

BUNDLED PAYMENT MODEL

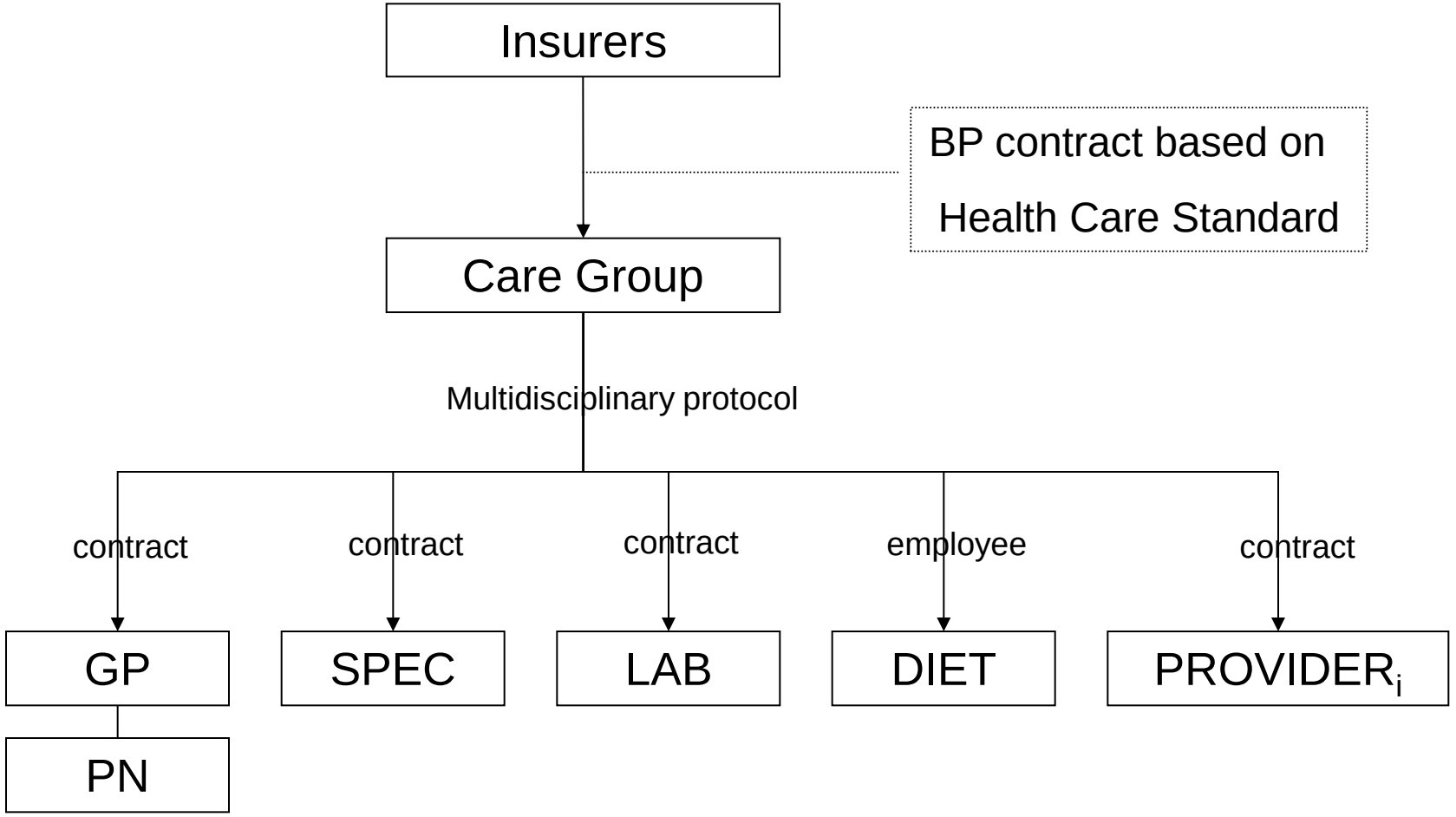
Background BP

- Fragmentary funding hampered the establishment of long-term integrated care programs on a national level.
- 2007: a bundled payment (BP) approach was introduced, first on experimental basis.
- 2010: BP system structurally implemented for diabetes , vascular risk management and COPD
- 2010- 2012: Scientific Evaluation Committee on BP: monitoring prerequisites to end transitional period
- 2015: evaluating effect on mortality, hospital utilization and medical spending

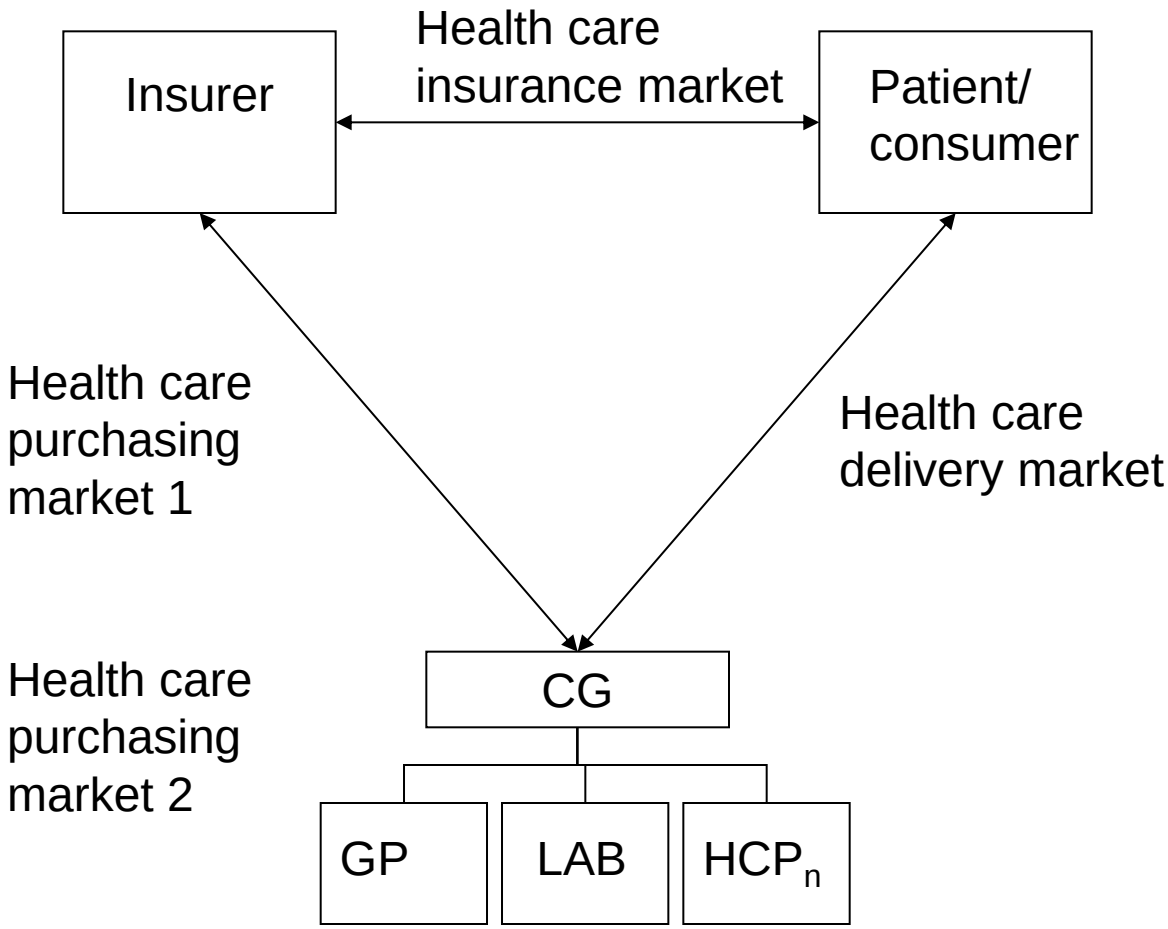
Bundled Payment (BP) system

- Single payment for all services across providers for one chronic disease
- Content of BP is in conformity with Health Care Standard (HCS)
- HCS describes activities (the ‘what’, not the ‘who’, ‘where’ and the ‘how’), and is agreed on by all national provider and patients organizations
- Fees for BP contracts and subcontractors are freely negotiable
- Negotiations with dominant insurer
- Mostly primary care services: not simultaneously with a hospital payment

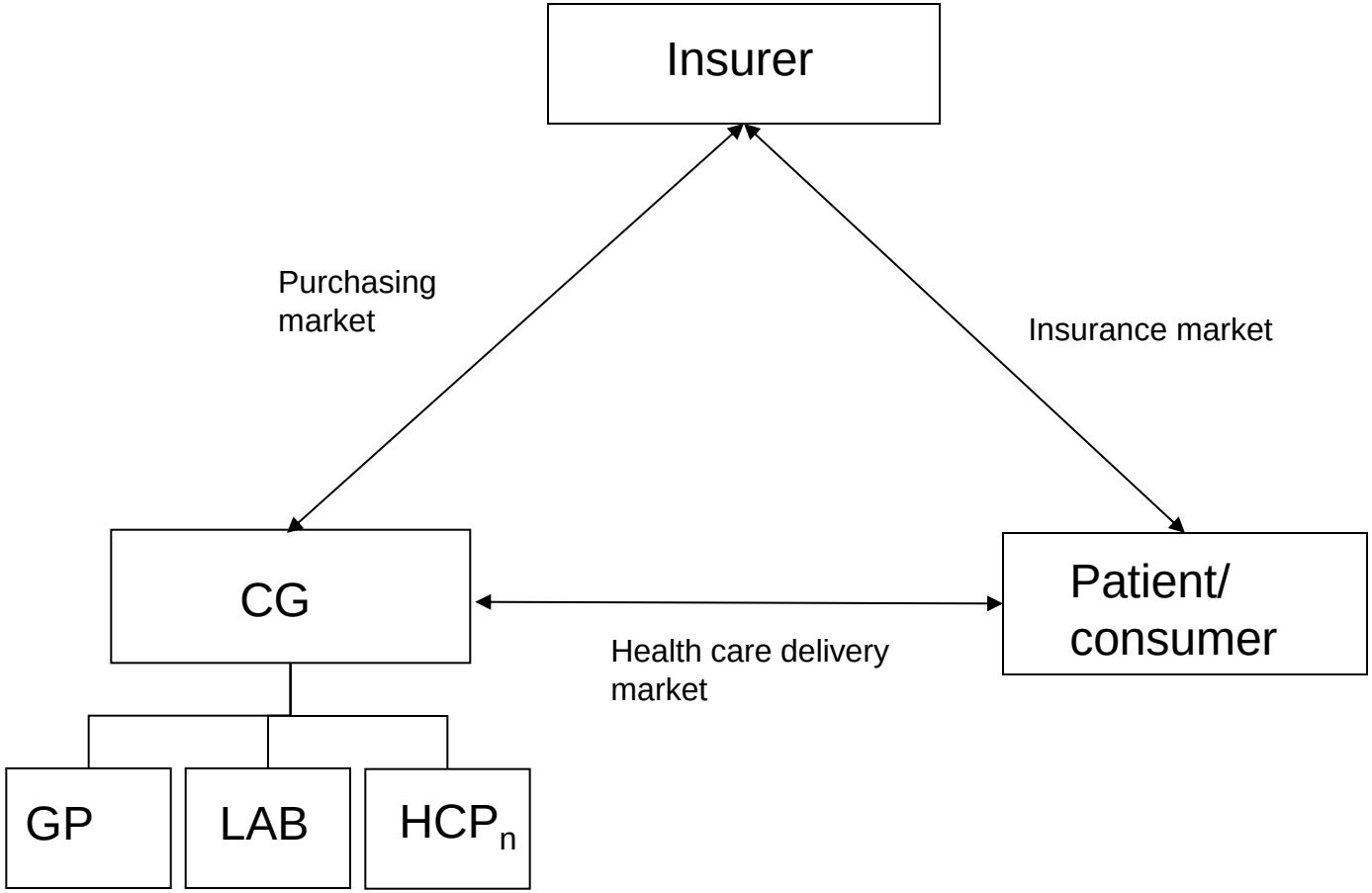
‘Outline of BP model’



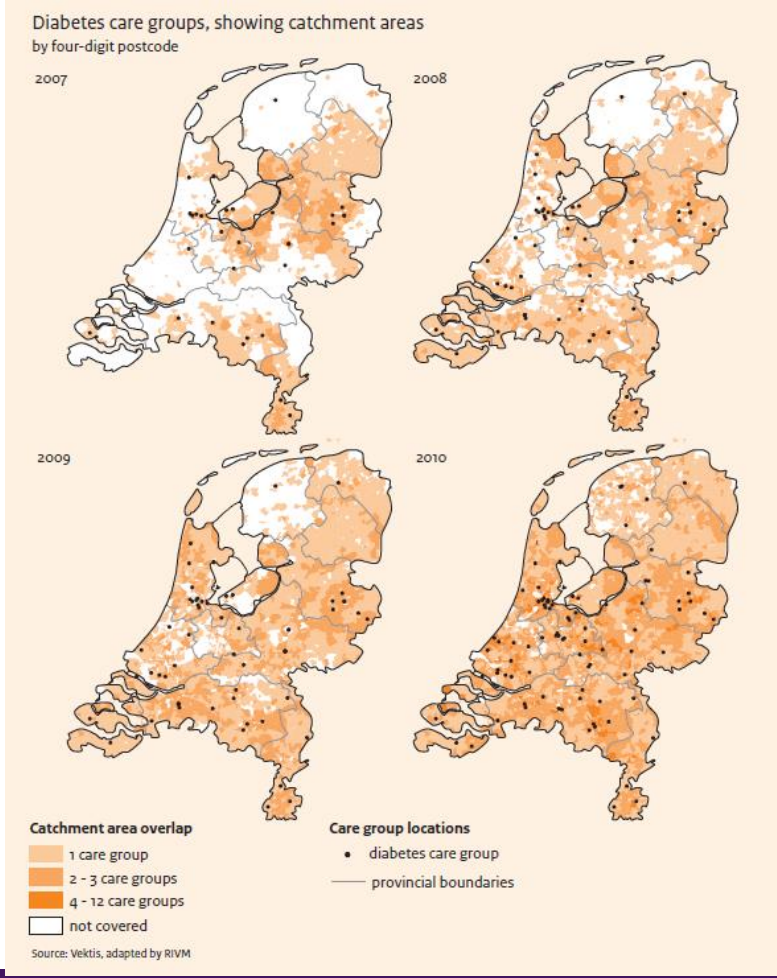
New situation



Dutch managed competition model

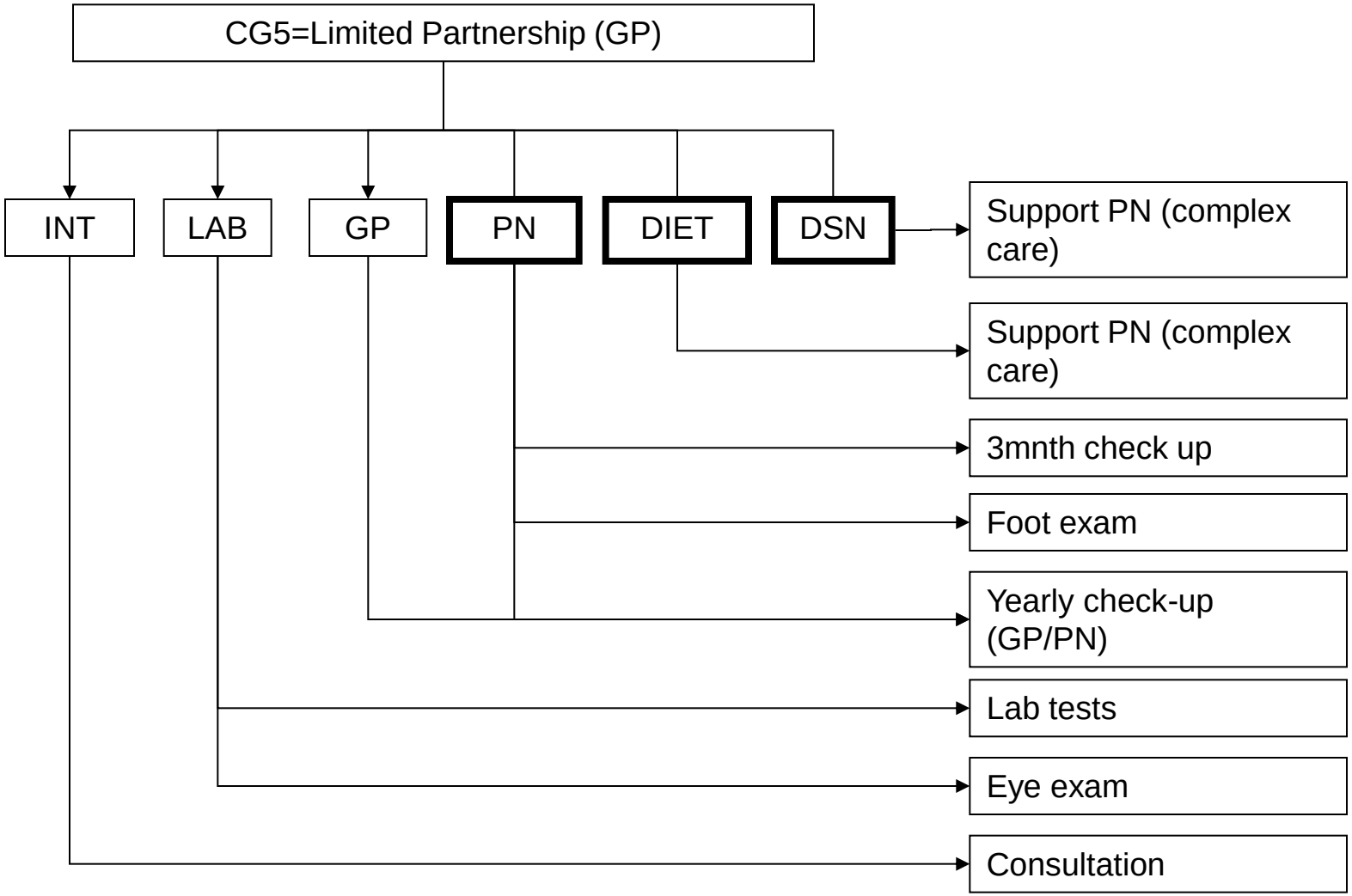


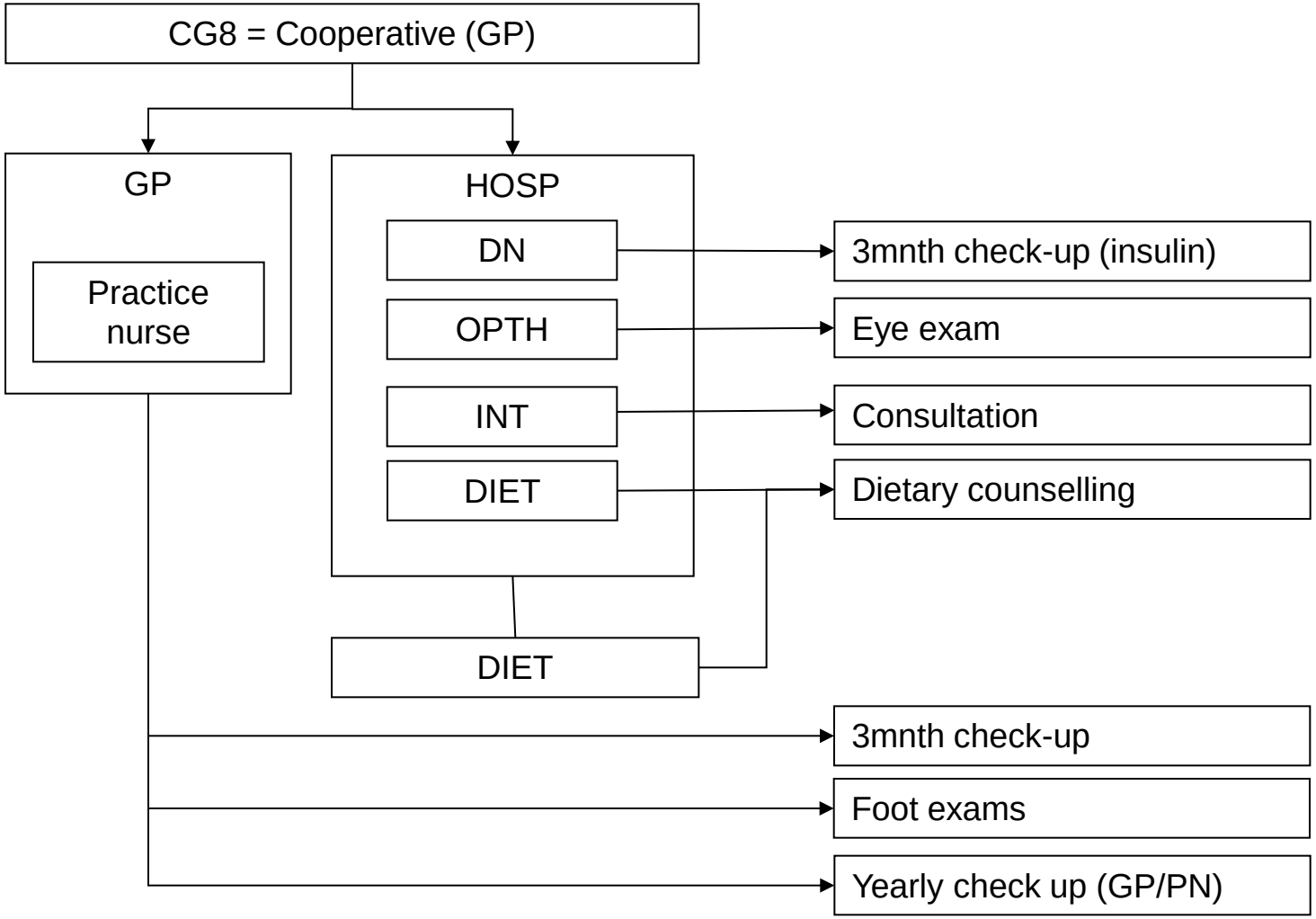
Geographical diffusion of CGs with catchment area 2007-2011 for diabetes

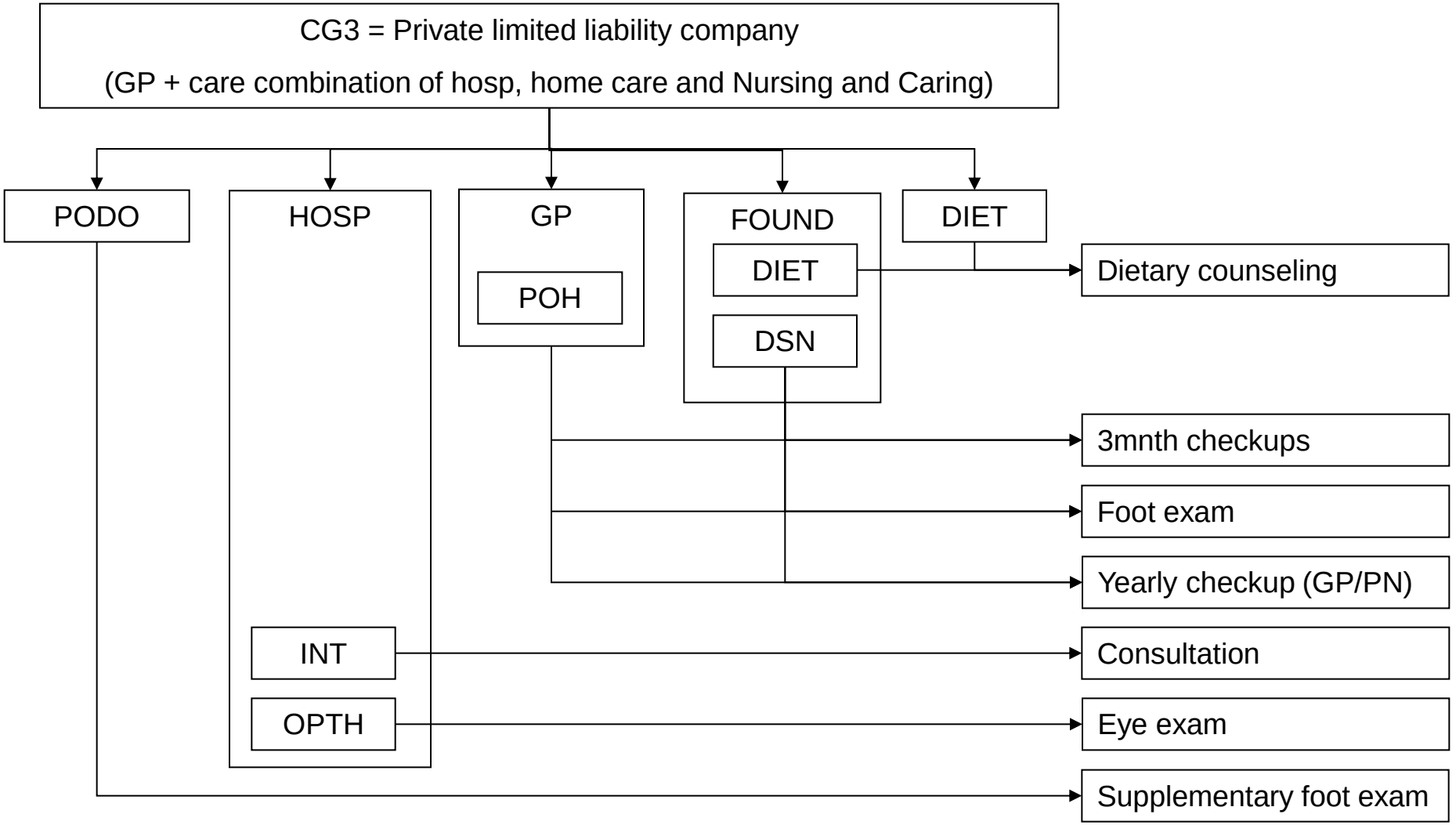


How are diabetes care groups organised?

- Care groups exclusively owned by General Practitioners (GP) (conflict of interest of GP)
- Sharp increase in the number of associated GPs
- All CGs supplied 'reflective information' their subcontracted care providers (benchmarking)
- All CGs supplied accountability information to their preferred insurer
- Care groups differ how they are organized (three examples)


CG5=Limited Partnership (GP)
INT
LAB
GP
PN
DIET
DSN
Support PN (complex care)
Support PN (complex care)
3mnth check up
Foot exam
Yearly check-up (GP/PN)
Lab tests
Eye exam
Consultation


CG8 = Cooperative (GP)
GP
Practice nurse
HOSP
DN
OPTH
INT
DIET
DIET
3mnth check-up (insulin)
Eye exam
Consultation
Dietary counselling
3mnth check-up
Foot exams
Yearly check up (GP/PN)


CG3 = Private limited liability company
(GP + care combination of hosp, home care and Nursing and Caring)
PODO
HOSP
GP
POH
FOUND
DIET
DSN
DIET
Dietary counseling
3mnth checkups
Foot exam
Yearly checkup (GP/PN)
INT
Consultation
OPTH
Eye exam
Supplementary foot exam

Content and fees of BP contracts?

Fee : €258 - €474 per patient per year (beginning years)

Always included:

- Checkups (annual and 3-months)
- Eye and footexams
- Dietary counseling new patients
- (Lab tests)
- Consultation specialist

Always excluded:

- Medication
- Supervised exercise programs
- Education/ self management

Does BP create incentives to reallocate and delegate tasks?

Yes!

- GP → practice nurse
- Opthamologist → optometrist
- Dietician or diabetes nurse → practice nurse

•Altered duties of GP towards more supervision

•More providers are working on 'top of their license'

Experience of stakeholders

Managers

- Perceived quality improvements in process of care
- Better understanding in individual care needs
- More transparency
- Negotiations with insurers difficult and time consuming
- IT hindering factor

Insurers

- insurers positive about quality of care
- increased transparency about quality of care
- still too monodisciplinary (solely GPs)

Experience of stakeholders (II)

Care providers

- improvements in health care delivery process
- Reflective information = succes factor!
- Some providers: BP is obstacle for patient-centeredness
- Administrative burden considered heavy
- IT constrains
- Risk of negative consequences of task reallocation
- Communication of GPs needs improvements

Patients

- High satisfaction with delivery of care, continuity of care

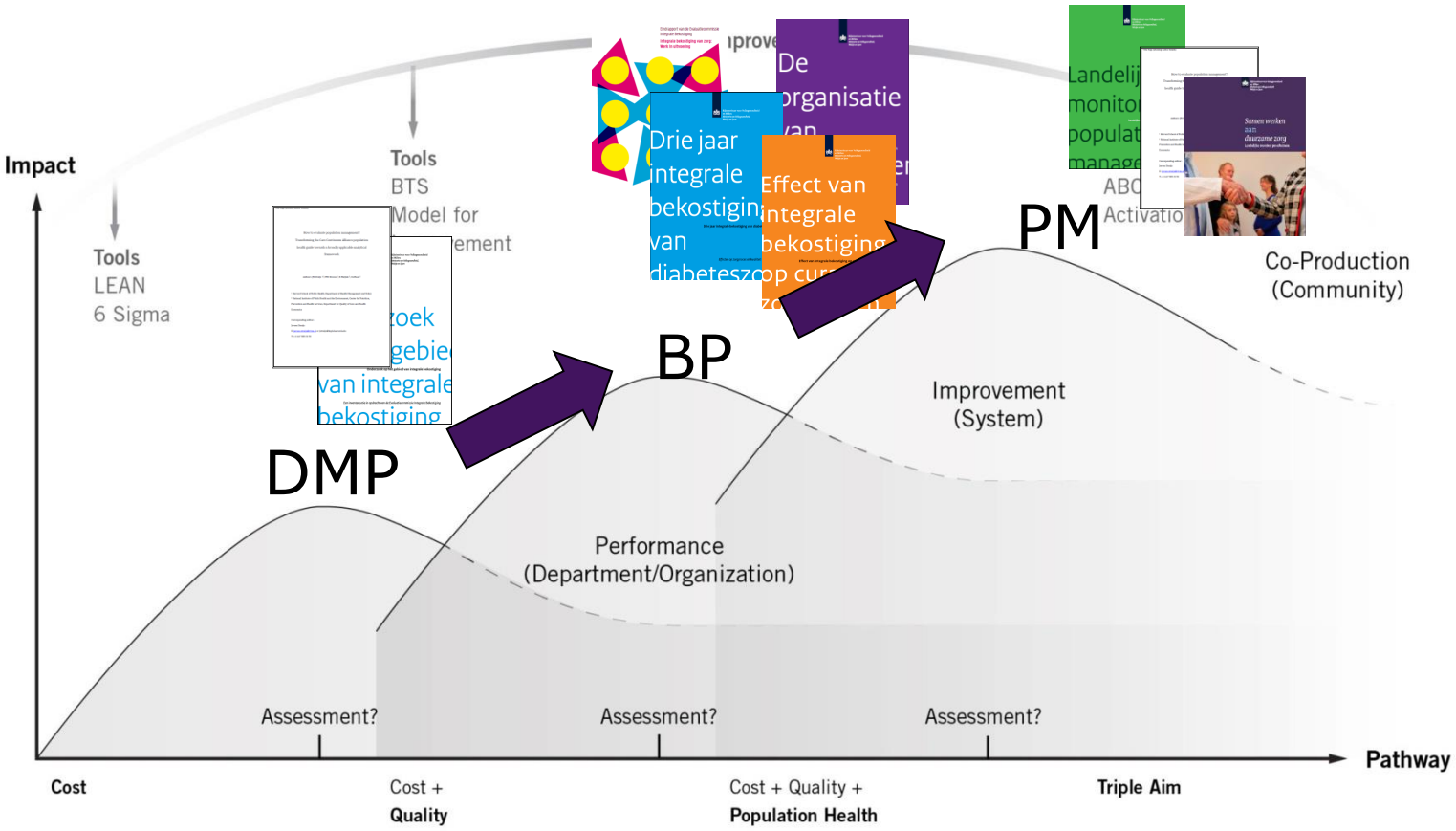
Overall conclusions / take home messages

- Nationwide implementation of care groups
- The organization and process of care improved
- Less patients enrolled in a care program used hospital care
- Evidence suggest that BP resulted lower mortality and lower medical spending
- Underlying mechanisms need to be studied
- Variation in quality as well as spending holds potential room for improvements?

So what's next?

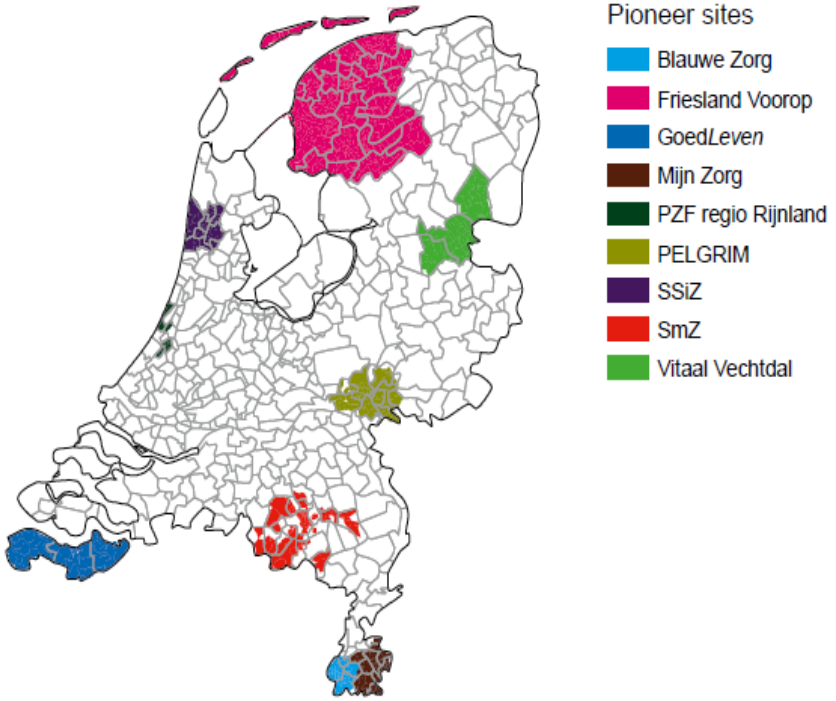
Pioneer sites
Population management

‘Triple Aim by Triple Method’ applied for the Netherlands



National monitor Pioneer sites

- Shift from BP towards Population Management
- 9 regions selected as pioneer sites of population management
- Pioneer sites are enrolled in the National Monitor of Population Management
- All aiming to improve the TA



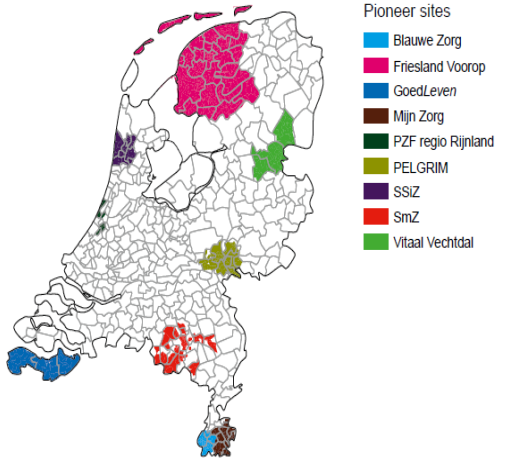
Where are we?

Themes & updates

Follow-up report: Process and outcomes

2013	2014	2015	2016	2017	2018

Objectives National Monitor PM



4 overall research questions:

1. How is population management designed?
2. What are the barriers and facilitators in PM?
3. How is health, quality of care and costs developed over time?
4. What is the association between these outcome measures?

→ Mixed methods

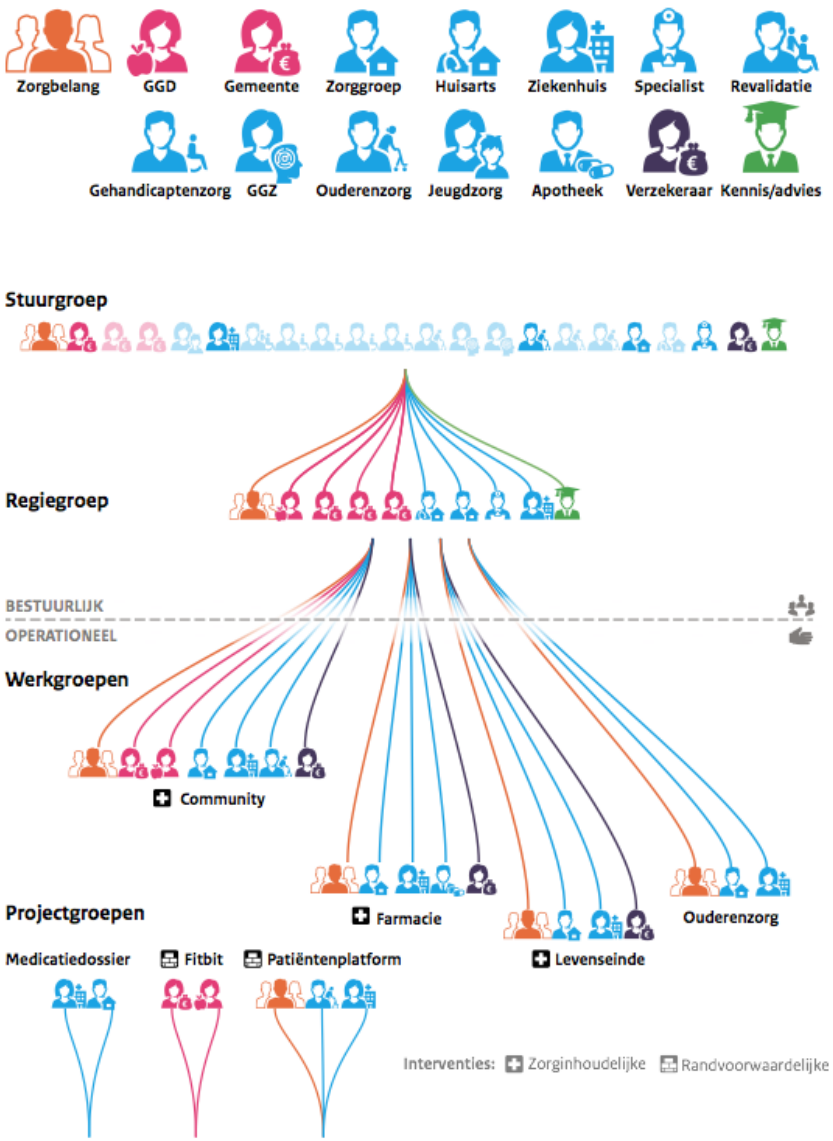
Organisation

- Early 2015, pioneer sites are partnerships of (at least two or more) health care organizations and the 'dominant' insurer
  - → No legal entity (yet)
  - → Agreements were signed to confirm the intended cooperation within the partnership

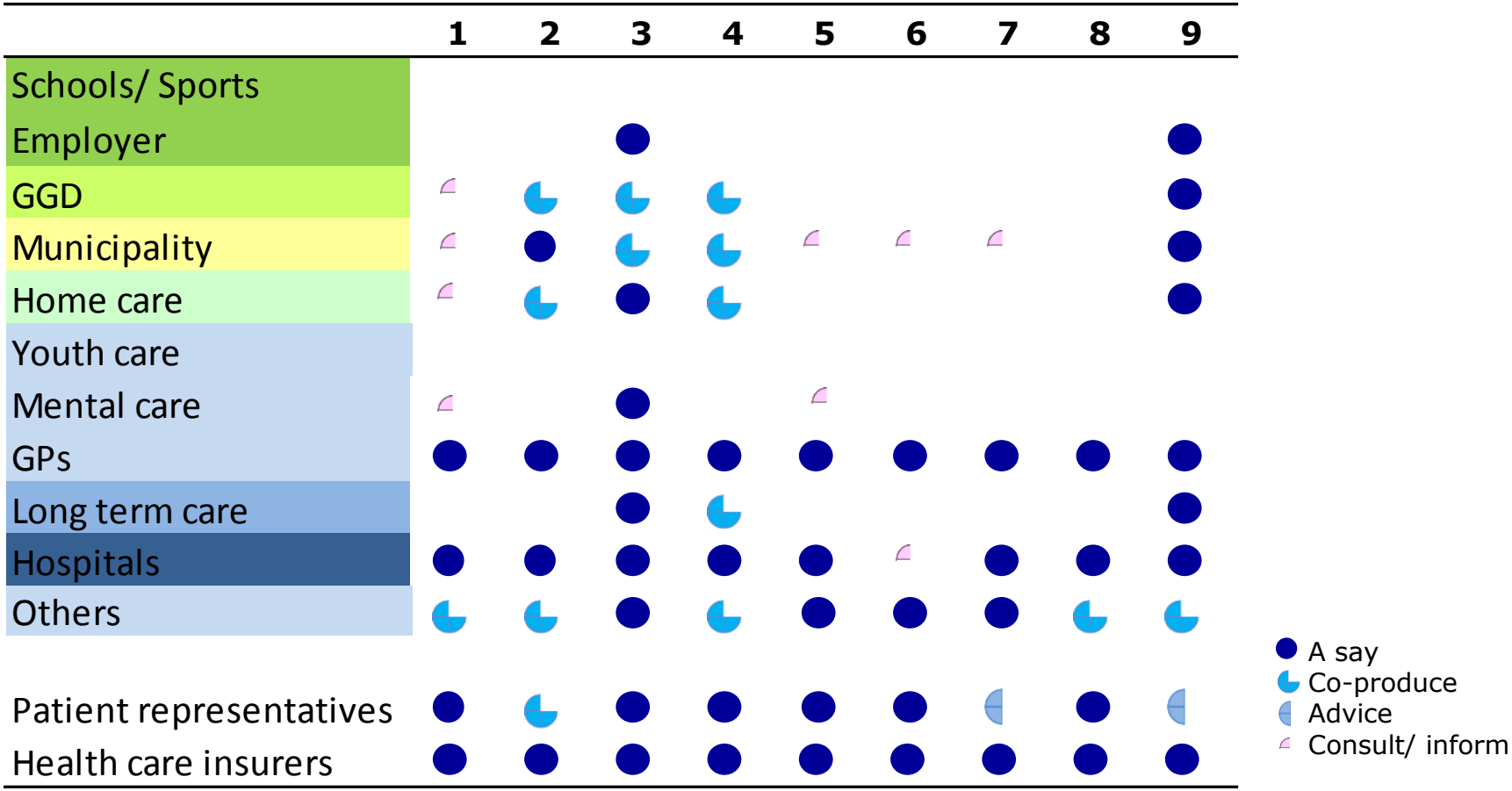
- Organisations are under development
  - Additional partners, such as mental care organizations, are more often involved.
  - Some regions explore the potentials / design legal entities

→ Key question: Dutch Accountable Care Organizations?

Figuur B 4.3: Schematische weergave van de proeftuin Goed*Leven*



Organisation: involved actors



Current Interventions

	1	2	3	4	5	6	7	8	9
Prevention									
Lifestyle interventions			●	●					●
Selfmanagement									
Awareness	●		●						●
Selfmanagement capacity				●				●	
Integrated care									
Frailty		○			○	●	●		●
Maternity care		○					●		
Mental care	○								
Diabetes					○		●	○	
COPD					○		●	○	
VRM					○		●		
Others								○	
Substitution							●		
Farmacy	●		●	●	○		●	●	●
1,5 care	●	○		●		●	●	○	
Concentration&specialisation		○							
Diagnostics	●						○	○	
Precondition									
Teamclimate	●	●	●	●			●		
Community involvement			●	●					○
Data-infrastructure		●			●				

Population

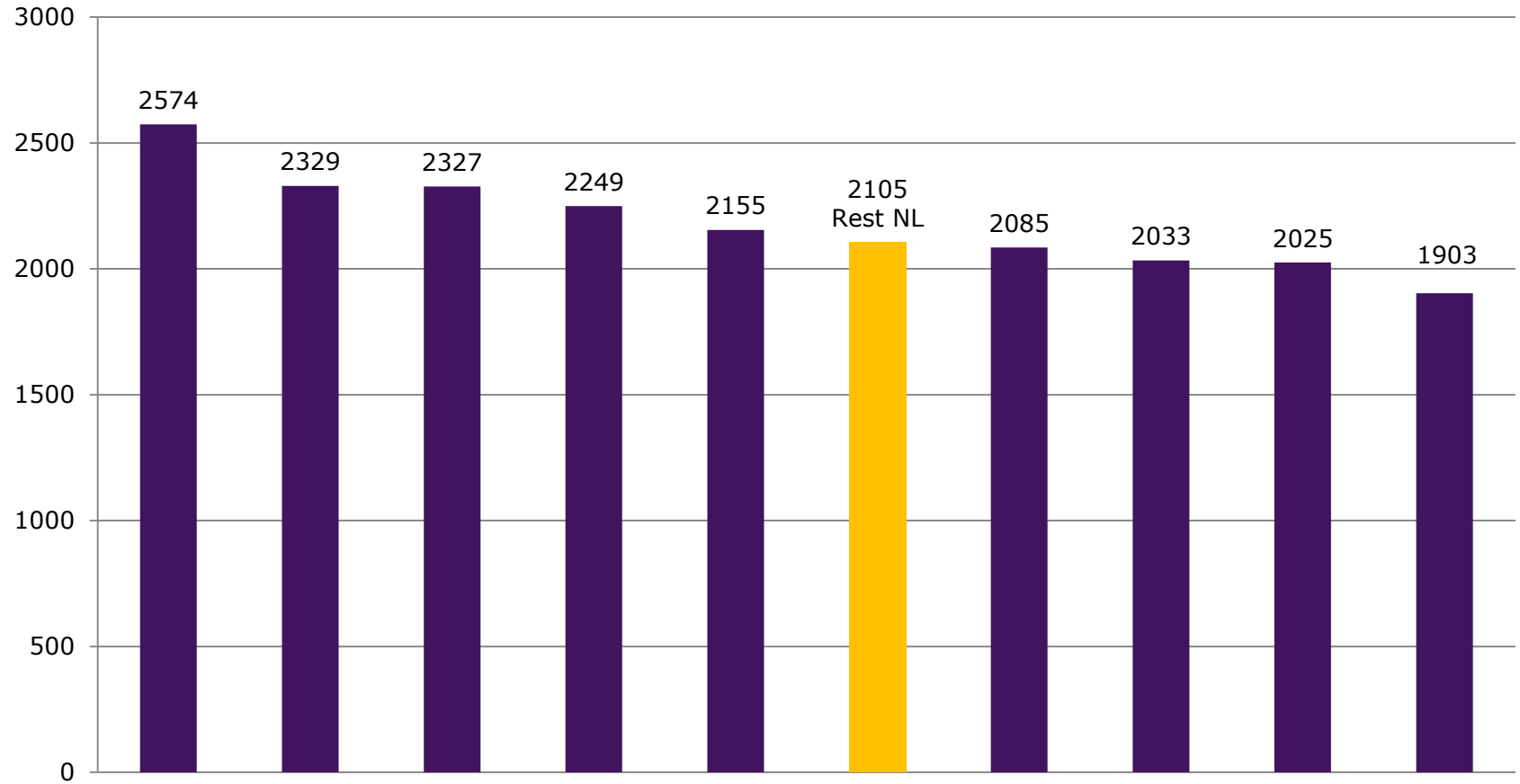
	1	2	3	4	5	6	7	8	9	Rest NL
Population	**142990**	**491860**	**84470**	**222290**	**143560**	**321600**	**209455**	**400915**	**84640**	**10770140**
Sexe (% male)	48,5	49,8	49,5	49,3	48,7	49	49,1	50,2	51,6	**49,1**
Age (% 65+)	23,6	23,2	27,6	25,2	18,4	21,4	23,1	22,8	23,2	**20,8**
Education (% low)	8	7,3	11	9,4	6,6	6,4	5,2	6,7	8,7	**8**
Income (% high)	20,9	16,7	24,2	17	30,8	23,5	26,4	25	17,4	**24,9**
Employed (%)	57,3	60,8	59,8	55,4	65,4	62,9	63	62,4	62,7	**63,2**
Disablled to work (% totally disabled)	5,8	3,2	4,5	6,9	2,2	4,8	4,6	4	3,2	**3,9**

Population health

	Blauwe Zorg	Friesland Voorop	Goed Leven	Mijn Zorg	PZF Rijnland	Pelgrim	SSiZ	SmZ	Vitaal Vechtdal	Rest NL
Experienced health (% more or less-bad')	26,2	19,2	26,7	32,2	19	22,7	22,4	24,5	21,9	23,6
Disabilities (% 1 or more)	14,8	12,4	17,5	18,9	11,2	13,8	11,9	15,5	14,9	14,9
Chronic conditions (% at least 1)	62,9	58	66,1	69,7	57	62,5	57,3	57,9	57,1	60,4
Anxiety and depression (% high risk)	6	3,9	5,2	7,7	4,7	6,4	4,3	5,8	4	5,7
BMI (% overgewicht)	46,5	47,4	53,5	54,4	42,1	48,1	45,1	48,4	51,3	48,3
Mortality (per 10.000)	104	91	110	110	78	89	82	82	87	84

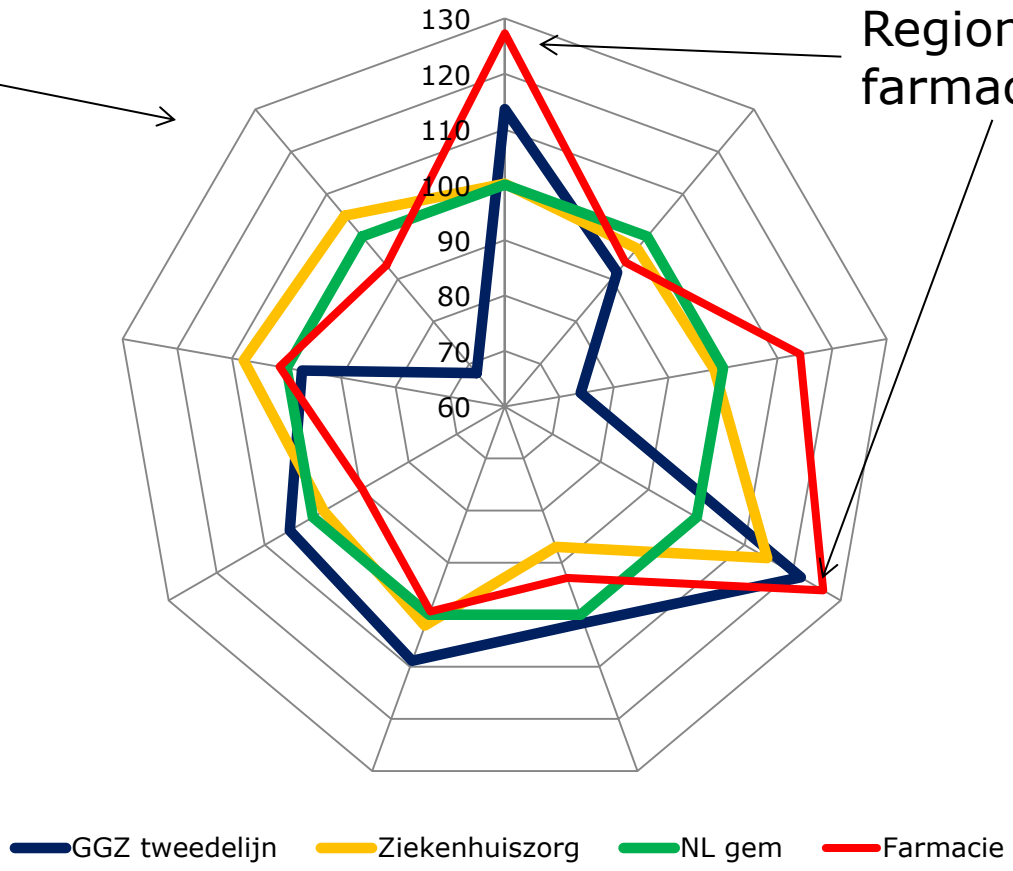
*red = significant unhealthier; green= significant healthier compared to other regions
**Not standardized results.

Costs – total Zvw costs per inhabitant per pioneer site (2011) general population(€ per capita)



Costs per sector per pioneer site (2012) general population (100=NL gem)

E.g. this region has higher secondary care but lower mental care costs compared to average.



Regions with high farmacy costs

To conclude; new era of delivery reforms has begun

- Pioneer sites focus on building the ‘fundaments’; how to align the overall Triple Aim and the ‘individual goals’
- Corporate governance is in development; role municipilaties and insurers?
- Payment reforms are expected on pioneer site level are expected in the near future; discussion mainly focusing on shared savings contracts
- The health, quality and cost vary between regions and subgroups
- Rigorous evaluations of these PM initiatives are key to derive transferable lessons

End Part 1