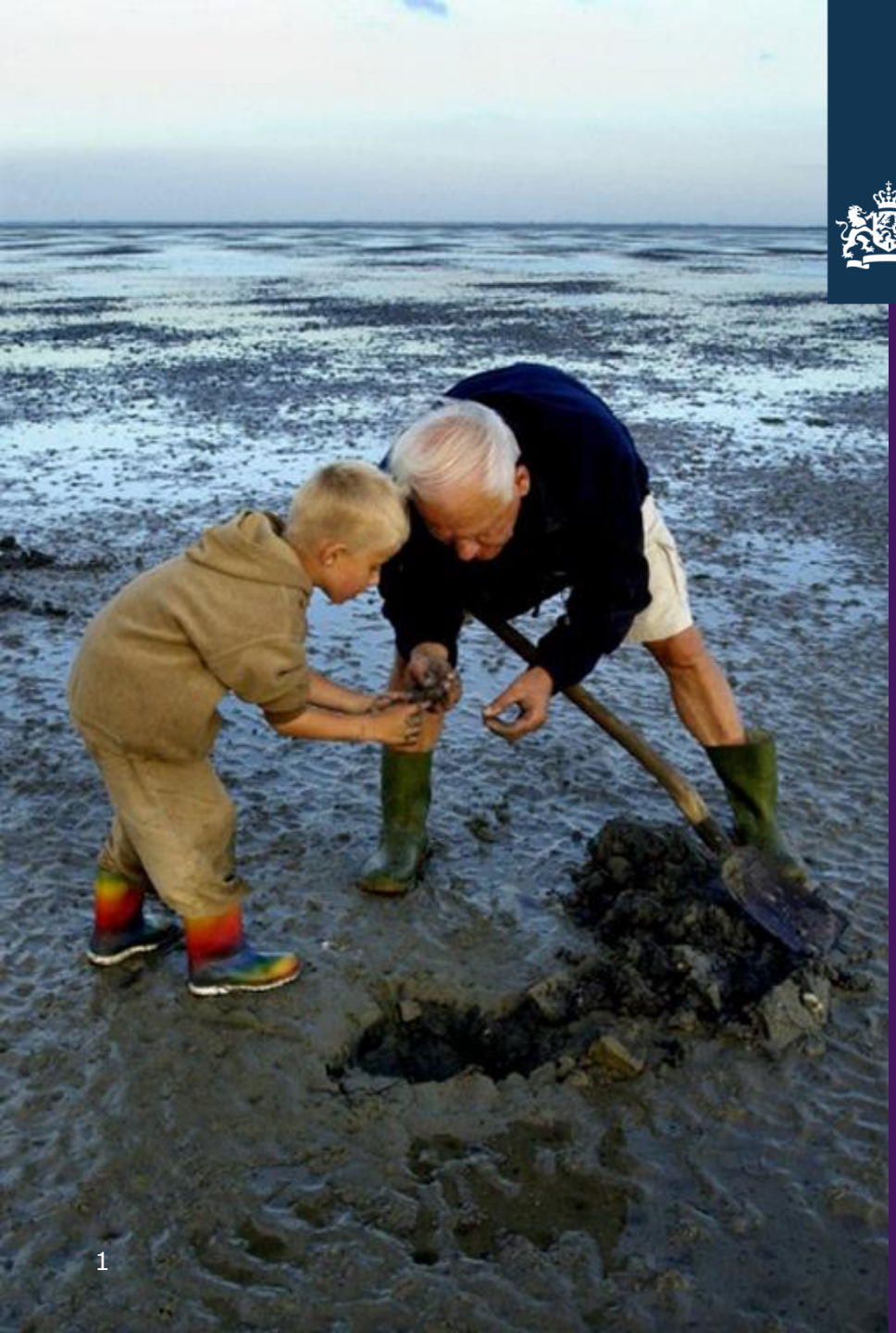


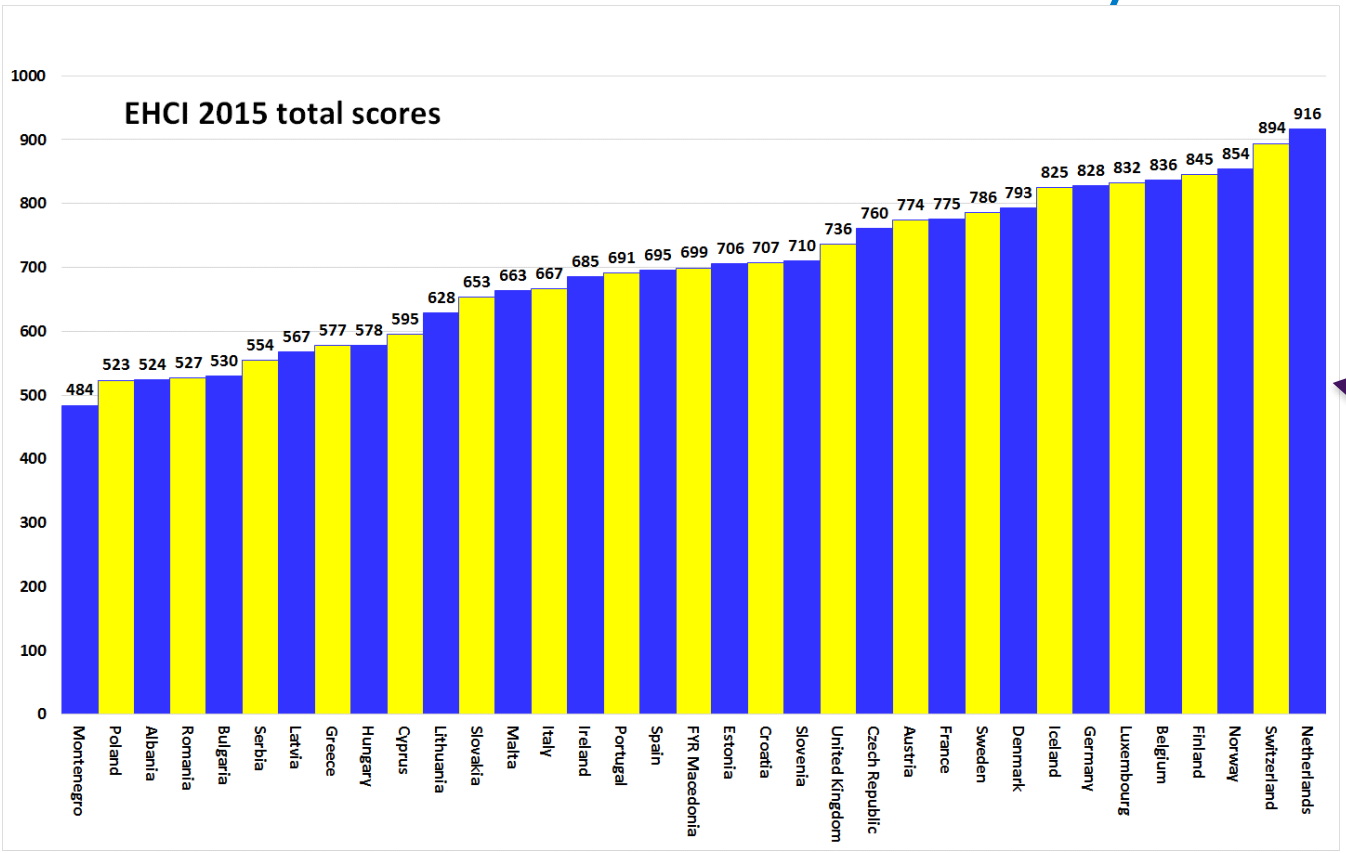
Rijksinstituut voor Volksgezondheid
en Milieu
*Ministerie van Volksgezondheid,
Welzijn en Sport*

Recent developments in health care (policy) in the Netherlands

Jeroen N Struijs, PhD

National Institute of Public Health and the Environment (RIVM),
Department of Quality of Care and Health Economics

Dutch health care system



The Netherlands

Reference: European Health Consumer Index, 2016

Dutch health care system

WEB FIRST

By Robin Osborn, David Squires, Michelle M. Doty, Dana O. Sarnak, and Eric C. Schneider

In New Survey Of Eleven Countries, US Adults Still Struggle With Access To And Affordability Of Health Care

ABSTRACT Surveys of patients' experiences with health care services can reveal how well a country's health system is meeting the needs of its population. Using data from a 2016 survey conducted in eleven countries—Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States—we found that US adults reported poor health and well-being and were the most likely to experience material hardship. The United States trailed other countries in making health care affordable and ranked poorly on providing timely access to medical care (except specialist care). In all countries, shortfalls in patient engagement and chronic care management were reported, and at least one in five adults experienced a care coordination problem. Problems were often particularly acute for low-income adults. Overall, the Netherlands performed at the top of the eleven-country range on most measures of access, engagement, and coordination.

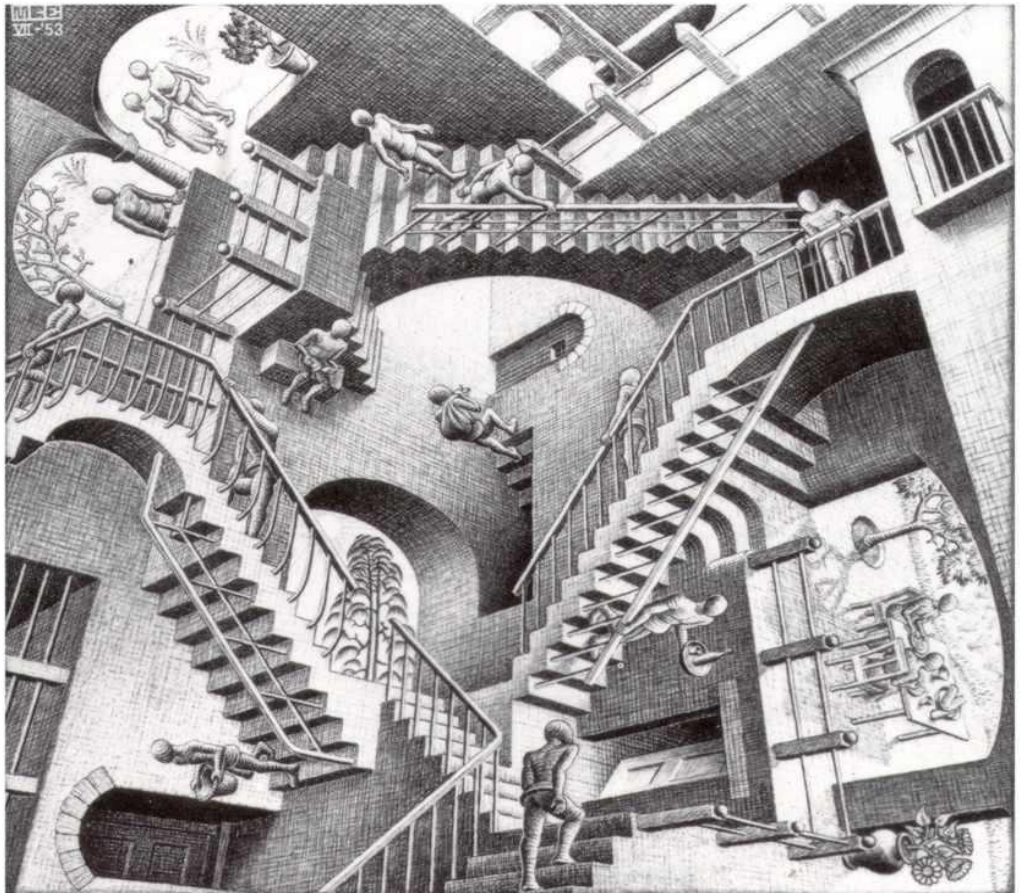
Commonwealth Fund's international survey among 11 high income countries

"Overall the Netherlands performed at the top of the eleven-country range on most measures of access, engagement and coordination"

Source:

Osborn et al., 2016, Health Affairs

Dutch health care system



Source: MC Escher

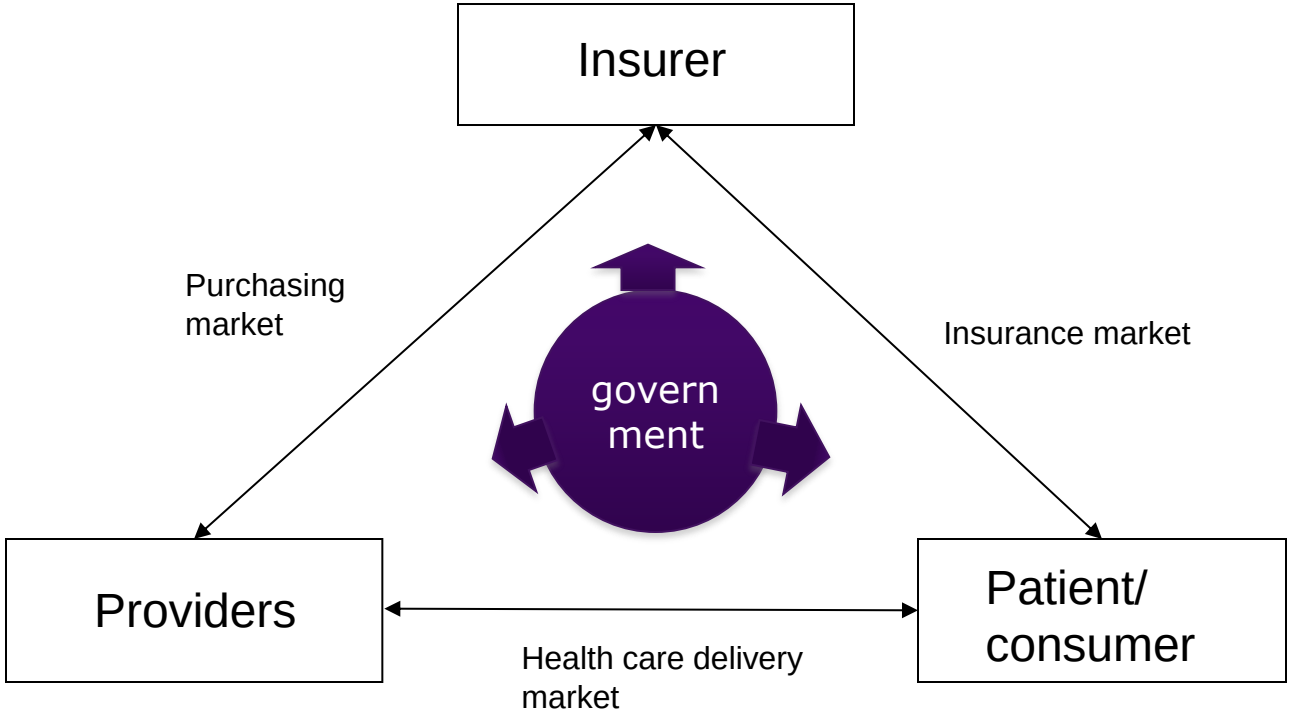
Vienna Health Care Lecture: the Netherlands

- Background Dutch Health Care system
- Pioneer sites Population Health Management (PHM)
- Primary Care Plus (PC+)
- Bundled Payment for birth care

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: 385 euro in 2017
- 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

Policy developments

•*Taskforce Health Care expenditures* (2012) formulated to slow down rising costs:

- (a) care should 'go back to the basics', with the GP still as gatekeeper
- (b) care should be provided at the 'right place', with more task substitution to primary care
- (c) all parties should share a mutual responsibility for controlling healthcare costs

Policy developments (II)

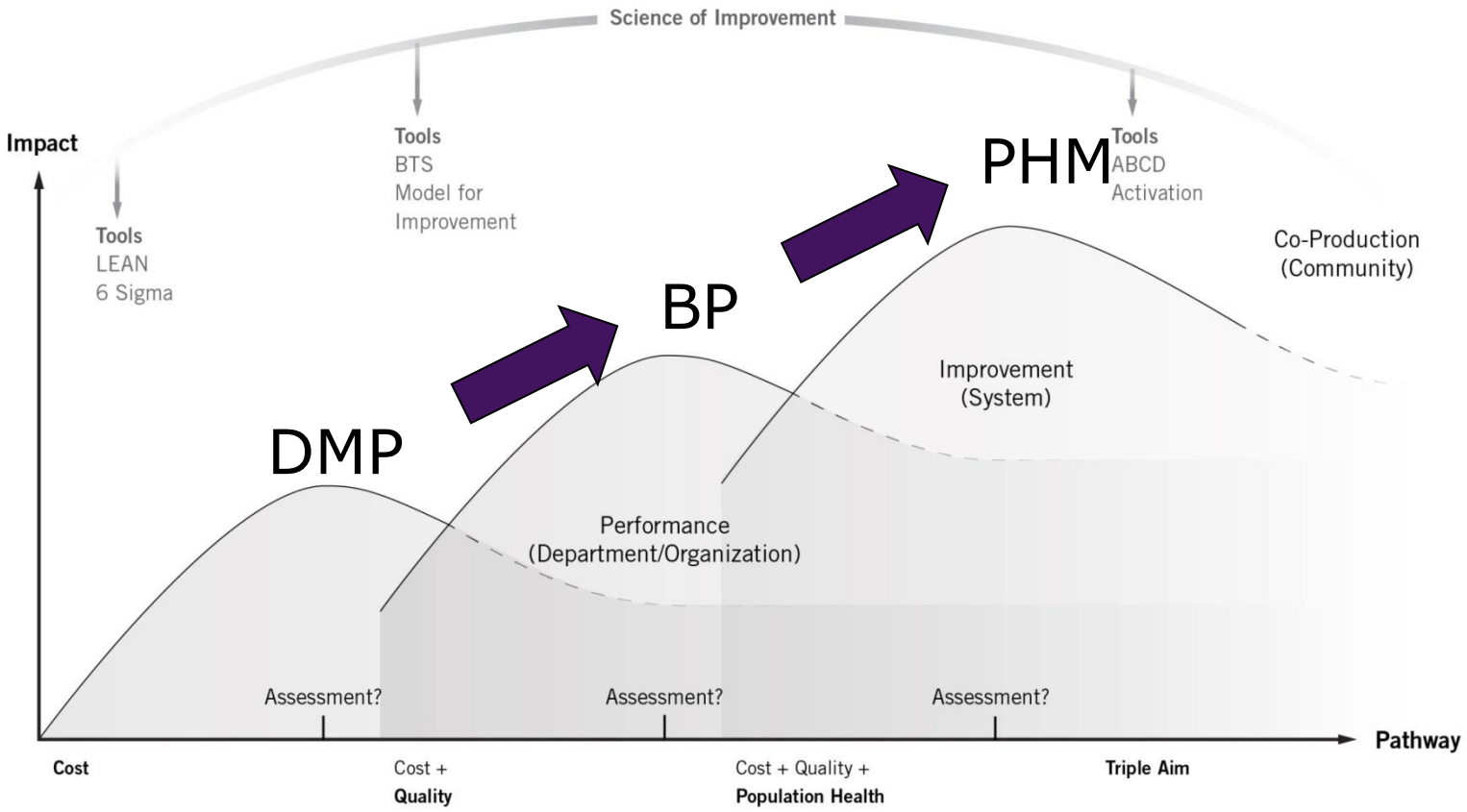
- *Taskforce Health Care expenditures* (2012) formulated to slow down rising costs:
  - (a) care should 'go back to the basics', with the GP still as gatekeeper
  - (b) care should be provided at the 'right place', with more task substitution to primary care
  - (c) all parties should share a mutual responsibility for controlling healthcare costs
- Similar recommendations by '*Agenda for Health care*' (14 parties)

Policy developments (III)

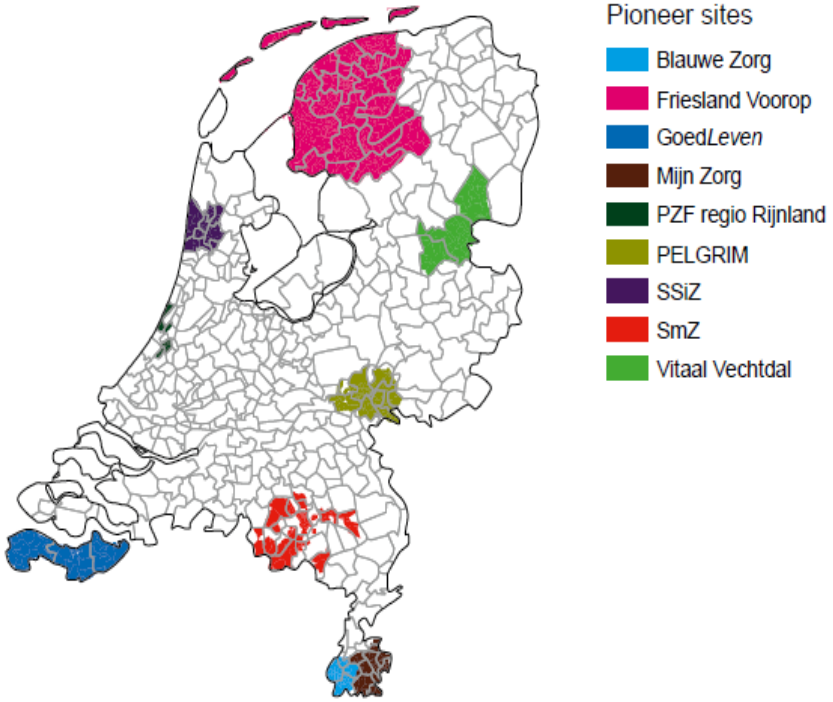
Hoofdlijnen-akkoord (2014)

- Dutch Ministry of Health, healthcare organizations, health insurers and patient organizations have agreed that
  - volume growth for hospital care should be limited to:
    - 1.5% in 2014
    - 1% per year from 2015 until 2017
  - primary care is allowed to grow:
    - by 1% in 2014
    - 1.5% per year from 2015 until 2017

Dutch journey toward Population Health Management



Pioneer sites Population Health Management



POP-2015-0149-ver9-Steenkamer_1P
Type: original-article

POPULATION HEALTH MANAGEMENT
Volume X, Number X, 2016

DOI: 10.1089/pop.2015.0149

Original Article

Defining Population Health Management: A Scoping Review of the Literature

Betty M. Steenkamer, MSc,[1] Hanneke W. Drewes, PhD,[2] Richard Heijink, PhD,[2] Caroline A. Baan, PhD,[1,2] and Jeroen N. Struijs, PhD[2]

Abstract

Population health management (PHM) has increasingly been mentioned as a concept to realize improvements in population health and quality of care while reducing cost growth (the so-called Triple Aim). The concept of PHM has been used in various settings and has been defined in different ways. This study compared the definitions of PHM used in the literature in order to improve the understanding and interpretation of the concept of PHM. A scoping literature search was performed for papers published between January 2000 and January 2015 that defined PHM. PHM definitions were summarized, focusing on: (1) overall aim, (2) PHM activities, and (3) contextual factors. Eighteen articles were retrieved. The overall aim was defined in terms of health (N = 14), costs (N = 8), and/or quality of care (N = 10). Definitions varied regarding the description of PHM activities, though all definitions contained elements in common with disease management and health promotion. Data management, Triple Aim assessment, risk stratification, evaluation, and feedback cycles were less likely to be mentioned. Contextual factors were scarcely brought forward in the definitions. Moderate variations were found across definitions in the way PHM was conceptualized. Frequently, essential elements of PHM were not specified. Differences in conceptualizations of PHM should be taken into account when comparing PHM initiatives that are working toward improvements in population health, (experienced) quality of care, and reduction of costs. (*Population Health Management* 2016;xx:xxx–xxx)

Dutch Pioneer Sites Population Health Management

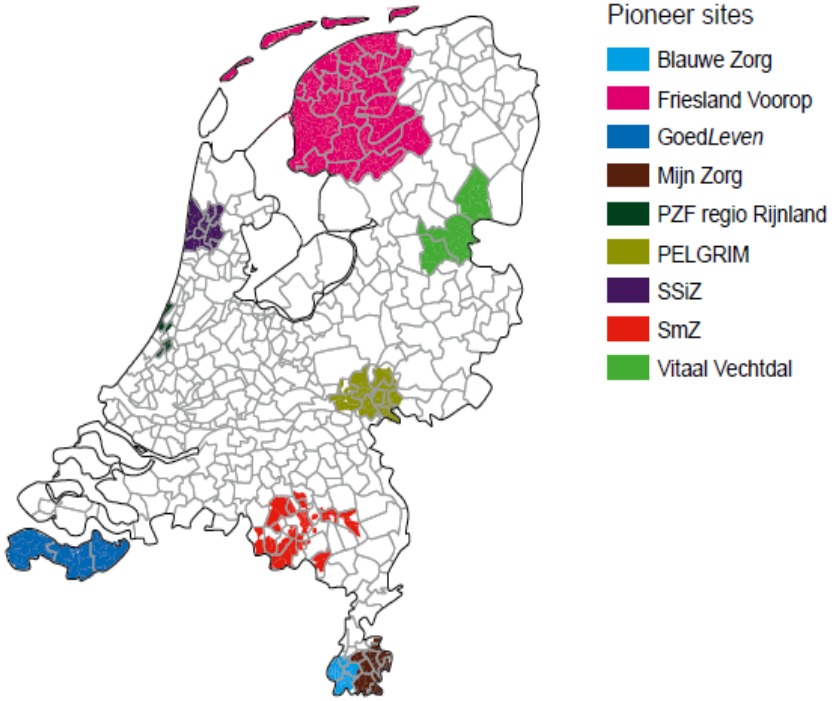
- Partnerships from local/regional actors;
  - health care providers,
  - insurers
  - municipalities
  - "the community"

- All aiming for the Triple Aim: improving quality of care and population health while reducing cost growth

- Interventions integrating health- and social care, prevention and welfare:
  - Redesign of the system and interventions (PC+)
  - Payment reforms (bundled payments for birth care)

National monitor Pioneer sites PHM (2013)

- 9 regions selected as pioneer sites of population management
- Pioneer sites are enrolled in the National Monitor of Population Management during 2013-2018



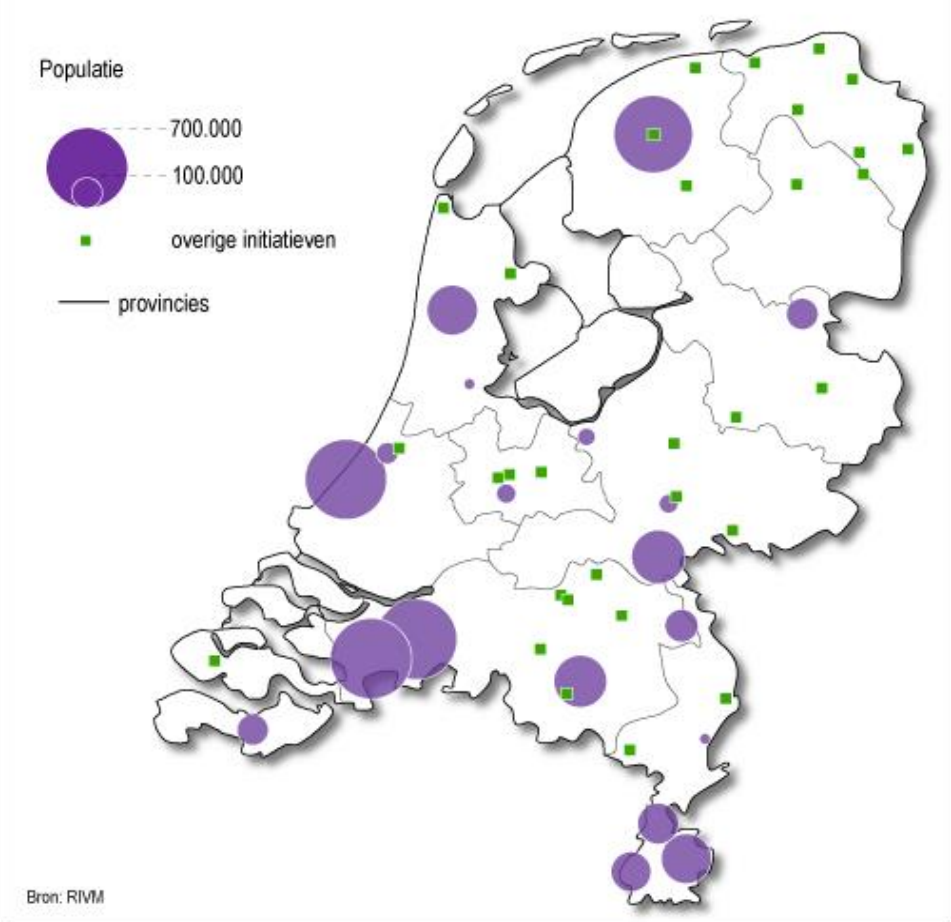
National Monitor Pioneer sites PHM

- Follow-up: 2013-2018
- Mixed methods

4 Research questions:

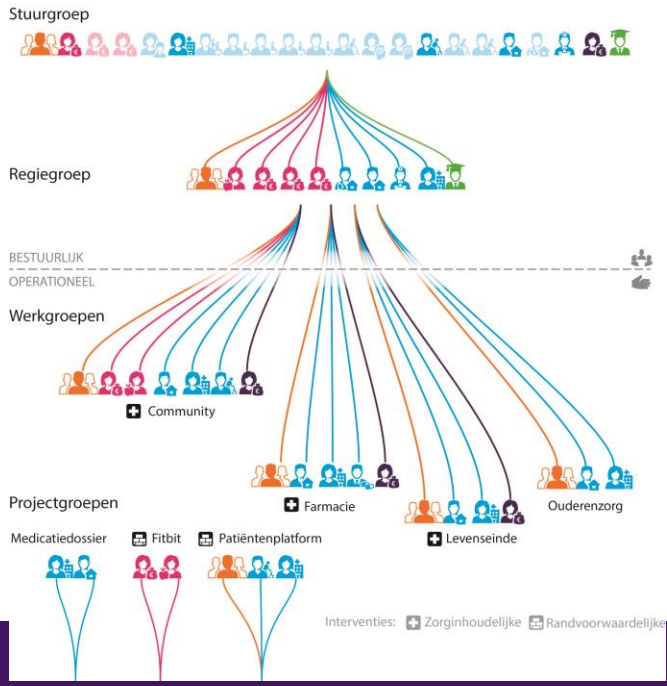
1. How is population management designed?
2. What are the barriers and facilitators in PM?
3. How is health, quality of care and costs developed over time?
4. What is the association between these outcome measures?

PHM not restricted till 9 pioneer sites….

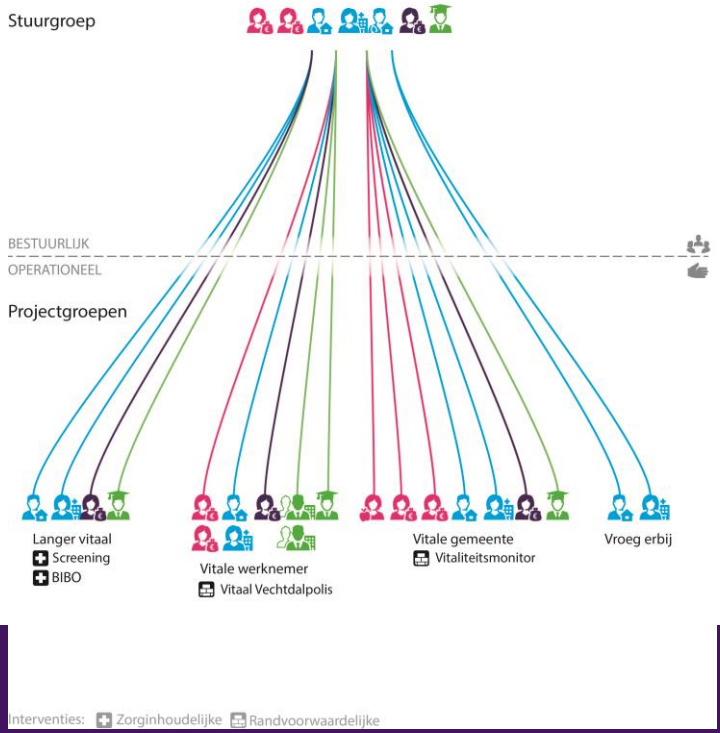


PHM pioneersites are complex partnerships

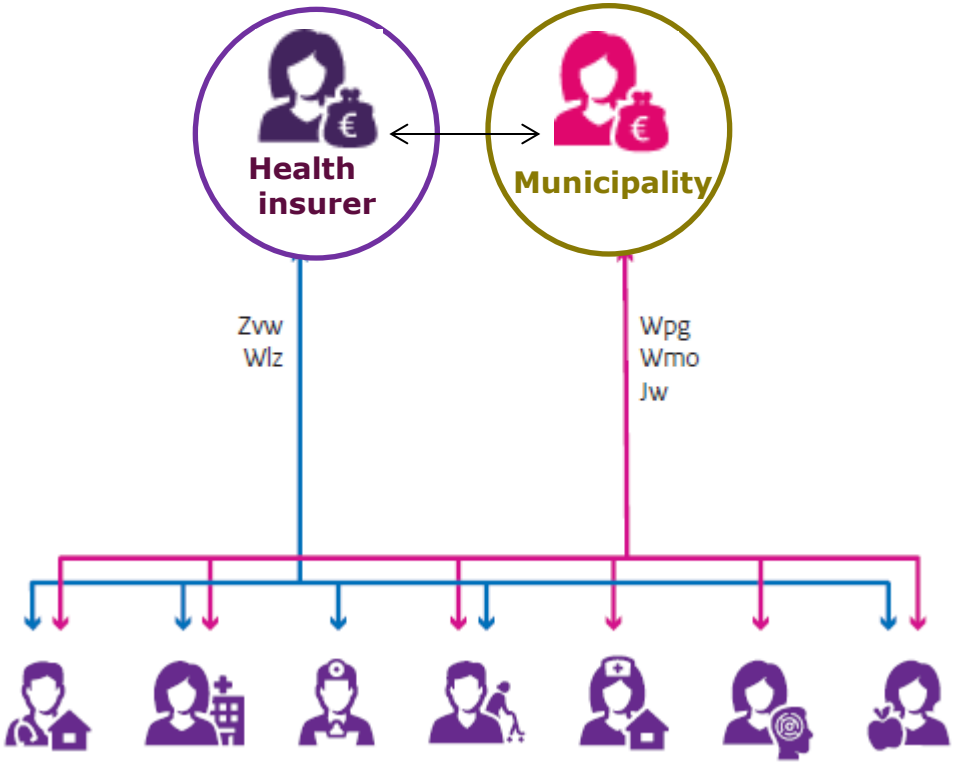
GoedLeven



Vitaal Vechtdal



PHM results in complex payment issues



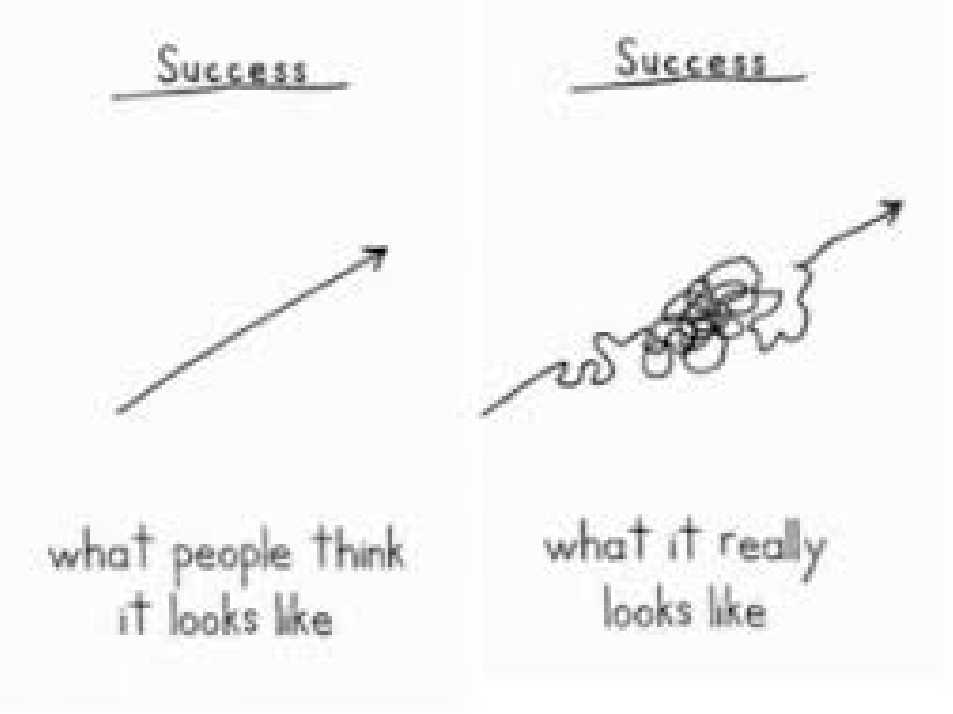
My key lessons so far…

- Care Groups were a necessity for starting PHM initiatives
- PHM is a complex governance and payment issue
- (Current Fee-For-Service model do not inhibit integration
- Build trust by bridging gaps in organizational cultures (distributed leadership, trust, etc.)
- Muster the political courage to realize transparency

Some English references about Dutch PHM

- HW Drewes, JN Struijs, JN, CA Baan (2016). "How the Netherlands Is Integrating Health and Community Services." NEJM Catalyst. Retrieved 14-11-2016, from http://catalyst.nejm.org/netherlands-integrating-health-community-services/.
- Struijs, JN, et al. (2015). How to evaluate population management? Transforming the Care Continuum Alliance Population Health Guide into a broadly applicable analytical framework. Health Policy 119: 522-529.
- Hendrikx, RJP, et al. (2016). "Which Triple Aim related measures are being used to evaluate population management initiatives? An international comparative analysis." Health Policy 120(5): 471-485.
- Steenkamer, B. M., et al. (2017). "Defining Population Health Management: A Scoping Review of the literature." Popul Health Manag 20(1).
- Elissen AM, Struijs JN, Baan CA, Ruwaard D. Estimating community health needs against a Triple Aim background: What can we learn from current predictive risk models? Health Policy. 2014 Dec 15. pii: S0168-8510(14)00341-8. Doi: 10.1016/j.healthpol.2014.12.007.

Primary care Plus



What is Primary care Plus

Goal

In general: Shifting hospital-based specialist care toward primary care

More specific: avoiding unnecessary referrals toward hospital-based specialist care

How

the substitution of specialist care in the hospital setting with specialist care in the primary care setting.

→ Better informing GPs to reduce their uncertainty by specialist care in a primary care setting

What is Primary Care Plus? (II)

–GPs refer patients with non-acute complains about whom they doubt toward PC+

–Specialists perform PC+-consultation in primary setting without the use of hospital diagnostics

–Duration of first PC+ consultation is max. 30-45 min, with a maximum of two PC+ visits

–five medical specialties: internal medicine, orthopaedics, dermatology, neurology and cardiology

–Specialists give a recommendation to GP:

(1) refer to hospital

(2) advice on treatment in primary care

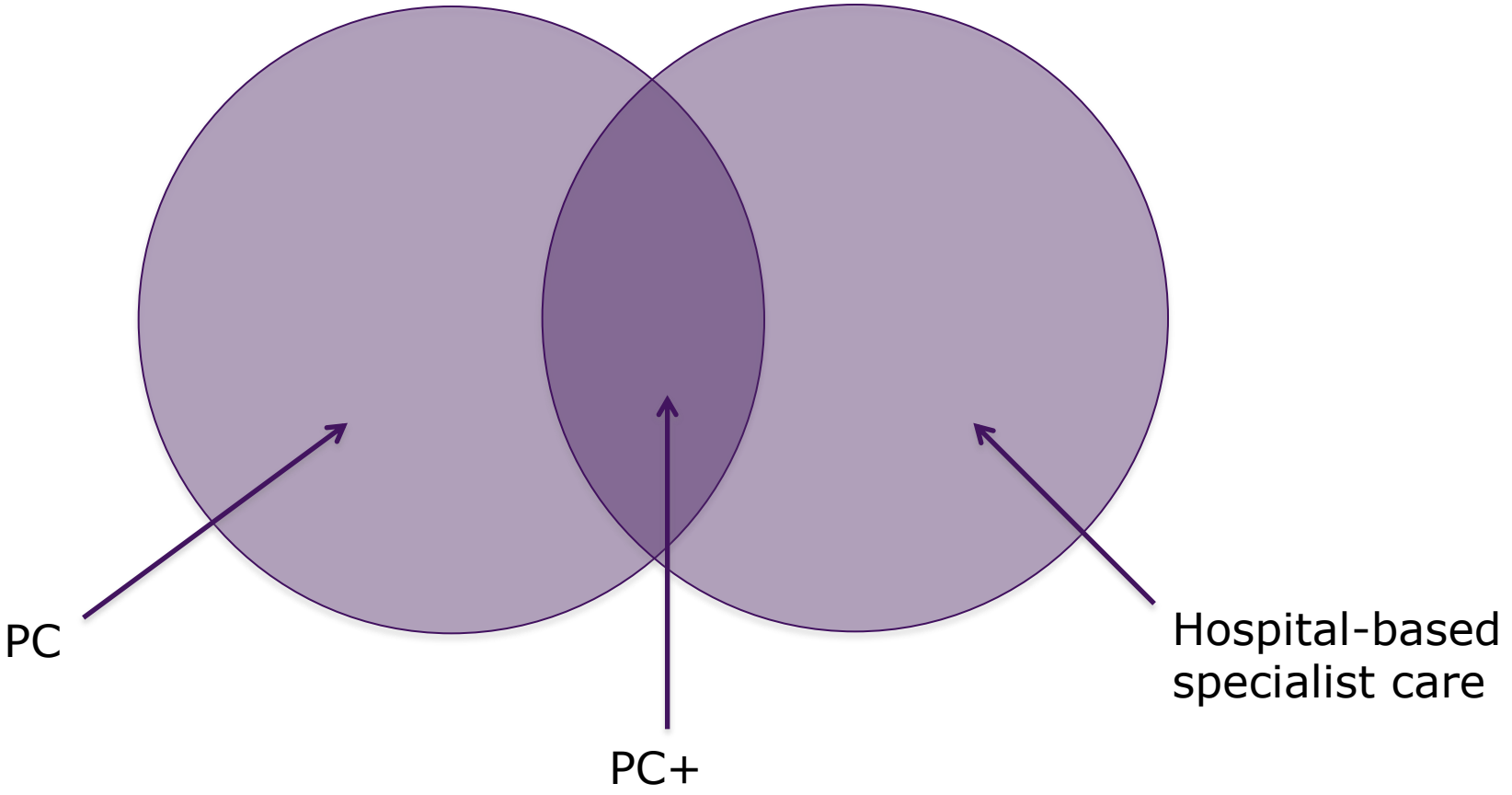
–GPs stays responsible during PC+ consultation

What is Primary Care Plus? (III)

- Different models:
  - Specialists work in GP practices (weekly or biweekly)
  - Specialists work at a PC+ center

- PC+ is **not** an intermediate station: to achieve efficiency it is a precondition that PC+ interventions should exclude patients who need hospital care anyway.

Subpopulations of PC+



Preconditions PC+ based on feasibility study

(source van Hoof et al., 2016)

1. the project management should make arrangements on a governmental level
2. the project management should arrange a collective integrated IT-system
3. the project management together with involved GPs and medical specialists should determine the appropriate profile for medical specialists
4. the project management together with involved GPs and medical specialists should design a referral protocol for eligible patients
5. the project management should arrange deliberation possibilities for GPs and medical specialists
6. the project management together with involved GPs and medical specialists should formulate a diagnostic protocol

Trying to select the appropriate patient groups

Source: Quanjel et al. (submitted)

Does PC+ lead to a decrease in referrals?

Source: Quanjel et al. (submitted)

PC+ summarized

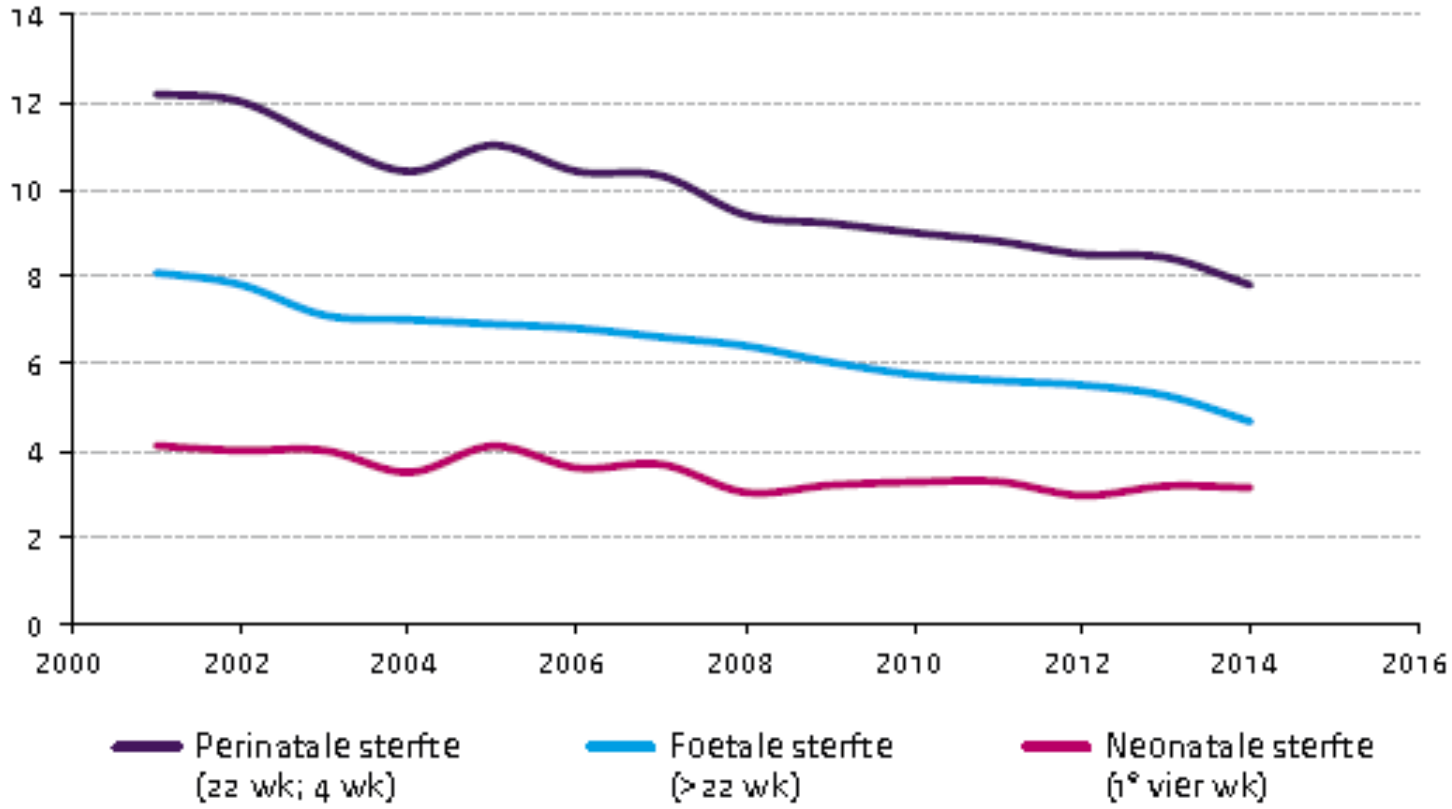
- Still in the early days: not all preconditions are met so full impact can not be studied
- Selecting the appropriate patient groups appears to be complex
- Only early results available (learning effects)

Some English references about Dutch PC+

- SJM van Hoof, MD et al. (2016). Substitution of outpatient care with primary care: a feasibility study on the experiences among general practitioners, medical specialists and patients. BMC Family Practice (2016) 17:108, DOI: htt://dx.doi.org/10.1186/s12875-016-0498-8
- van Hoof, SJM et al. (2016). Substitution of Hospital Care with Primary Care: Designing the Conditions of Primary Care Plus. International Journal of Integrated Care, 16(1): 12, pp. 1–11, DOI: http://dx.doi.org/10.5334/ijic.2446
- Quanjel et al. *Evaluating a Dutch cardiology primary care plus intervention on the Triple Aim outcomes: study design of a practice-based quantitative and qualitative research*" (accepted for publication BMC Health Services Research)

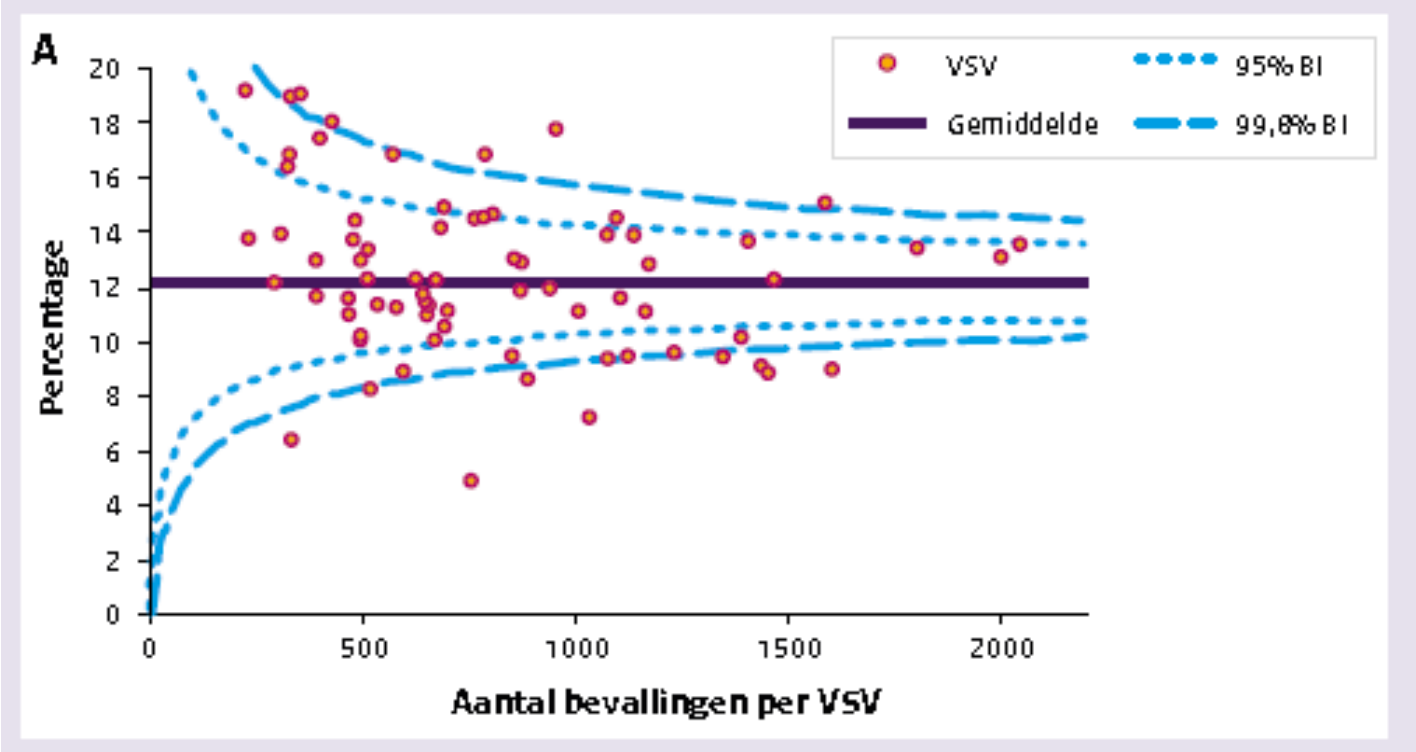
Bundled Payments for birth care

Birth care outcomes are improving but



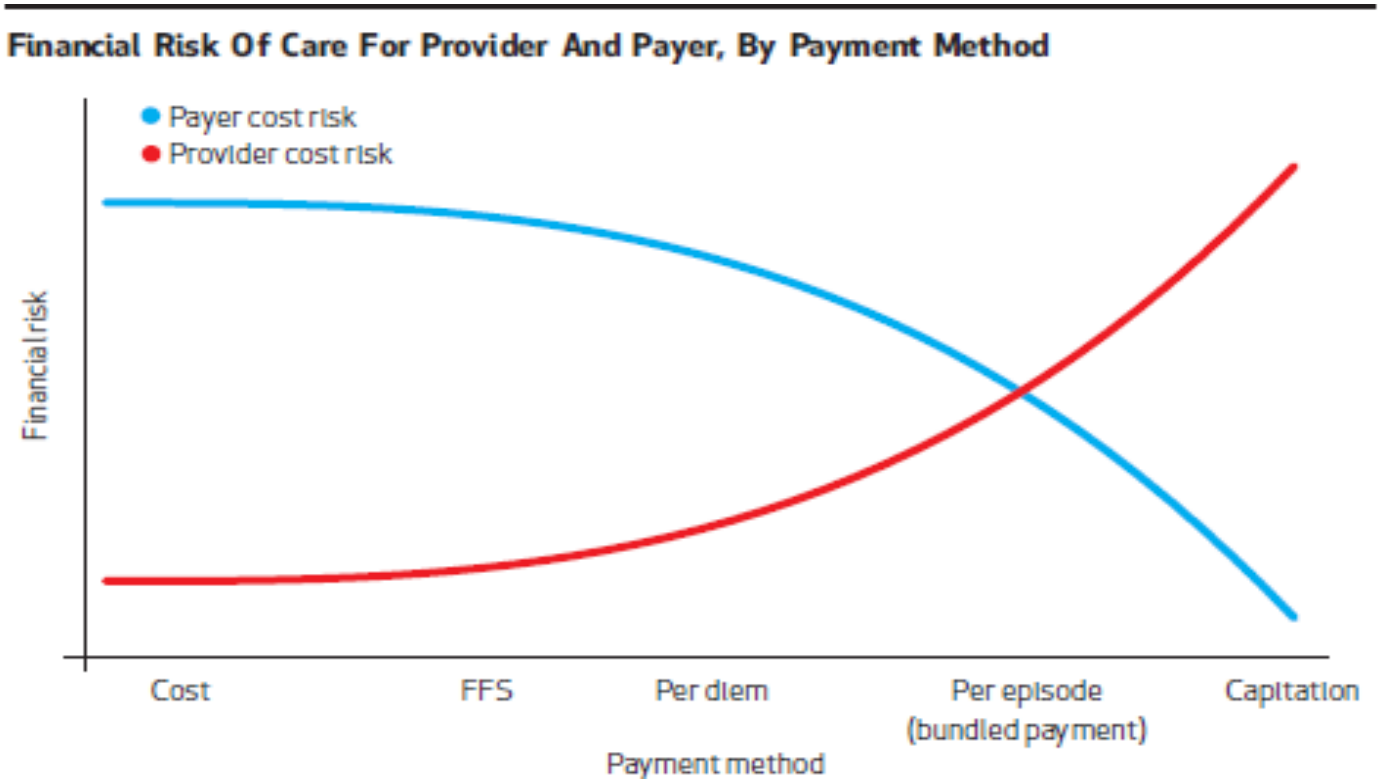
Source: Perined, in cooperation with RIVM

Room for improvements…



Percentage Unplanned 'C-sectios' per by women in low risk group
(Source: PRN 2014 and analyzed by RIVM)

‘shifting accountability from payers toward providers’



Reference: Frakt, 2011

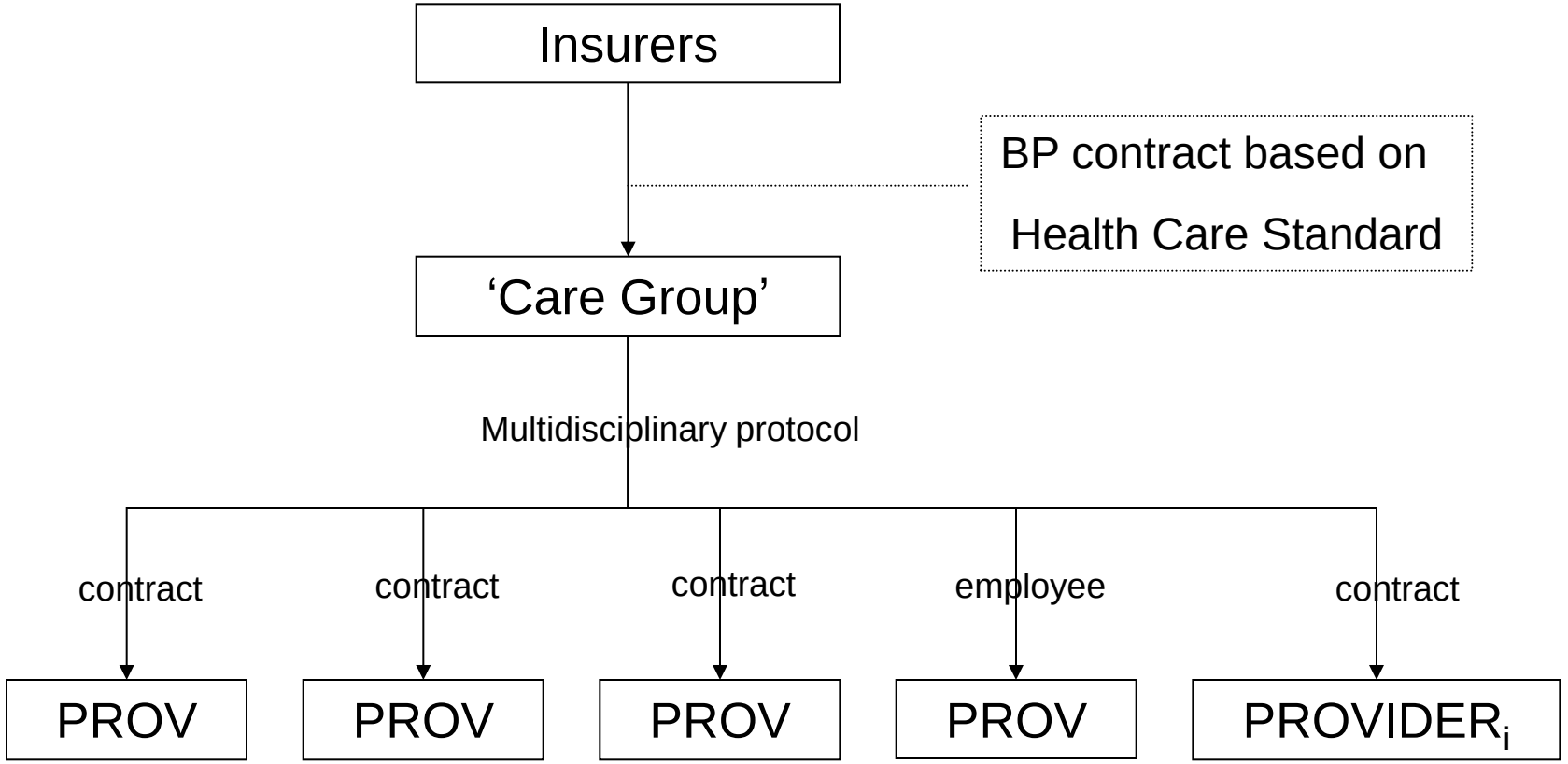
Bundled Payment (BP) system for diabetes care

in short

- 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

Bundled Payment model

‘Outline of BP model’



Content BP contract (advice KPMG)

- 2 modules (<16 weeks, >16 weken)
- Health Care Standard and Quality indicators (i.e.. AOI-5, ReproQ)

BP model with 9 modules

Prenatal	Natal	Postnatal
1. <16weeks		
2. Regular >16w	4. Regular	7. Regular
	5. hospital-based without medical indication	
3. Complex >16w	6. Complex	8. Complex
		9. Maternity care

Conclusions

- Introduction of a bundled payment for birth care not without controversy:
  - Designing a legal entity is very complex governance question
  - Lack of knowledge leads to uncertainty about the (financial) consequences
  - This uncertainty is enforced by lack of national guiding principles, differences in purchasing policies between insurers
  - Most actors are uncertain about the potential effects of bundled payment
- Currently, six regions signed BP contracts for birth care
- Going from competition toward collaboration leads to inherent tension and takes time
- Monitoring is crucial insights in the effects!

What's next?

- Diabetes: extending 'primary care' bundles with secondary care and medication
- Potentially other chronic conditions will be introduced among which dementia, arthrosis, obesitas
- How to combine single-disease bundles with global budgets with two-sided shared savings model? ('pioneer sites population management')

Some English references about bundled payment

- JN Struijs. How Bundled payments are working in the Netherlands. *New England Journal of Medicine* Insight Center. October 12, 2015. Available at: http://images.nejm.org/editorial/supplementary/2015/hbr12-struijs.pdf
- Struijs JN, Baan CA. Integrating Care through Bundled Payments — Lessons from the Netherlands*. N Eng J Med* 2011, 264;11:990-991.
- DH de Bakker, **JN Struijs**, CA Baan, J Raams, B Vrijhoef, JE de Wildt, FT. Schut. First experiences with bundled payments for chronic care in the Netherlands. *Health Affairs*, (2012):426-433.

Take home messages VHCL

- Many Dutch policies aiming to shift hospital care toward primary care among which PC+, bundled payments within or next to PHM
- Strengthening primary care is not enough, it must be 'organized' (on a regional level)
- Shifting financial risk toward providers appeared to be a key enabler in health care delivery transformation
- Shift from patient centered (DMP+BP) toward population centered (PHM)
- PHM is a complex governance and payment issue

Download at:
http://www.rivm.nl/bibliotheek/rapporten/2016-0031.pdf

Thanks for your attention!

Jeroen Struijs
E: jeroen.struijs@rivm.nl

Caroline Baan
E:caroline.baan@rivm.nl