Using Regional Funding to Achieve Transparent and Personalized Health Care

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Published in:
Personalized Specialty Care

DOI:
10.1007/978-3-030-63746-0_20

Publication date:
2021

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Abstract

In this chapter we discuss funding issues from a quality perspective at different levels of health care: the level of the patient and health care provider, the health care organization, and the health care network in the region. We will outline a number of issues that health care professionals as well as patients encounter in daily practice. Finally, we will argue how regional responsibility for the health and health care costs of the population can contribute to transparency in care outcomes and quality-enhancing funding.

Keywords

Value-based Health Care · Personalized Care · Quality of Care · Health care purchasing · Regionalized care · Payment models · Financial incentives

From the perspective of health care quality, a lot of attention is paid to the question of what valuable health care is, how we can best measure it, and how we give value a place in the consultation room. There is also growing awareness that we need to

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N. van Weert, J. Hazelzet (eds.), *Personalized Specialty Care*,
https://doi.org/10.1007/978-3-030-63746-0_20

organize health care more from the perspective of the patient or citizen and less from the perspective of the health care provider or health care institution.

This means that patients and health care providers have "the right conversation" in the consultation room. That conversation can provide clarity about what is important to a patient in their life and how health care can contribute to these values. Good communication between health care providers and patients also provides the necessary understanding of possible outcomes and limitations of a treatment. This facilitates adequate, joint decision-making. In addition, the health care provider and the patient pay attention to the patient's own role in their treatment. After all, therapy compliance and healthy behavior strongly influence treatment outcomes.

Achieving this personalized health care requires insight into the structure, process, and outcomes of care. A good structure means well-equipped staff, with sufficient resources for treatment and diagnostics. The care process is established by means of treatment guidelines and agreements for a good division of tasks and collaboration. Particularly in the area of care outcomes, supportive care funding is an essential precondition, and transparency in care outcomes is needed to encourage health care providers to continue to improve these outcomes.

20.1 Funding Issues

We distinguish between three levels of funding issues in order to achieve this value-based, personalized care: in the relationship between patient and health care provider, in the organization of care, and in collaboration in the region.

20.1.1 Patient and Health Care Provider

As a patient, you want access to the best health care as quickly as possible. In the Netherlands, citizens are obliged to purchase private health care insurance for this purpose so that they can actually receive the diagnostic procedures and treatments established in the basic package. The patient has an important role in indicating which treatment they want to receive. It is well known that good communication and, in turn, trust between health care providers and patients can contribute to better treatment choices of patients with regard to health care outcomes and the cost of health care. However, due to their limited knowledge and information, patients always remain highly dependent on the expertise of the health care provider.

Health care providers therefore have a duty to, within the set framework of treatments, advise which treatment is necessary and most suitable. However, the current financing of health care—payment per activity (or fee-for-service)—mainly stimulates the availability of care, and provides no incentive to make choices about what kind of health care is or is not necessary and to perform the chosen treatment in the best possible way [1–3]. Taking the time for a good discussion in the consultation room, and choosing a treatment together that suits the individual wishes of the patient are therefore not included in the current funding. Ideal funding stimulates

health care that contributes as much as possible to the health of the individual patient at the lowest possible cost. Financial incentives should reward the latter instead of focusing on the supply of health care products on the basis of guidelines, routine, or agreed production targets.

20.1.2 The Health Care Organization

Funding also plays an important role at the level of the health care institution in organizing health care in the best possible way and making choices about the kind of health care the institution provides. Health care institutions are funded per health care product they supply in the form of diagnosis-related groups (DRGs). Within this system, health insurers have been agreeing on a lump sum and revenue limit for years. On the one hand, this means that there is an incentive to create the budget using sufficient production. On the other hand, there is limited leeway to provide more health care when needed.

Although reimbursement of health care is based on specified care services, the current method of funding does not take into account differences in the effectiveness of various treatment options or the health care needs of individual patients. Health insurers are expected to stimulate quality improvement by choosing the best institution for each treatment. However, in practice, this market mechanism focuses mainly on waiting times and costs [4]. It seems unrealistic to expect insurers, health care institutions, and professionals to be able to make critical choices about the provision of health care when there is a lack of transparency about outcomes from both a biomedical and a patient perspective.

These types of choices become even more difficult when they extend beyond the boundaries of the department. At many health care institutions, the distribution of resources between disciplines is a complicated puzzle: the historical budget supplemented by the importance of the health care institution and the department predominates. It is sometimes known within hospitals that certain treatments generate more income than others, which creates an incentive to focus on those treatments [2, 3]. By doing so, the provision of that type of treatment becomes a way of covering overhead costs for infrastructure and organization.

This raises the question of whether the cost of treatments always corresponds to the value created and whether it is realistic to have to calculate the correct reimbursement for each individual patient. An alternative is to monitor the health gains for patients at the institutional or population level (including PROMs) and to distribute the payment (for diagnostics, treatment, and counselling) on that basis [5, 6].

20.1.3 The Region

Similarly, funding for health care activities in the region creates tension between health insurers and care providers. This makes it difficult to achieve “the right care in the right place.” For example, it is known that COPD patients benefit from a

timely, comprehensive diagnosis and treatment plan from the hospital and a good follow-up plan with the general practitioner and physiotherapist [7]. However, in practice there is a lot of variation, and it is difficult to coordinate primary and secondary health care [8]. The current separation of financial responsibility and production incentives is an obstacle to proper coordination and agreements between care providers. Bundled payment could strengthen this coordination and function as a control tool for the health care network. So far, however, it seems that tension is being created over which provider should perform which task within the bundle [9]. Bundled payment therefore also needs to be combined with joint financial responsibility. This may mean that we move from one bundle per patient to funding an entire population. Then the general practitioner, hospital, and physiotherapist—and perhaps even the health insurer and the municipality—are responsible for the health care budget, but above all for the patient's health.

20.2 Better Funding Requires Transparency

The above illustrates the problems with regard to funding and transparency we face in the Dutch health care sector. Table 20.1 summarizes the advantages and disadvantages of different funding models. The current method of funding, with an emphasis on payment per activity and budgets per institution, does not provide an incentive for coordination in order to make the right choices for patients and society as a whole. Experiments with rewards based on imperfect structure, process, and outcome indicators are interesting, but may be accompanied by registration load, risk selection, and mixed effects. For example, research shows that the motivation of professionals changes when their remuneration is directly linked to performance indicators [10]. Financial incentives can lead to health care providers focusing more on goals that, for instance, benefit the health care organization rather than society as a whole.

At the moment, hospitals mainly focus on curative health care, such as through hospitalizations. Preventing future hospitalizations is not rewarded, and health care providers are thus not given the opportunity to do this in their work. Joint funding or population budgets offer solutions, but then the question of how tasks and costs are divided between health care providers remains. By providing a better overall picture of health gains through PROMs and clinical outcomes, we can work towards a system that rewards what matters to patients and society: health at the individual and population levels.

20.3 The Right System Incentives

In order to achieve better incentives at the levels of the patient, health care provider, and region, better incentives are also needed at the level of the health care system. The current health care market holds *health care providers* individually responsible

Table 20.1 Different types of funding and their advantages and disadvantages

Type	Advantages	Disadvantages	References
Funding based on lump sum budget and per capita	Lowers transaction costs, continuity of income	Risks for waiting times	[1, 2, 13]
Payment per activity	Reduces waiting times, increases transparency of services	Increases volume, offers no incentive for collaboration	[1–3, 14]
Pay for performance	Encourages quality improvement	Shifts focus to performance instead of outcomes for the patient, incentivizes risk selection, leads to high administrative burden	[10, 15–17]
Shared savings	Incentivizes efficiency and innovation	Incentivizes risk selection and health care avoidance, poses no risk for health care provider, presents a moral dilemma: extra payment for quality improvement	[11, 12]
Bundled payment	Stimulates collaboration and a better division of tasks	Presents challenges when involving all stakeholders, risks high transaction costs and registration load, creates the need for transparency, presents challenges when taking comorbidity into account	[9, 18–21]
Population funding	Stimulates collaboration and a better division of tasks	Challenging to involve all stakeholders	[12, 22]

for the care they organize and provide. This does not seem to stimulate the intended quality improvement and, on the contrary, constitutes a barrier to personalized care, i.e., the best possible care for the individual patient. The market mechanism with competition between *health insurers* in turn leads to a more short-term cost-oriented vision with limited influence on content. At the same time, health insurers should encourage health care providers to be transparent about care outcomes and to strive for an improvement in quality.

The question is therefore whether the current market system can lead to transparency and an improvement in quality when there is no joint responsibility at the regional level for the euros we spend on the health of the population. There are already interesting examples at the regional level, where primary, secondary, and tertiary health care providers, together with health insurers, take responsibility for the health—including costs—of the population. Examples are the Accountable Care Organizations in the United States [11] and Gesundes Kinzigtal in Germany [12]. In the Netherlands, the national Hoofdlijnakkoorden (Framework Agreements) illustrate that joint financial responsibility facilitates a regional shift in health care. We can continue this movement when health insurers are given greater regional responsibility.

To this end, it may not be necessary—or desirable—to drastically change the current health care system. For example, it can already help to give a large regional health insurer the lead in its region's health care procurement. In order to do so, it is necessary to provide even more long-term prospects and for health insurers to encourage collaboration rather than competition. Only then will investing in better regional health care infrastructure, better collaboration, and division of tasks in health care chains become financially interesting for health insurers and health care providers in the long term. This will also provide an incentive to create transparency and agree on new forms of funding, which are a prerequisite for personalized care and a healthier population.

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