Integrated care: achieving better coordination of care for the chronically ill
Lessons from the Netherlands Bundled-Payment Initiative

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Let me introduce myself

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University of Tilburg

Chairman evaluation committee bundled payments
Dutch health care system: general

• Bismarck social insurance
• Health care reform since 2006
• Universal mandatory health insurance
• Insurers compete for insured
• Insured press insurers to contract low price/high quality care
• Stepwise introduction
Dutch health care system: providers

- GP: list system (av. 2200), gatekeeper system, 50% CAP/50% FFS
- Other primary care providers: FFS
- Primary care = cottage industry
- Hospital sector: FFS (DBC-system) since 2002
Performance Dutch health care system

- first on dimensions of equity and access
- second on quality
- third on efficiency, 12 % of GDP spent on health
- fourth on healthy and productive lives.

Commonwealth Fund, Davis et al 2010
Weaknesses

1: Interdisciplinary collaboration within primary care less developed

2: Collaboration between primary and secondary care hindered by differences in financing

→ Lack of coordination of care for chronically ill needing care from multiple providers from both primary and secondary care
Dutch solution since 2010: bundled payments for chronic care

- Diabetes, COPD, vascular risk management
- Health insurers pay a single (negotiable) fee to the ‘care group’
- Care group responsible for organization and delivery of care
- Subcontract other providers
Disease specific care standards

- Set at national level (providers and patients)
- Complete care continuum (from early recognition to palliative stage)
- Evidence based
- Patient perspective: individual care plan
- Promotion of self management
- Multidisciplinary
- Specify treatments, not disciplines
- Basis for quality improvement
- Specify performance indicators
- Basis for payments
Care standards

Present for:
- Diabetes
- COPD
- Vascular Risk Management
- Obesitas

Under construction for:
- Dementia
- Artrosis
- Asthma
- Depression
- Stroke
- Metabolic disease
- Cancer
Primary care for cancer

Growing awareness

• Growing numbers of cancer survivors
• Follow-up monitoring by specialists
• Lot of comorbidity
• Increasing use of primary care

Utilization of GP services

<table>
<thead>
<tr>
<th>Service</th>
<th>Cancer survivors</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations GP</td>
<td>3.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Home visits</td>
<td>2.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Prescriptions * 10</td>
<td>1.5</td>
<td>1.0</td>
</tr>
</tbody>
</table>
What is in the bundled payment?

<table>
<thead>
<tr>
<th>In bundled payment</th>
<th>Not in bundled payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care and outpatient specialist care (consultative) as described in care standards for the specific disease</td>
<td>Primary care cost for other complaints/diseases of bp-patients</td>
</tr>
<tr>
<td>Av. € 400</td>
<td>Medication costs</td>
</tr>
<tr>
<td></td>
<td>Hospital costs</td>
</tr>
<tr>
<td></td>
<td>Av. € 4400</td>
</tr>
</tbody>
</table>
Incentives for well-coordinated care at a reasonable price

• Competition among care groups for contracts with health insurers
• Competition between subcontractors for contracts with care groups
• Providing performance indicators part of the contract
Implementation

• Experiments with diabetes care groups, 2006-2009
• Nationwide implementation in 2010
• Transitions period 2010-2012: insurers and providers free to finance care the old way
• Evaluation committee advising how to continue
Final report evaluation committee

- June 2012
- Main effects, side effects, conditions
- Multiperspective (insurer, patient, principal contractor, subcontractor)
- Integration existing research
- Stakeholders meetings
- Cost analysis (National institute for public health and the environment)
1. For final assessment too early

- Effects on cost and quality will be on long term
- Cost data lag behind (only for experimental situation before 2010 and only for diabetes)
2. Better organized care

- Nationwide network of care groups
- GPs, practice nurses, dieticians, physiotherapists, podotherapists, internists, ophthalmologists
- Diabetes (80%), COPD (30%), VRM (occasionally)
Rapid growth of diabetes care groups

- Owned by gp’s
- 50 – 100 gp’s
- Av 6500 patients
- GP, nurse, dietician, internist, ophtalmologist
COPD and VRM lag behind
3. Small effects on quality of care

- Better guideline adherence
- Substitution from secondary to primary care: lower proportion of patients is treated in hospital (25% less than ‘regular care’)
- Large variation between groups and practices
4 Initially (2009) higher costs (3%)

- Investment costs in primary care (av. Cost per diabetes patient: 400 euro)
- Hospital costs did not decrease despite less patients
- Double payments
- Large variation between groups and practices
5. Improvement possible

• Quality assurance by care groups underdeveloped
• Transparency system does not function properly yet (data and ICT-requirements)
• Lack of steering by insurers: double payments, separate contracting primary and secondary care
5. Strengthen position of patients

- Patients unaware being included in a bundled payment program
- Self management and individual care plans underdeveloped
- Commitment of patients with care plan by reduction on copayments (?)
6. Issues around competition

- Only four insurers
- Care groups have regional monopolies
- Complicated (dominant vs following insurers)
- Subcontractors in a weak position (ie practice nurses replace dieticians)
- No evidence for risk selection
- Supervision by Dutch Health Care Authority
7. Issue: comorbidity and prevention

- Approach is single disease based
- Co-/multimorbidity not incorporated
- Does not fit in generalistic primary care
- How about prevention?
Recommendations evaluation committee

• Transition period cannot be ended
• Care groups must fulfill higher requirements for bundled payments
• Bundled payments is an intermediate step
• In a continuum towards more integrated payments based on populations
## Continuum of payment systems

<table>
<thead>
<tr>
<th></th>
<th>a. Fee for service</th>
<th>b. Fee for service with add-ons</th>
<th>c. Single disease bundled payment</th>
<th>d. Multiple disease bundled payment</th>
<th>e. Population based payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment</strong></td>
<td>Per discipline, per service</td>
<td>Per discipline, per service + allowance for coordination</td>
<td>Per patient with disease</td>
<td>Per patient with (multiple) diseases</td>
<td>Per patient</td>
</tr>
<tr>
<td><strong>Contracts</strong></td>
<td>Insurer/provider verzekerar</td>
<td>Insurer/provider with add on for collaboration</td>
<td>Principal contractor with insurer, principal contractor and subcontractor</td>
<td>Principal contractor with insurer, principal contractor and subcontractor</td>
<td>Principal contractor with insurer, principal contractor and subcontractor</td>
</tr>
<tr>
<td><strong>Quality assurance</strong></td>
<td>Monodisciplinary</td>
<td>Monodisciplinary</td>
<td>Multidisciplinary</td>
<td>Multidisciplinary</td>
<td>Multidisciplinary</td>
</tr>
<tr>
<td><strong>Transparency</strong></td>
<td>Per service</td>
<td>Per service</td>
<td>Indicators</td>
<td>Indicators</td>
<td>Indicators</td>
</tr>
<tr>
<td><strong>Role patient</strong></td>
<td>Self-Coordinated</td>
<td>Depends</td>
<td>Disease based care plan incl. selfmanagement</td>
<td>Disease exceeding care plan incl. selfmanagement</td>
<td>Patient oriented care plan, incl. self management and prevention</td>
</tr>
</tbody>
</table>
Prospects

• Elections on September 12, new coalition, same minister of health
• Transition period will continue
• Experiments with population based financing are starting already
Thanks for your attention!

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Literature:
Bakker DH de, JN Struijs, CB Baan, J Raams, JE de Wildt, HJ Vrijhoef, FT Schut, Early results from adoption of bundled payment for diabetes care in the Netherlands show improvement in care coordination. Health Affairs 31, 2 (2012): 426-433