Alternative Payment Models in health care
An introduction

Jeroen Struijs, PhD

National Institute for Public Health and the Environment, Department Quality of care and Health Economics
Leiden University Medical Centre-Public Health and Primary Care – Health Campus The Hague

February 8th 2023, Leergang Leiderschap Netwerkzorg Vlissingen

Learning Objectives Workshop

After this workshop, you should be able to:

1) Critique and form economic arguments for and against particular payment policies (the ‘why’)

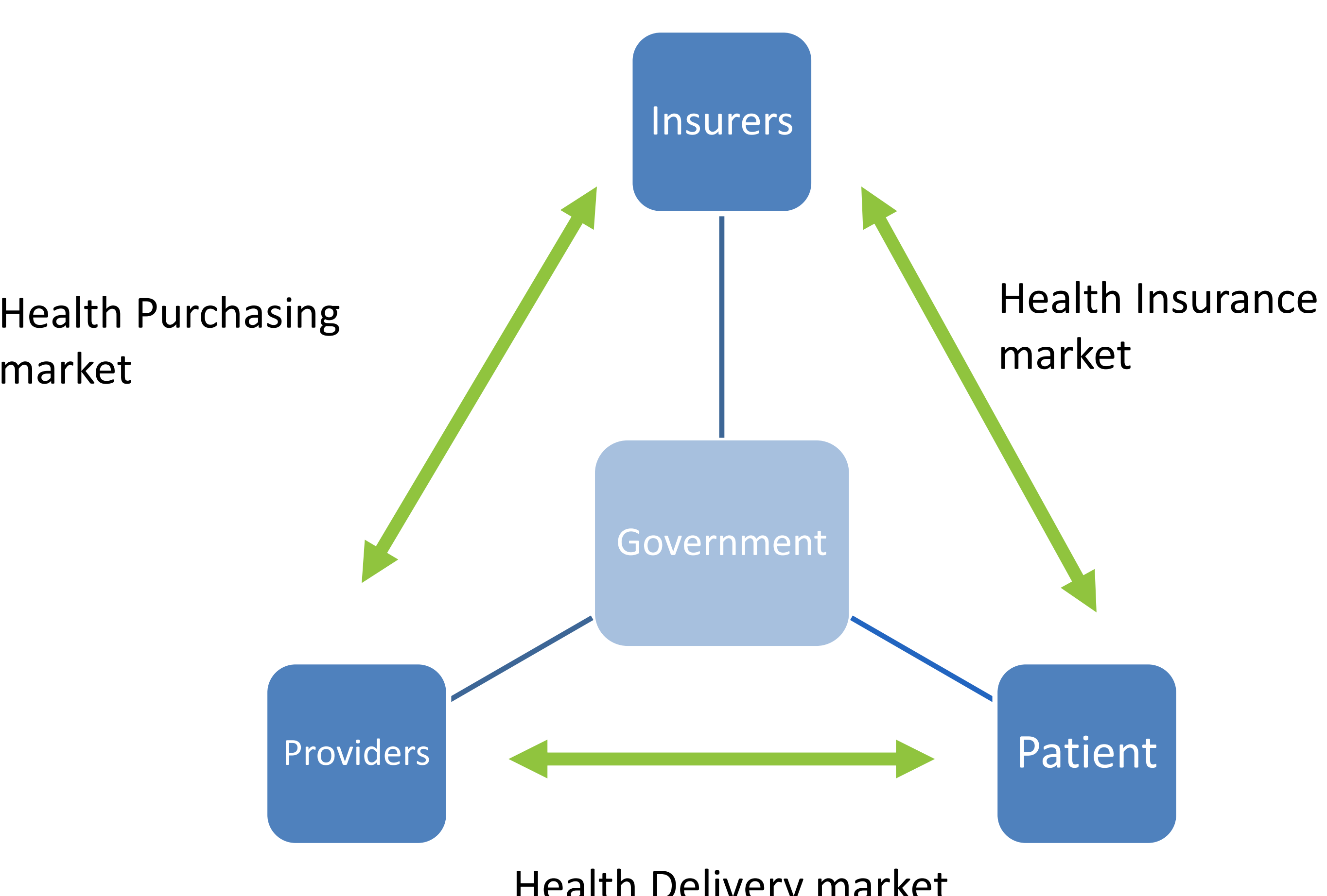
2) Describe key design elements of alternative payment models including shared savings and bundled payments (the ‘what’)

3) Discuss the ACP and the five building blocks for an APM (the ‘how’)

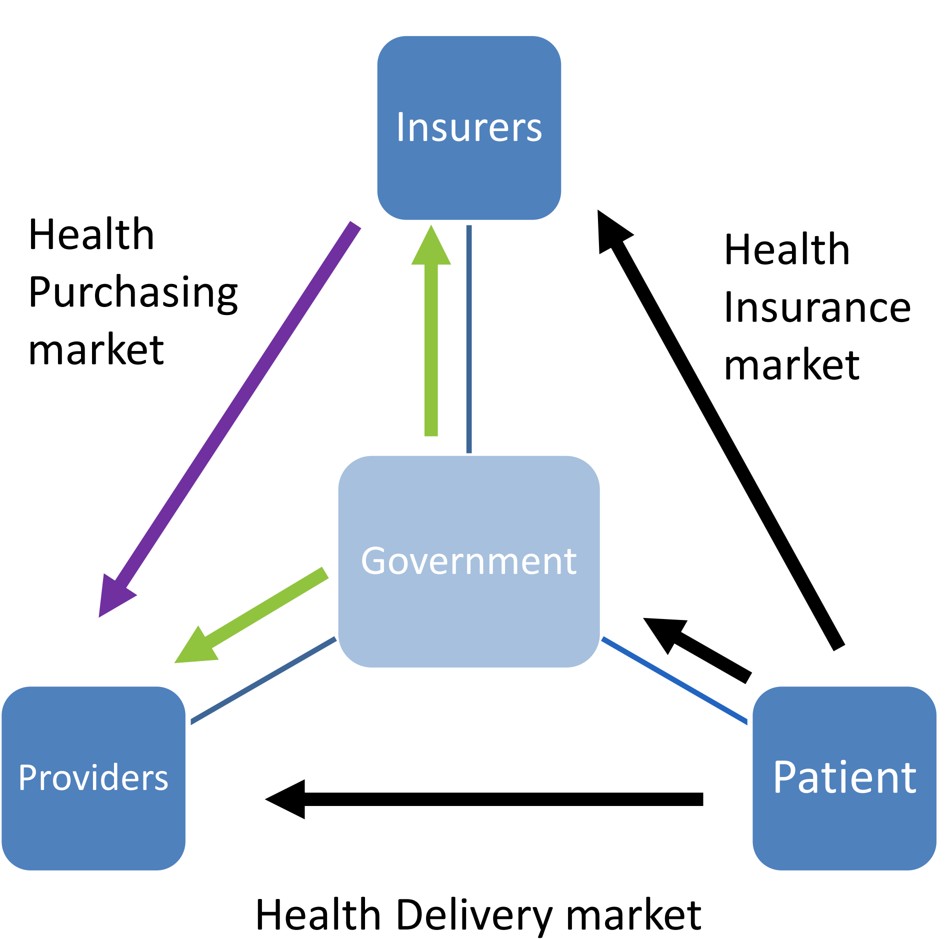
Financing vs. Paying

- Financing (in Dutch: financiering):
  - How is the cake built up?
- Payment (in Dutch: Bekostiging:
  - How do we *divide* the cake?
  - Now: mostly volume-based, i.e. you get more of the cake when you produce more.

Managed competition model (Health Insurers Act)

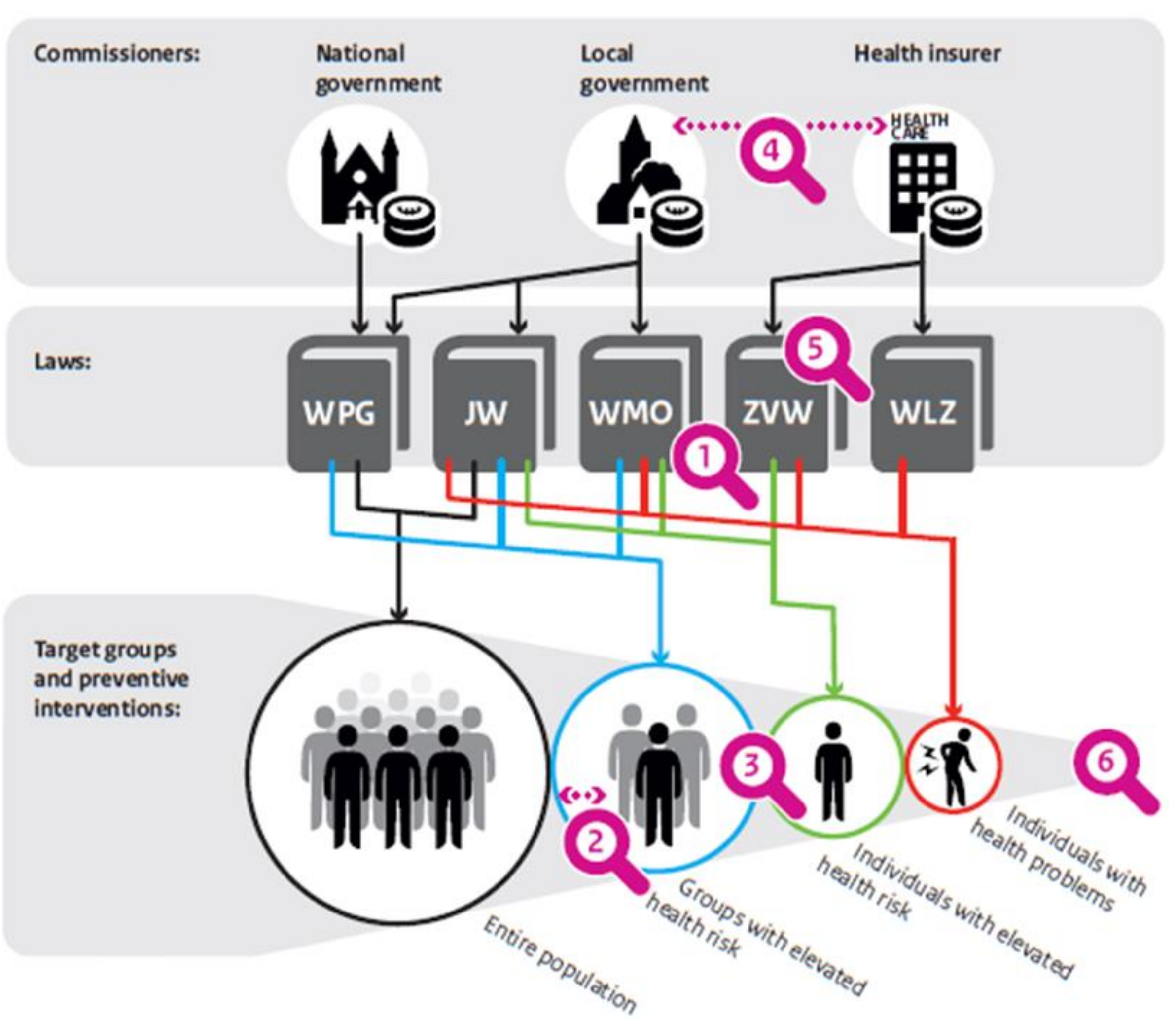


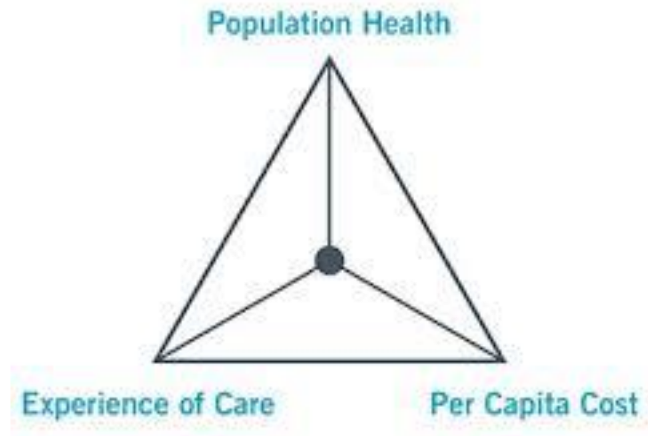
Managed competition model (Health Insurance Act)



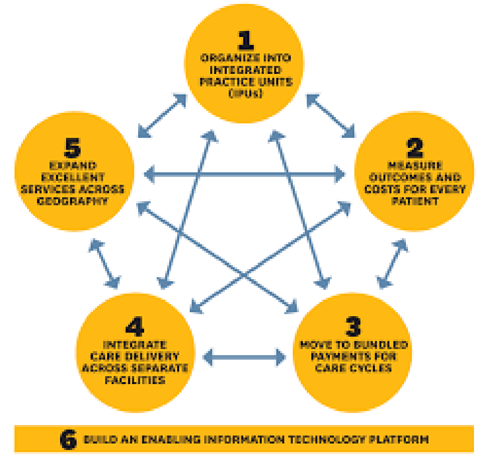
- Employers, citizens / patients pay taxes, premiums, co-payments
- Governmental bodies partly fund purchasers and compensate risks via the risk equalization scheme, and partly fund providers directly
- Purchasers contract with providers and pay claims

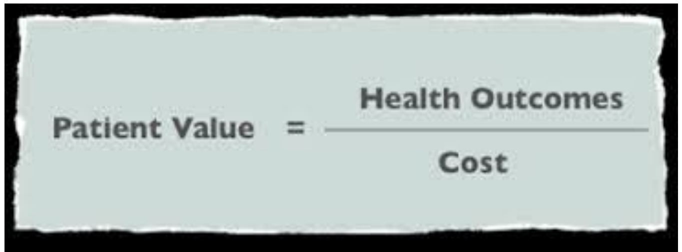
Health promotion: even more complex as parts are in different laws





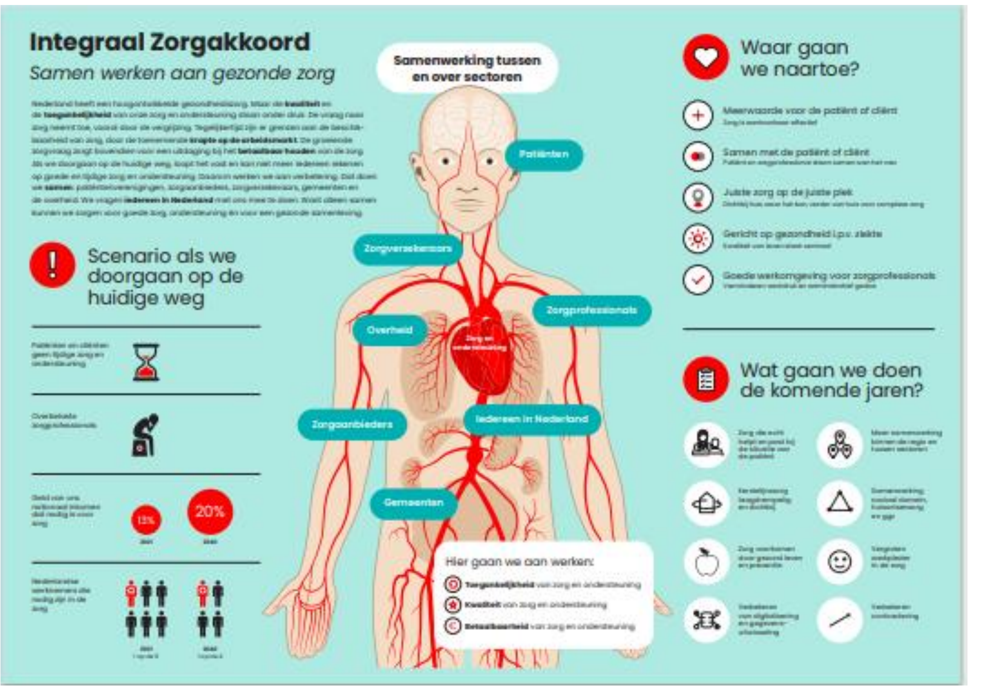
Value-based health care





Source:
Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: care, health, and cost. *Health affairs*, *27*(3), 759-769.

Source:
Porter, M. E. (2010). What is value in health care. *N Engl J Med*, *363*(26), 2477-2481.


Integraal Zorgakkoord
Samen werken aan gezonde zorg
Samenwerking tussen en over sectoren
Waar gaan we naartoe?
Meerwaarde voor de patiënt of cliënt
Samen met de patiënt of cliënt
Juiste zorg op de juiste plek
Gericht op gezondheid i.p.v. ziekte
Goede werkomgeving voor zorgprofessionals
Scenario als we doorgaan op de huidige weg
13%
20%
Patiënten
Zorgverzekeraars
Zorgprofessionals
Overheid
Zorgaanbieders
Iedereen in Nederland
Gemeenten
Wat gaan we doen de komende jaren?
Hier gaan we aan werken:
Toegankelijkheid van zorg en ondersteuning
Kwaliteit van zorg en ondersteuning
Betaalbaarheid van zorg en ondersteuning

Samenwerken aan
passende zorg:
de toekomst is nú

Passende zorg
Goed bestuur & professionele bedrijfsvoering
Passende bekostiging en contractering
Datagedreven beleid en uitvoering
Wendbare organisatie

Learning Objectives Workshop

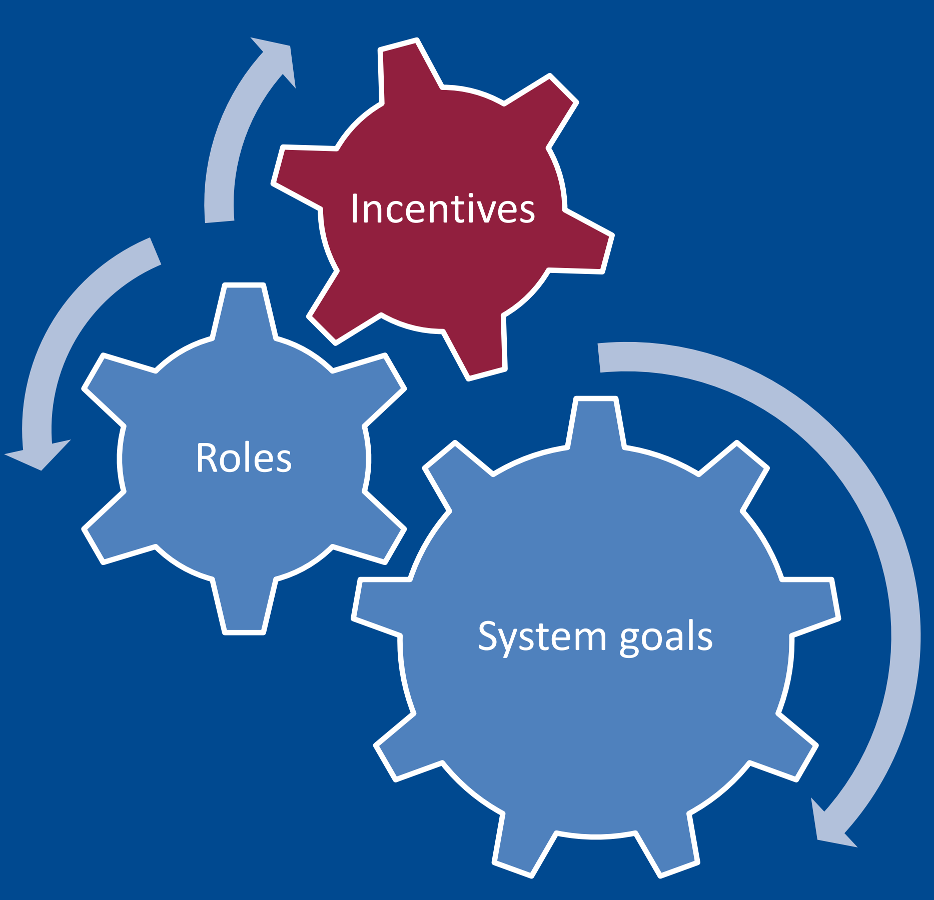
After this workshop, you should be able to:

1) Critique and form economic arguments for and against particular payment policies (the ‘why’)

2) Describe key design elements of alternative payment models including shared savings and bundled payments (the ‘what’)

3) Discuss the ACP and the five building blocks for an APM (the ‘how’)

Why payment reforms?

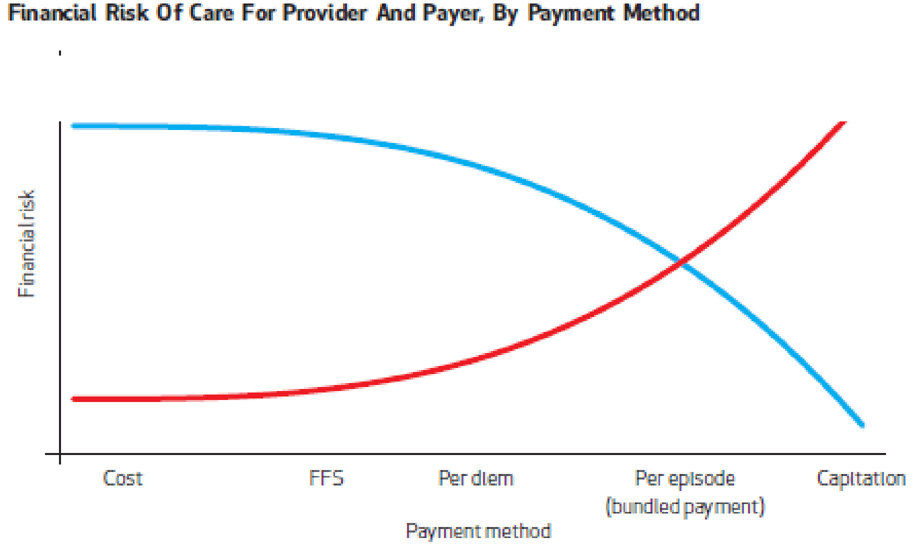


Payment models and incentives are part of the contract between payer and provider

Providers are in the best position to identify ways to:

- **reduce overuse and waste**
- **coordinate care across settings**
- **steer patients to the most appropriate, high-quality providers**
- **provide needed care by reducing underuse**

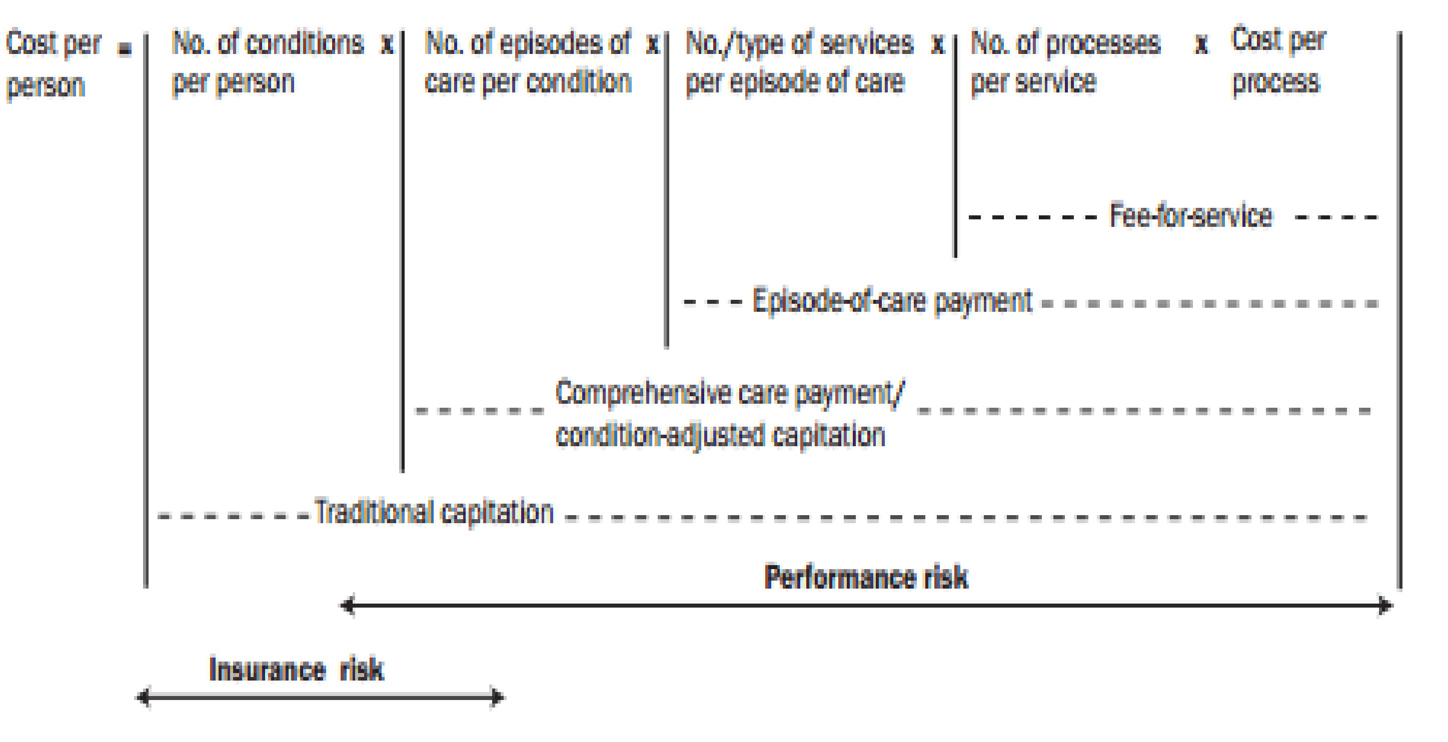
Providers react on financial incentives, mostly in the theoretically expected way



Allocation of risk

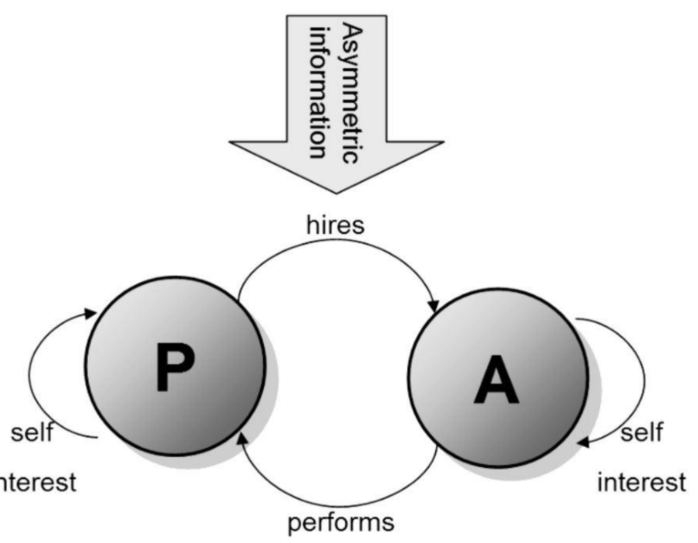
Frakt *et al.,* (2012) Beyond capitation: How new payment experiments seek to find the 'sweet spot' in amount of risk providers and payers bear

Allocation of risk



Source: Miller, H.D., *From volume to value: Better ways to pay for health care.* Health Affairs, 2009.

Agency theory



Information asymmetry may be problematic in case of conflicting interests

The agent may then exploit his information surplus, giving rise to agency problems

Examples?

The challenge

How can we design payment models in such a way that provider incentives are better aligned with the overarching system goals?

Before we continue:
No payment model is perfect!

- All systems may have unintended consequences
- We rely greatly on the intrinsic motivation and professionalism of providers. It is very important that payment systems do not undermine that professionalism.

- Payment reforms are not about paying providers less (or more) but about paying providers differently

Learning Objectives Workshop

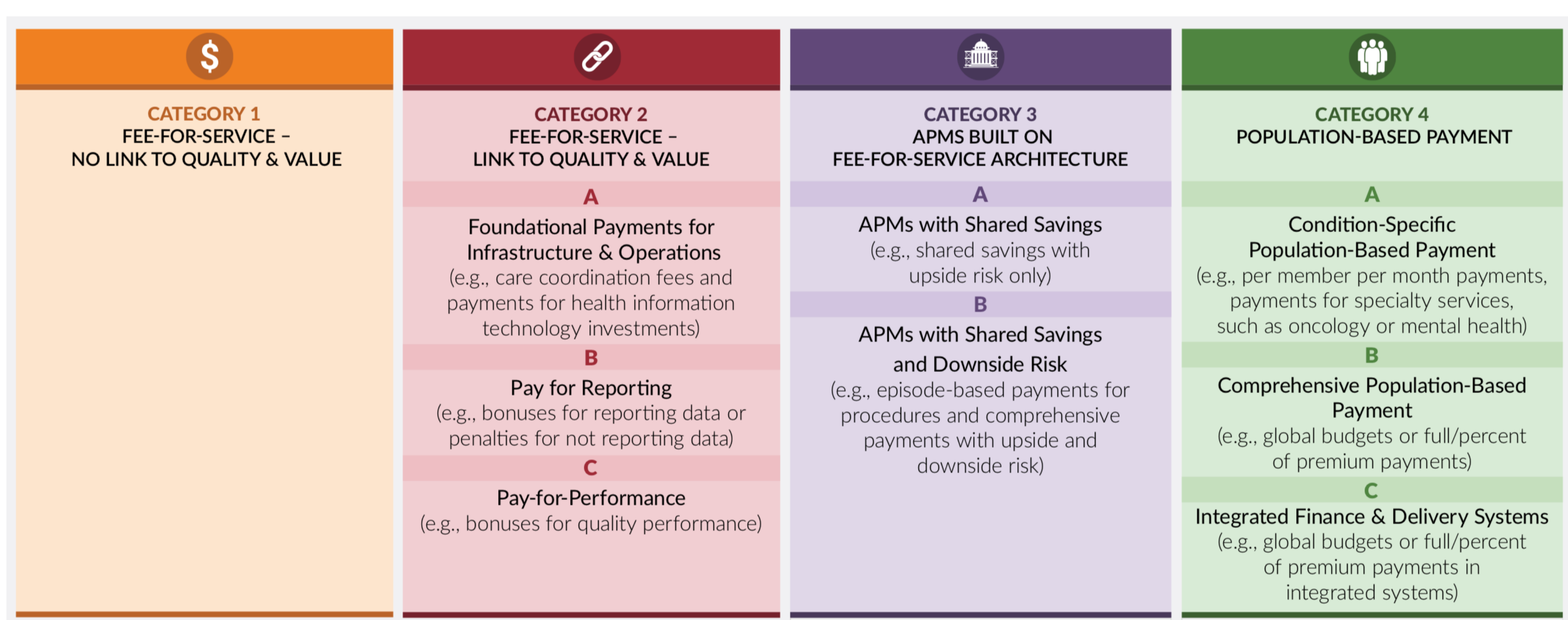
After this workshop, you should be able to:

1) Critique and form economic arguments for and against particular payment policies (the ‘why’)

2) Describe key design elements of alternative payment models including shared savings and bundled payments (the ‘what’)

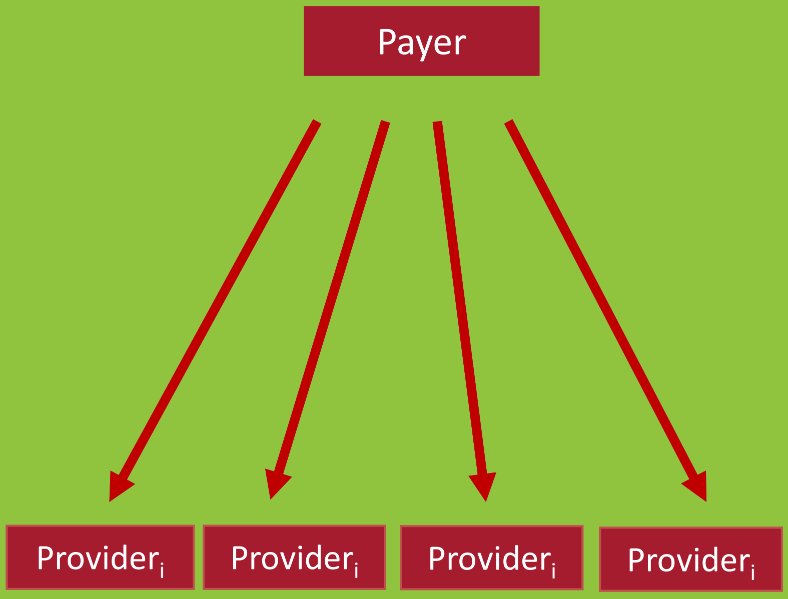
3) Discuss the ACP and the five building blocks for an APM (the ‘how’)

‘HCP-LAN’ APM framework

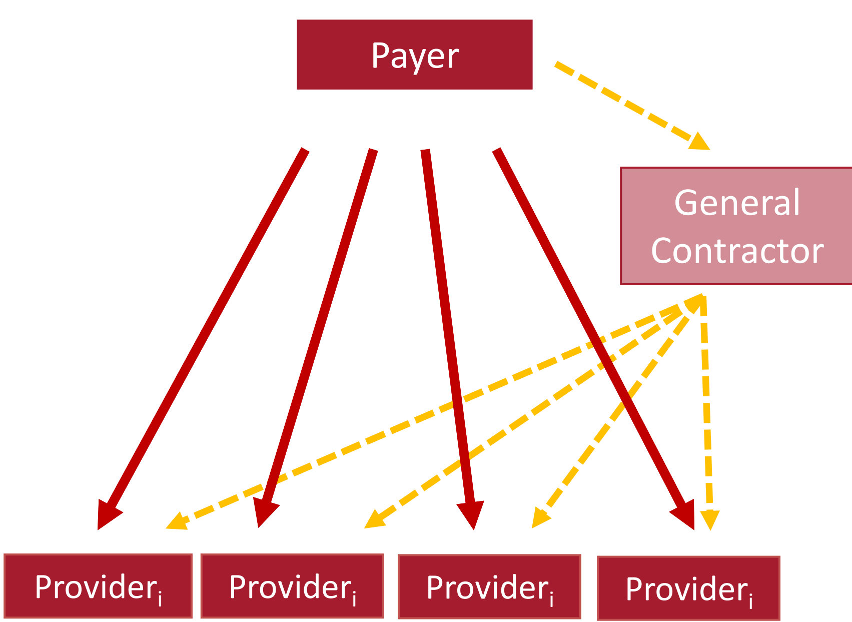


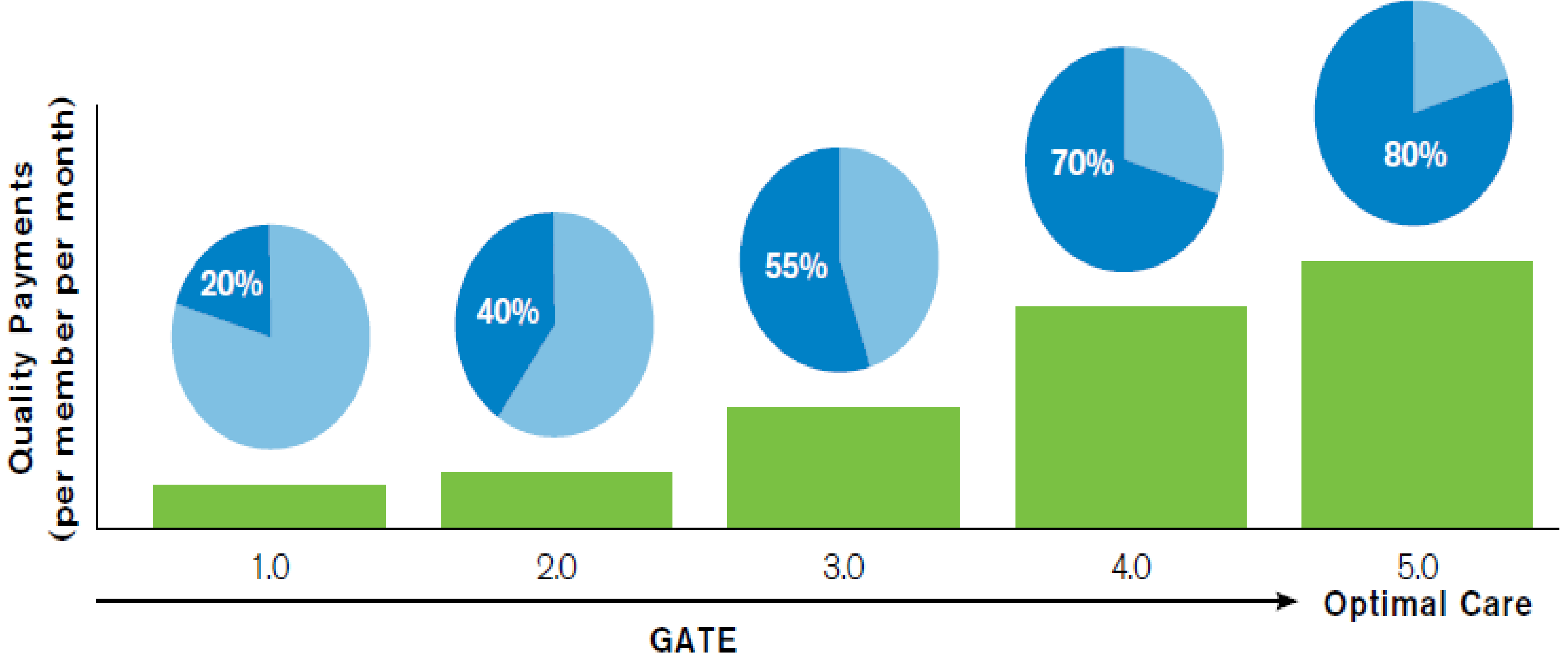
Source: https://hcp-lan.org/

Traditional FFS



Shared Savings (category 3)





Quality Performance Incentive
Provider Share of Surplus (increases as quality improves)
Provider Share of Deficit (decreases as quality improves)

Source: Blue Cross Blue Shields

Alternative Quality Contract (US)

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Health Care Spending, Utilization, and Quality 8 Years into Global Payment

Zirui Song, M.D., Ph.D., Yunan Ji, B.A., Dana G. Safran, Sc.D., and Michael E. Chernew, Ph.D.

ABSTRACT

BACKGROUND
Population-based global payment gives health care providers a spending target for the care of a defined group of patients. We examined changes in spending, utilization, and quality through 8 years of the Alternative Quality Contract (AQC) of Blue Cross Blue Shield (BCBS) of Massachusetts, a population-based payment model that includes financial rewards and penalties (two-sided risk).

METHODS
Using a difference-in-differences method to analyze data from 2006 through 2016, we compared spending among enrollees whose physician organizations entered the AQC starting in 2009 with spending among privately insured enrollees in control states. We examined quantities of sentinel services using an analogous approach. We then compared process and outcome quality measures with averages in New England and the United States.

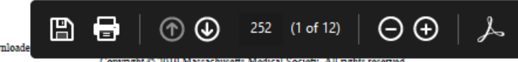
RESULTS
During the 8-year post-intervention period from 2009 to 2016, the increase in the average annual medical spending on claims for the enrollees in organizations that entered the AQC in 2009 was $461 lower per enrollee than spending in the control states (P<0.001), an 11.7% relative savings on claims. Savings on claims were driven in the early years by lower prices and in the later years by lower utilization of services, including use of laboratory testing, certain imaging tests, and emergency department visits. Most quality measures of processes and outcomes improved more in the AQC cohorts than they did in New England and the nation in unadjusted analyses. Savings were generally larger among subpopulations that were enrolled longer. Enrollees of organizations that entered the AQC in 2010, 2011, and 2012 had medical claims savings of 11.9%, 6.9%, and 2.3%, respectively, by 2016. The savings for the 2012 cohort were statistically less precise than those for the other cohorts. In the later years of the initial AQC cohorts and across the years of the later-entry cohorts, the savings on claims exceeded incentive payments, which included quality bonuses and providers' share of the savings below spending targets.

CONCLUSIONS
During the first 8 years after its introduction, the BCBS population-based payment model was associated with slower growth in medical spending on claims, resulting in savings that over time began to exceed incentive payments. Unadjusted measures of quality under this model were higher than or similar to average regional and national quality measures. (Funded by the National Institutes of Health.)

From the Department of Health Care Policy, Harvard Medical School (Z.S., M.E.C.), the Department of Medicine, Massachusetts General Hospital (Z.S.), the Department of Medicine, Tufts University School of Medicine, and Haven (D.G.S.), Boston, and the Graduate School of Arts and Sciences, Harvard University, Cambridge (Y.J.) — all in Massachusetts. Address reprint requests to Dr. Song at the Department of Health Care Policy, Harvard Medical School, 180A Longwood Ave., Boston, MA 02115, or at song@hcp.med.harvard.edu.

This article was updated on July 18, 2019, at NEJM.org.

N Engl J Med 2019;381:252-63.
DOI: 10.1056/NEJMsa1813621
Copyright © 2019 Massachusetts Medical Society.



Downloade

Copyright © 2019 Massachusetts Medical Society. All rights reserved.

- AQC the most comprehensive evaluated shared savings model
- Evaluation after 8 years FU:
  - slower growth in medical spending on claims
  - resulting in savings that over time began to exceed incentive payments
  - Unadjusted measures of quality higher than or similar to average regional and national quality measures

Source: Song et al. N Engl J Med 2019; 381:252-263. DOI: 10.1056/NEJMsa1813621

Similar results in the Netherlands

Dutch shared savings program targeted at primary care: Reduced expenditures in its first year

Arthur Hayen[a,*], Michael Jack van den Berg[b], Jeroen Nathan Struijs[b], Gerard Pieter Westert (Gert)[c]

[a] Tilburg University, PO Box 90153, 5000 LE, Tilburg, the Netherlands
[b] National Institute for Public Health and the Environment, PO Box 1, 3720 BA Bilthoven, the Netherlands
[c] Radboud University (Radboud University Medical Center), PO Box 9101, huispost 114, 6500 HB Nijmegen, the Netherlands

ARTICLE INFO

Article history:
Received 7 October 2019
Received in revised form 16 October 2020
Accepted 26 January 2021

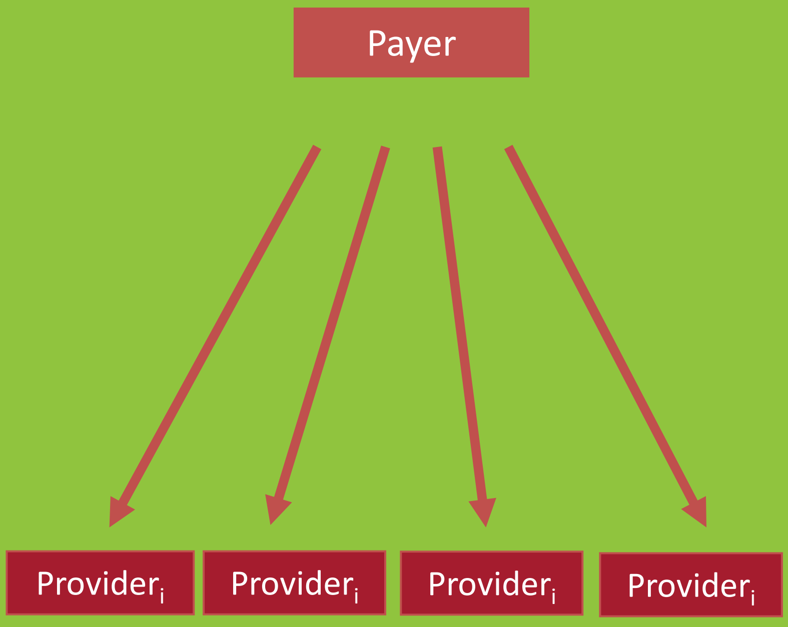
Keywords:
Payment reform
Shared savings
Primary care

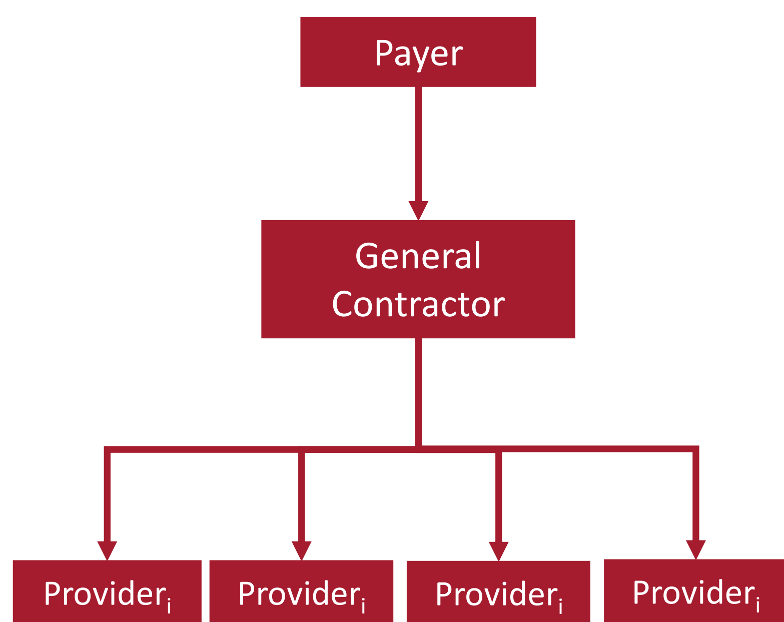
ABSTRACT

In countries where GPs fulfill a central role in the health care system, like in the Netherlands, the lack of value-based incentives in GP payment systems may have negative consequences for value delivered in other parts of the health care spectrum. We evaluate an experiment in which GPs were allowed to share in savings in total health care expenditures, conditionally on achieving quality targets. At least in theory, these so-called 'shared savings contracts' incentivize GPs to become critical gatekeepers, coordinate the provision of care and substitute for specialist services when appropriate. This study evaluates a Dutch shared savings program targeted at GPs. This study employs a difference-in-differences design using a regional control group of non-participating GPs. We find that program participation led to savings in health care expenditures (-2%), while patient satisfaction was unaffected and while the results for other quality indicators were ambiguous. Additional analyses show that savings have been predominantly realized by lowering the volume of specialist care, and that almost every participating GP displayed cost-saving behavior. This finding suggests that shared savings contracts, even when added as a mere complemented to existing volume-based payment models, already elicit substantive effort to increase the value of health care provided.

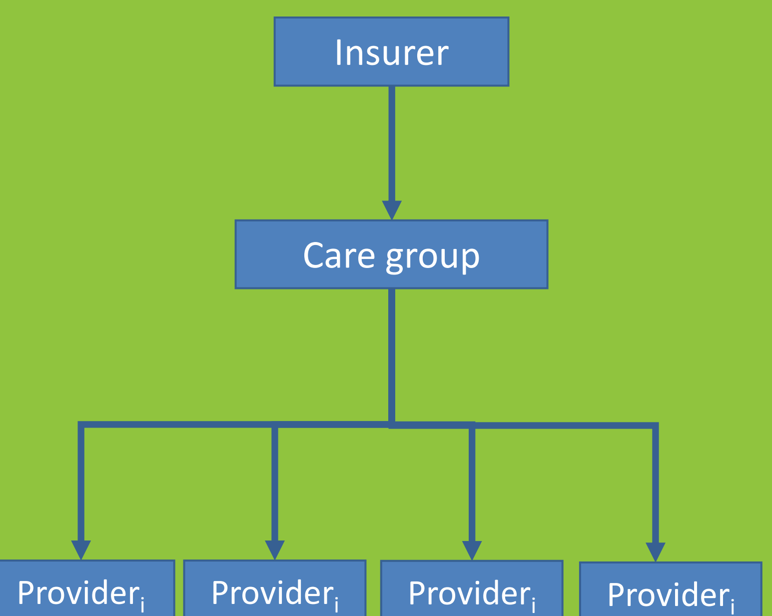
© 2021 The Authors. Published by Elsevier B.V. This is an open access article under the CC BY license (http://creativecommons.org/licenses/by/4.0/).

Source: Hayen, A., van den Berg, M. J., Struijs, J. N., & Westert, G. P. (2021). Dutch shared savings program targeted at primary care: reduced expenditures in its first year. *Health Policy*.


Traditional FFS
Payer
$Provider_i$
$Provider_i$
$Provider_i$
$Provider_i$


Bundled Payment (category 4)
Payer
General Contractor
$Provider_i$
$Provider_i$
$Provider_i$
$Provider_i$

Bundled payment for diabetes care (2007; n=110)



The NEW ENGLAND JOURNAL of MEDICINE

PERSPECTIVE

Integrating Care through Bundled Payments — Lessons from the Netherlands

Jeroen N. Struijs, Ph.D., and Caroline A. Baan, Ph.D.

In industrialized countries, the number of people with chronic diseases continues to increase, putting tremendous pressure on health care systems. At the same time, there is a growing need for more patient-centered care.[1] Various approaches to addressing these challenges have been introduced, including, in the United States, the concept of the accountable care organization (ACO) — a vehicle for implementing comprehensive payment reform and redesign of the health care system in an effort to control growth in health care costs and improve value.[2-4] In the Netherlands, numerous initiatives were introduced to enhance the quality and continuity of care for chronic diseases, but their fragmentary funding hampered the establishment of long-term programs. In 2007, the Dutch minister of health therefore approved the introduction of a bundled-payment approach for integrated chronic care, initially on an experimental basis with a focus on diabetes. In 2010, the bundled-payment concept was approved for nationwide implementation for diabetes, chronic obstructive pulmonary disease (COPD), and vascular risk management.

Under this system, insurers pay a single fee to a principal contracting entity — the "care group" — to cover a full range of chronic disease (diabetes, COPD, or vascular disease) care services for a fixed period. A care group is a newly created actor in the health care system, consisting of a legal entity formed by multiple health care providers, who are often exclusively general practitioners (GPs). The care group assumes both clinical and financial responsibility for all assigned patients in the diabetes care program. For the various components of diabetes care, the care group either delivers services itself or subcontracts with other care providers. The bundled-payment approach supersedes traditional health care purchasing for the condition and divides the market into two segments — one in which health insurance companies contract care from care groups and one in which care groups contract services from individual providers, be they GPs, specialists, dietitians, or laboratories. The price for the bundle of services is freely negotiated by insurers and care groups, and the fees for the subcontracted care providers are similarly freely negotiated by the care group and providers.

General decisions about patient services to be covered in the diabetes care bundle were made at a national level and are codified in the Dutch Diabetes Federation Health Care Standard (DFHCS) for type 2 diabetes, which was approved by all national provider and patient associations. The DFHCS is limited to generic diabetes care and specifies only the treatment activities to be included, not who is to provide them or by what means. The services in the diabetes bundle are provided free of charge to patients, since they are covered by the standard insurance package that all Dutch citizens must carry.

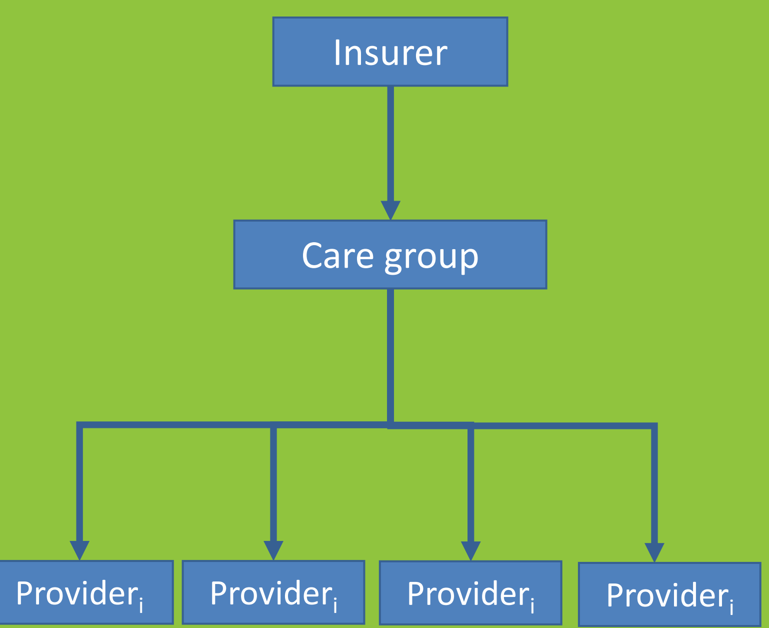
The aims of these care groups are similar to those of ACOs, as currently conceived in the United States, but there are differences in some essential features. For example, care groups are dominated by GPs, whereas ACOs may comprise a wide range of providers — at least primary care physicians, specialists, and one or more hospitals. In addition, patients are to be assigned to ACOs on the basis of their patterns of service use, whereas patients are assigned to a care group on the basis of their disease (beginning with diabetes). In addition, the care group bears the full financial risk for the cost of care, whereas ACOs won't bear the risk of higher-than-expected costs.[4]

Both concepts are relatively new: the ACO concept has not been fully tested, and the Medicare ACO program doesn't begin until January 2012; care groups were launched on an experimental basis in 2007, focused only on type 2 diabetes. The implementation process for the bundled-payment system is under evaluation, and data from electronic health records of 10 care groups, extensive interviews with stakeholders, and patient questionnaires are being used to assess the satisfaction of all stakeholders and the quality of delivered care.[5]

Nevertheless, a number of lessons can be taken from the Dutch experiment on the basis of the evaluation of 10 care groups.

Source:
Struijs, J. N., & Baan, C. A. (2011). Integrating care through bundled payments—lessons from the Netherlands. *N Engl J Med*, *364*(11), 990-991.

Bundled payment for diabetes care (2007; n=110)



How Bundled Health Care Payments Are Working in the Netherlands

by Jeroen N. Struijs

October 12, 2015

The system for paying health care providers is extremely fragmented. In response, both the United States and the Netherlands are now experimenting with bundled-payment models, whereby a single prospective payment is made for all services for a patient with a given condition, even when multiple providers deliver that care. I believe that the ongoing Dutch experience with bundled payments has unique

Source:
Struijs, J. N. (2015). How bundled health care payments are working in the Netherlands. *Harvard Business Review*.

Similar results around the world

ISSUE BRIEF
APRIL 2020

Bundled-Payment Models Around the World: How They Work and What Their Impact Has Been

Jeroen N. Struijs, Eline F. de Vries, Caroline A. Baan, Paul F. van Gils, and Meredith B. Rosenthal

ABSTRACT

ISSUE: Understanding the impact of bundled-payment models on value in health care requires a better understanding of how design choices and implementation strategies affect cost and quality.

GOAL: To describe the key design elements of bundled-payment models and evaluate empirical evidence about their impact on quality of care and medical spending.

METHODS: Scan of the scientific and grey literature.

FINDINGS AND CONCLUSIONS: We identified 23 initiatives in eight countries that have implemented bundled-payment models, focusing on procedures such as total joint replacements and cardiac surgery, as well as chronic conditions like diabetes and breast cancer. Of the 35 studies retrieved, 32 reported effects on quality of care and 32 reported effects on medical spending. Twenty of 32 studies reported modest savings or a modest reduction in spending growth, while two studies (both based on the same initiative) demonstrated increased spending in the early years of the bundled-payment model's implementation. Eighteen of 32 studies reported quality improvements for most evaluated measures, while other studies showed no difference in measured quality. Our study provides evidence that bundled-payment models have the potential to reduce medical spending growth while having either a positive impact or no impact on quality of care.

TOPLINES

- An eight-country study reports predominantly positive impacts — irrespective of country, medical procedure, or condition — of bundled-payment models that aim to impact both spending and quality of care.
- Privacy laws that affect information-sharing and the difficulty of defining quality criteria are among the operational challenges of implementing bundled-payment models around the world.

Empirical evidence

- QoC: 18 of 32 studies reported improvements for most evaluated measures, while other studies showed no difference in measured quality
- Spending:
  - 20 of 32 studies reported modest savings or a modest reduction in spending growth,
  - two studies (both based on the same initiative) demonstrated increased spending in the early years of the bundled-payment model's implementation
- Key message: BP models have the potential to reduce medical spending growth while having either a positive impact or no impact on quality of care

Source:
https://www.commonwealthfund.org/sites/default/files/2020-04/Struijs_bundled_payment_models_around_world_ib.pdf

Learning Objectives Workshop

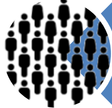
After this workshop, you should be able to:

1) Critique and form economic arguments for and against particular payment policies (the 'why')

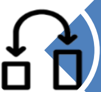
2) Describe key design elements of alternative payment models including shared savings and bundled payments (the 'what')

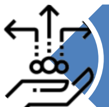
3) Discuss the ACP and the five building blocks for an APM (the 'how')

DESIGN: Refining the building blocks


Define the population

Define included care services

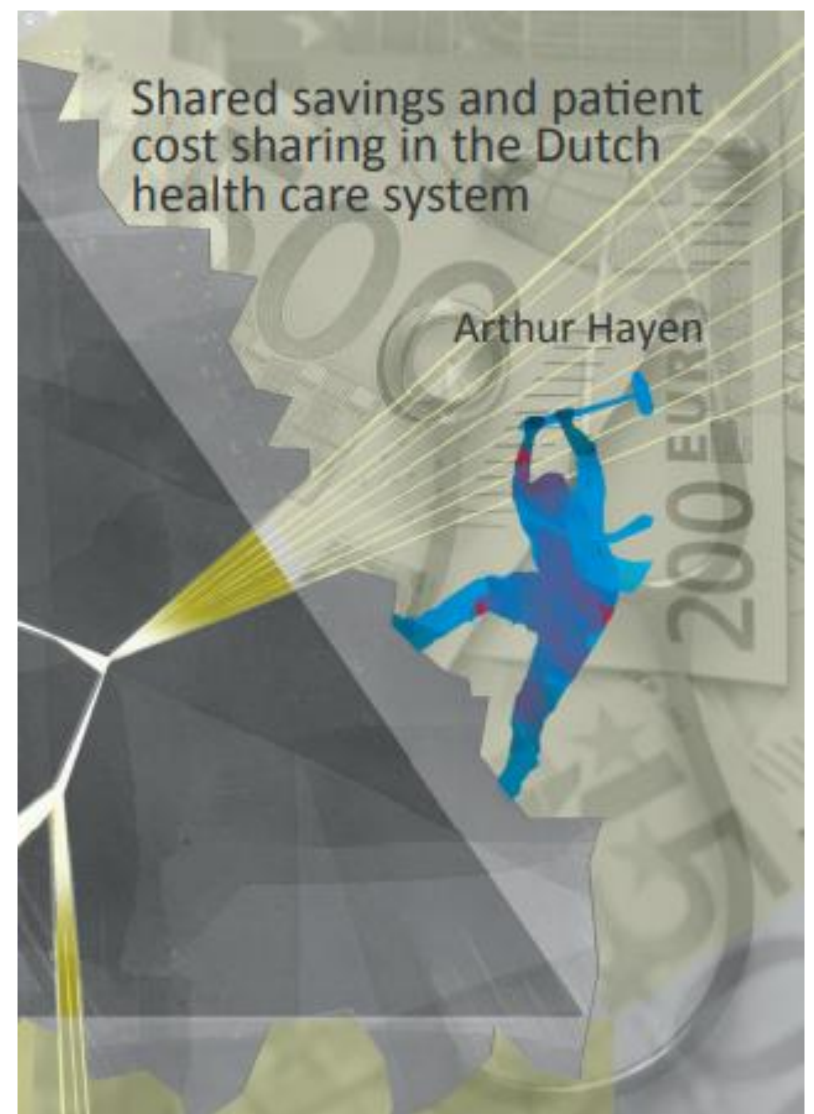

Benchmark definitions


Distribution of (Shared savings)

Quality of care /Outcomes

Hayen, A. P., van den Berg, M. J., Meijboom, B. R., Struijs, J. N., & Westert, G. P. (2015). Incorporating shared savings programs into primary care: from theory to practice. *BMC health services research*, *15*(1), 1-15.

PhD-thesis Arthur Hayen



1. Define the population and ACP

For which patients is the ACP going to be held accountable?

- ACP: Which provider or groups of providers is the entity you want to held accountable for 'solving' your case?
- Which: What's the basis for patient assignment?
  - Disease, demographics, health care use, geographic location, *combination*
  - Prospective or retrospective assignment?
  - Patients or patient years?

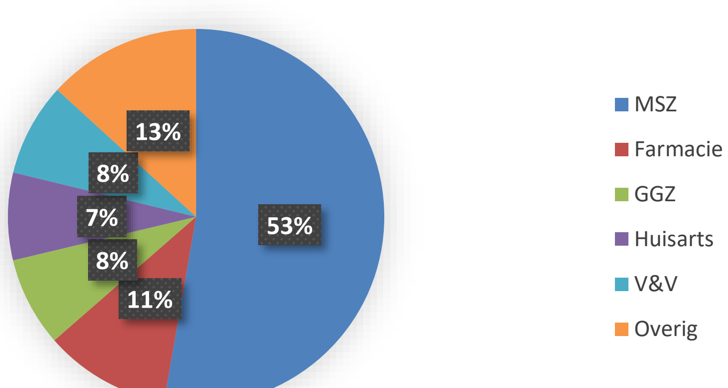
Shared savings PhD thesis	All-in tarief	Bundled payment
All insured who were registered with the partipating GPs for the entire year	All insured who are registered with the participating GP, as determined by the start of the quarter	**Breast cancer:** women diagnosed with breast cancer, excl: reoccurence + conservative treatment **Maternity care:** Every pregnant women who uses a service within the network

Define the scope of the model

For which services is the ACP being held accountable, and to what extent?

- Services: for what health care services can the ACP truly be held accountable?
  - Accountability implies accountability for prices, volumes and product mix;
  - Don’t let them ‘take the gamble’;

- Extent: .. And to what extent?
  - Cap expenditures
  - Exclude services?
  - Exclude patient groups?



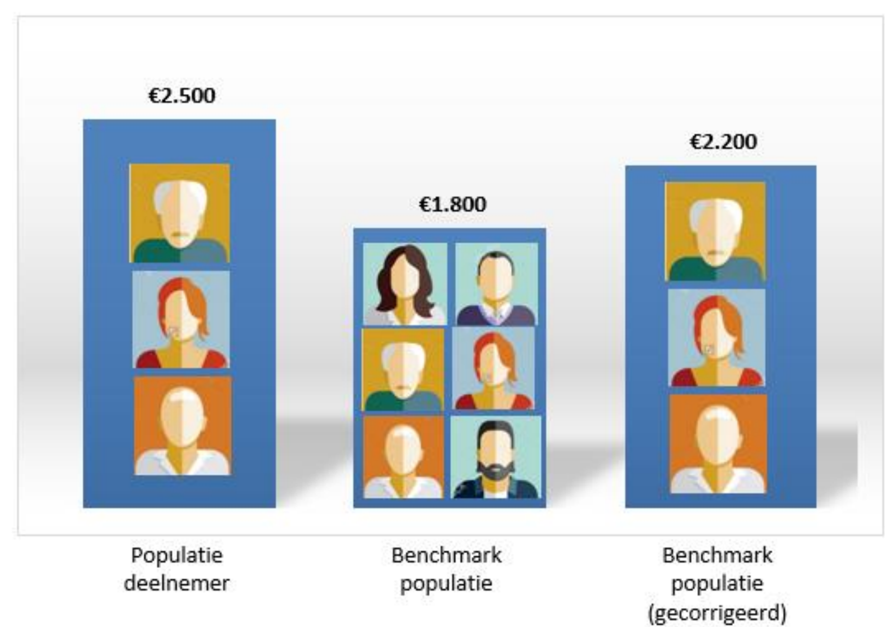
(continued)

Shared savings	All-in tarief	Bundel
Total health care expenditures, under both basic and supplemental health insurance, no dental health services, and capped at 25.000 dollar	Total GP expenditures	Cataract: surgery, outpatient care and diagnostic care (120 days before and after the surgery), aftercataract

Define the expenditure benchmark

What's a good benchmark (or price)?

- Price (bundled payment, capitated fee) or benchmark (shared savings)
- How to set a price?
  - Should be lower than the mere sum of its parts (incentive to lower costs!)
  - Different prices for different risk profiles
- Benchmark:
  - 'Counterfactual' of 'challenging', but always *realistic*
  - E.g. own historical expenditures, but national growth trend
  - When should we compare apples and oranges?



(continued)

Shared savings	A three-year weighted expenditure average, multiplied by the growth in expenditures of the control group during the performance year
All-in	Historical expenditures + annual inflation correction
Bundled payment	**Hip/knee:** price surgery last year + Dutch per capita average of complication costs + other included care services **Matenity care:** 9 modules based on prenatal, natal and postnatal phase

How are savings/losses being shared?

- Not all APMS share savings or losses (APM Framework)
- When you underspend the benchmark, does this truly reflect savings?
  - Statistical test
  - P-value: what’s the chance of observing this particular savings result when in reality, GPs have not put any effort in realizing savings?

- Why do we share savings?
  - What happens if we would share all savings in the GP case?
  - Safety net (in case of losses)
  - Cap: 5% - 7,5% revenue
  - Introduce ‘shared losses’ in exchange for a higher sharing rate in case of savings

- Sharing rate based on quality (analogue to AQC)

(vervolg)

Shared savings	Sharing rate with a cap; savings – preinvestment costs;
All-in	No sharing
Bundled payment	No sharing + lifting the volume restriction in case quality improves

Tying quality to payment model

- Integrating both incentives for costs and quality is what make APMs unique
- Helps in keeping intrinsic motivation of providers intact
- Reward both improvement and performance in an absolute sense
- Focus on the downside of your APM when thinking about (additional) quality indicators

(vervolg)

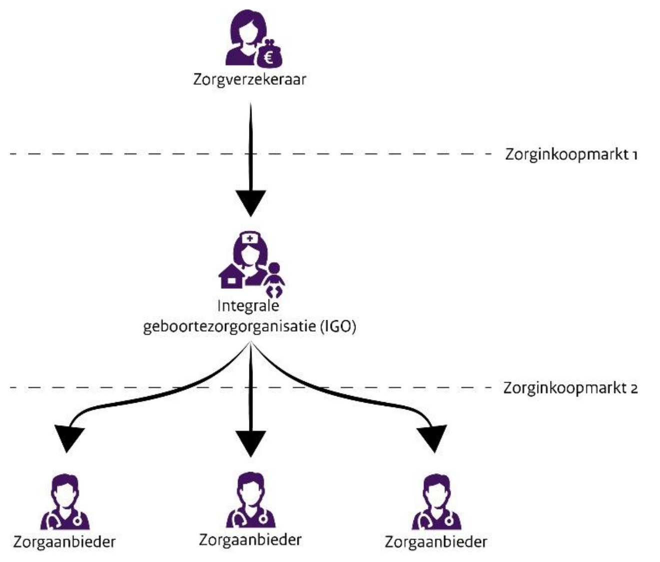
Shared savings	Patient satisfaction, Adherence to guidelines, accredition (score based on both absolute quality and improvement)
All-in	Not dependent on quality
Bundled payment	Lifting the volume ceiling: PROMS, revisions, post-operative infections, and cost drivers (bv: length-of-stay)

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

Integrale bekostiging
van de geboortezorg:
ervaringen na drie jaar en
de eerste zichtbare effecten

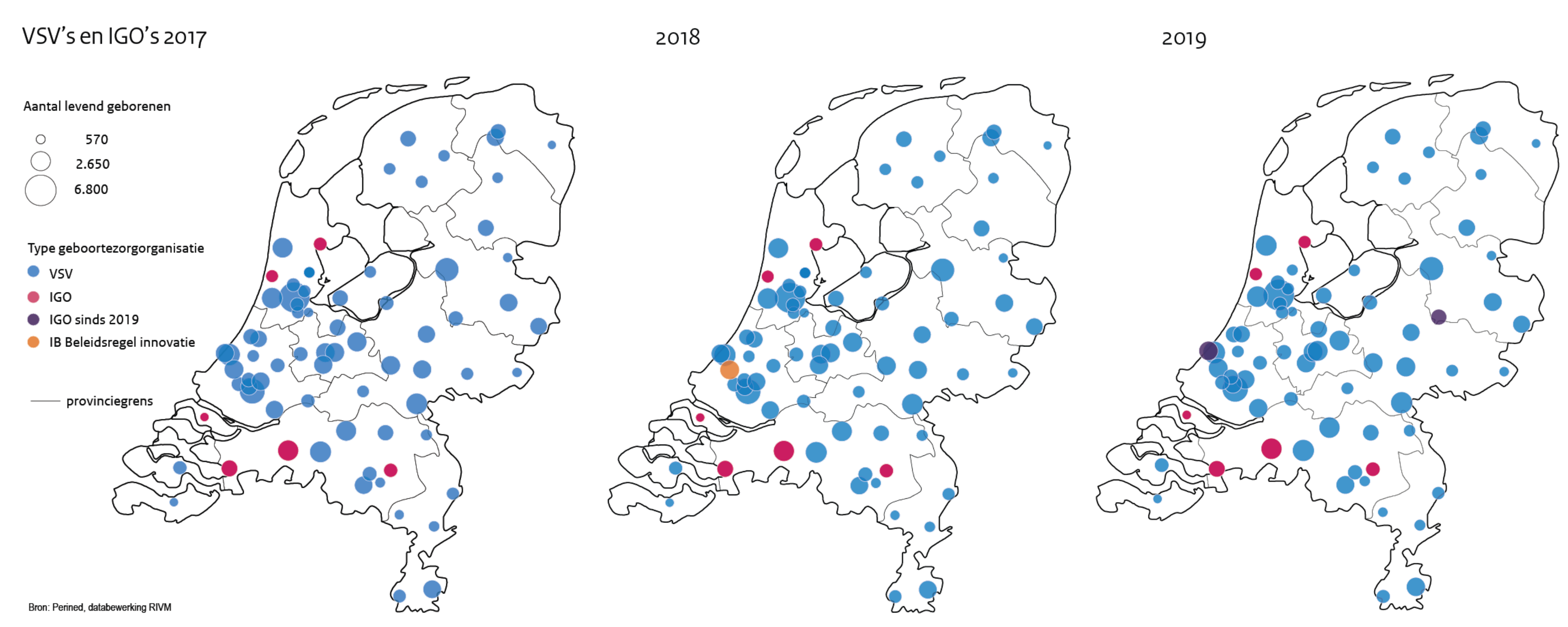
Update RIVM monitor Bundled payments for maternity care

Outline Dutch BP model for maternity care



Prenatal	Natal	Postnatal
1. <16 wks		
2. Regular (>16wks)	4. Regular	7. Regular
	5. Polyclinic (without medical reasons)	
3. Complex (>16 wks)	6. Complex	8. Complex
		9. Maternity care assistance
Overhead		

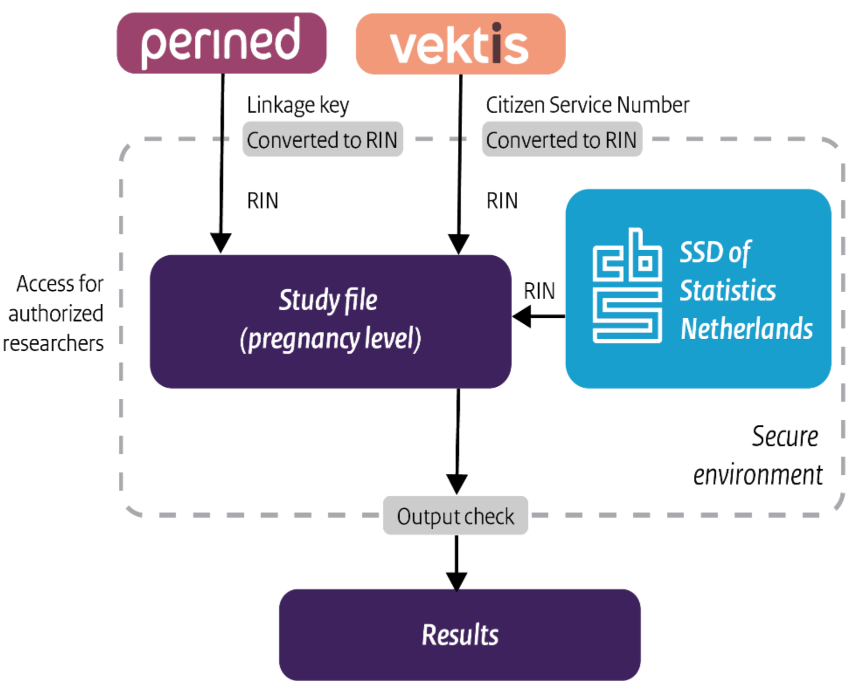
Development of IMCOs during 2017-2019



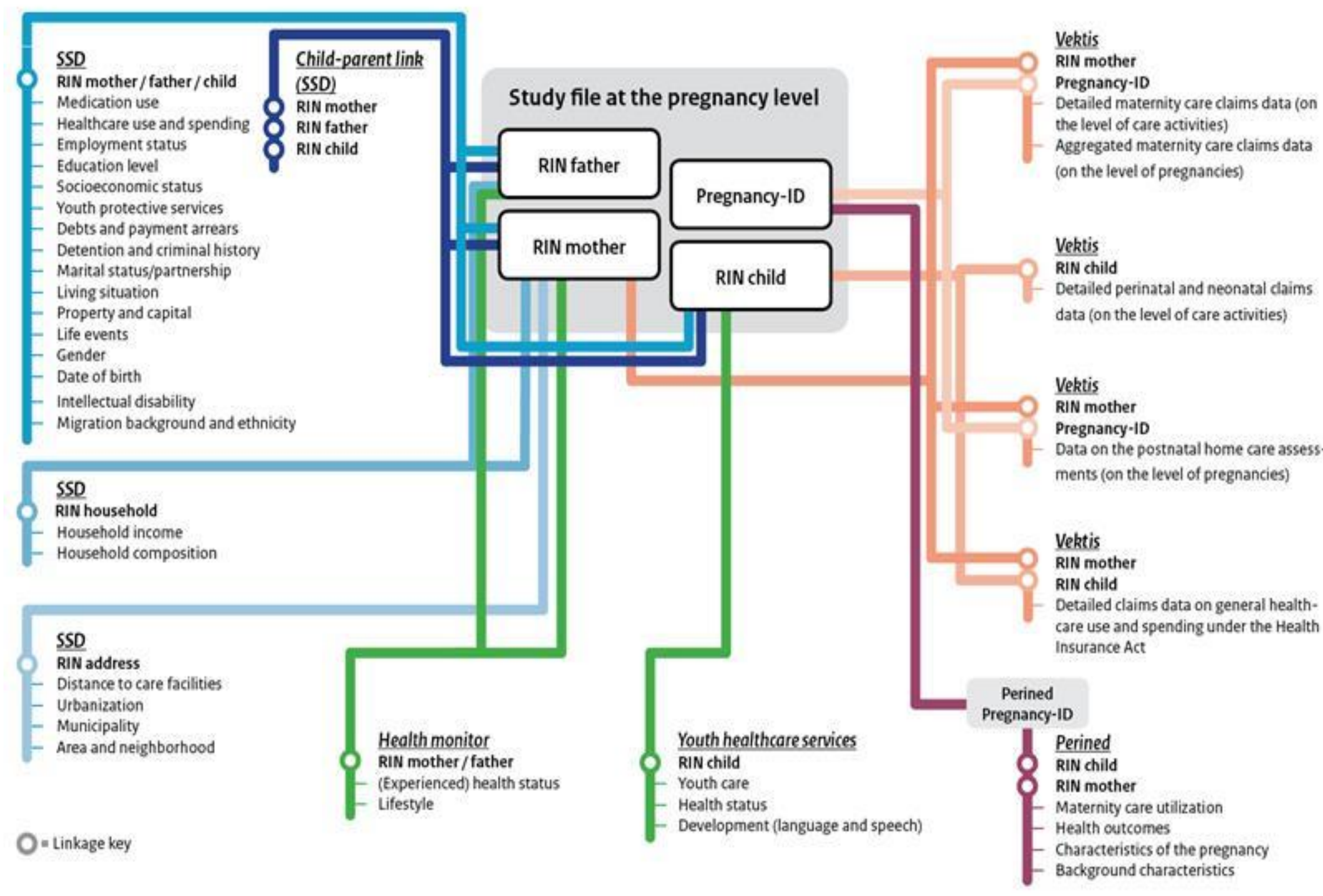
OBJECTIVES

Gain insights in:

- the experiences with organizing an integrated maternity care organization (imco) and working with bundled payments
- **The effects on quality of care and medical spending and health outcomes of maternity care (Today's presentation)**



DIAPER (Data-infrastructure for Parents and Children)


SSD
RIN mother / father / child
Medication use
Healthcare use and spending
Employment status
Education level
Socioeconomic status
Youth protective services
Debts and payment arrears
Detention and criminal history
Marital status/partnership
Living situation
Property and capital
Life events
Gender
Date of birth
Intellectual disability
Migration background and ethnicity
Child-parent link (SSD)
RIN mother
RIN father
RIN child
Study file at the pregnancy level
RIN father
RIN mother
Pregnancy-ID
RIN child
Vektis
RIN mother
Pregnancy-ID
Detailed maternity care claims data (on the level of care activities)
Aggregated maternity care claims data (on the level of pregnancies)
Vektis
RIN child
Detailed perinatal and neonatal claims data (on the level of care activities)
Vektis
RIN mother
Pregnancy-ID
Data on the postnatal home care assessments (on the level of pregnancies)
Vektis
RIN mother
RIN child
Detailed claims data on general healthcare use and spending under the Health Insurance Act
SSD
RIN household
Household income
Household composition
SSD
RIN address
Distance to care facilities
Urbanization
Municipality
Area and neighborhood
Health monitor
RIN mother / father
(Experienced) health status
Lifestyle
Youth healthcare services
RIN child
Youth care
Health status
Development (language and speech)
Perined
Pregnancy-ID
Perined
RIN child
RIN mother
Maternity care utilization
Health outcomes
Characteristics of the pregnancy
Background characteristics
= Linkage key

Conceptueel: difference-in-differences

Pre-interventie

Post-interventie

Controlegroep (selectie van VSV's)

Interventiegroep (N = 6)

Effect
interventie

Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

2015

2016

2017

2018

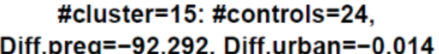
Volledige gegevens van zwangerschap

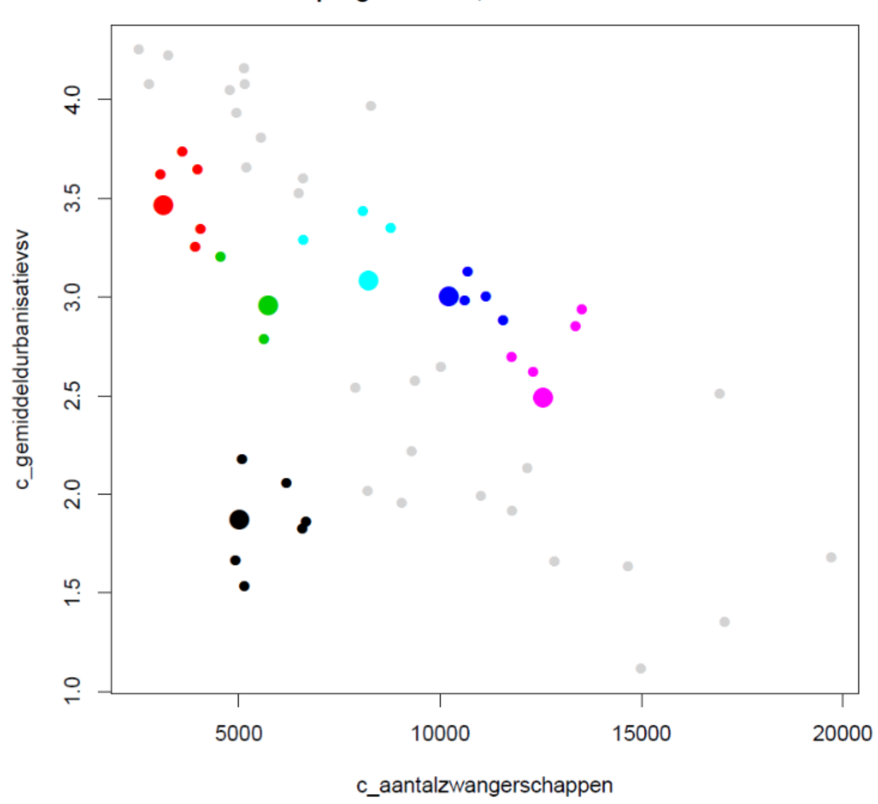
Laatste gegevens Vektis

Eerste zwangerschap voledig onder IB

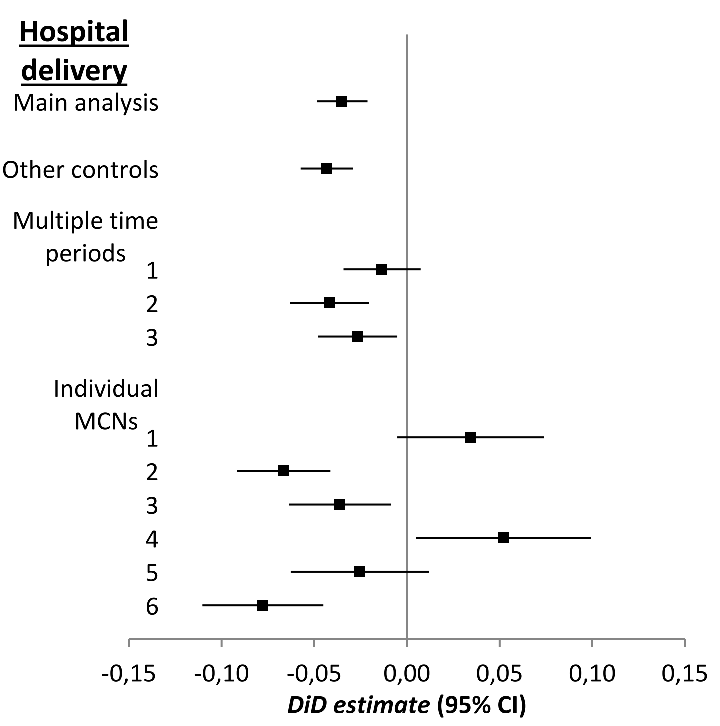
Start IB contracten

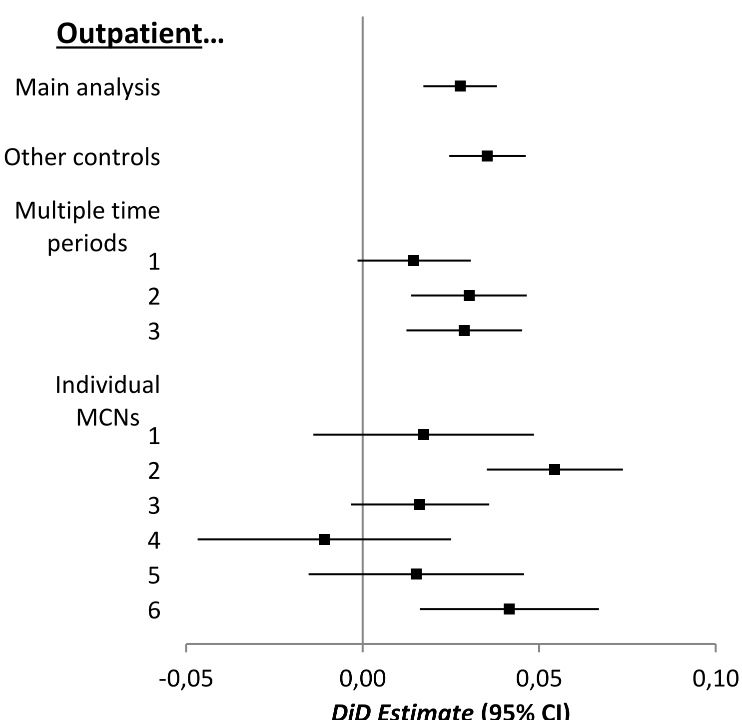
Matching on level IMCOs-regional partnerships





Analyse uit rapport 2020





Key messages Bundled payment for maternity care in the Netherlands

Experiences

All actors positive about collaboration
Administrative burden is an enormous bottleneck
Transition in culture not yet realized

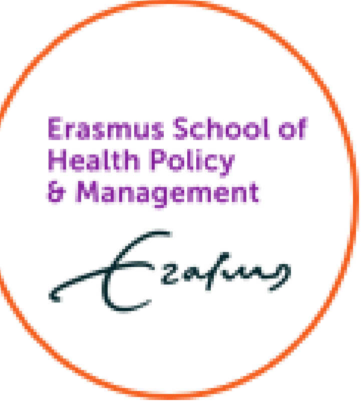
First tangible effects

Small changes in place of births and activities
Smaller spending growth
No effects on health outcomes

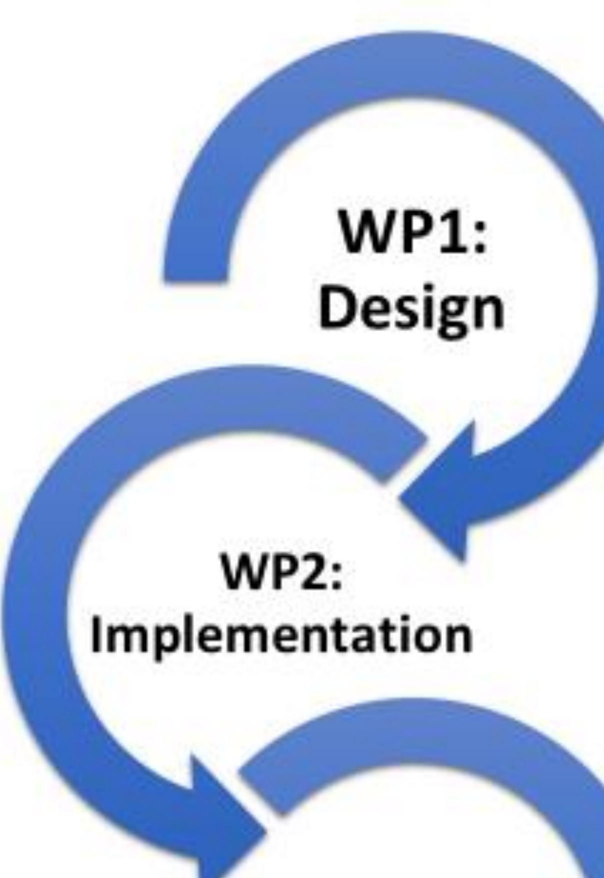
Discussie

Administrative burden risk for maintaining support
How incentive translate into practice differs
Longterm effects unknown

Academisch expertisecentrum alternatieve bekostiging in de zorg



MEET THE TEAM:



- **The "Why" and the "What"**
  - Theoretical underpinning and considerations
  - Contextual factors
  - Building blocks for design choices
- **The "How"**
  - Field experiments
  - Identifying effective implementation strategies
  - Strategic Roadmap to enhance APM adoption
- **The "Effects" via mixed methods approach**
  - Realist Evaluation (Context-Mechanism-Outcomes)
  - Causal inference approaches

Activities
BUNDLE

Workshops / Lectures
Goal:
to create a common language between different stakeholders

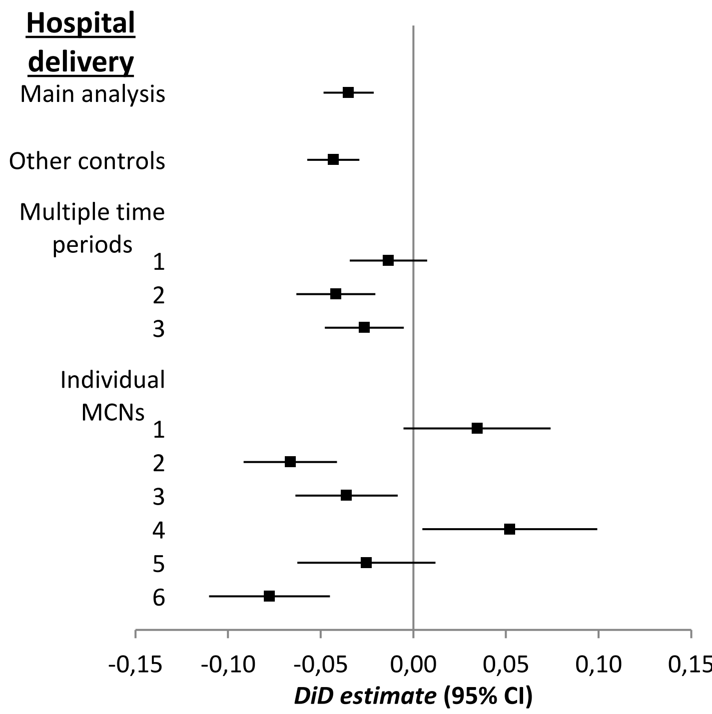
In-company support
Goal:
Guidance in developing an APM

Evaluations
Goal:
Evaluation of the designed and implemented APM

Current projects

Commissioned by:
Ministry of Health, Welfare and Sport

Bundled payment for maternity care

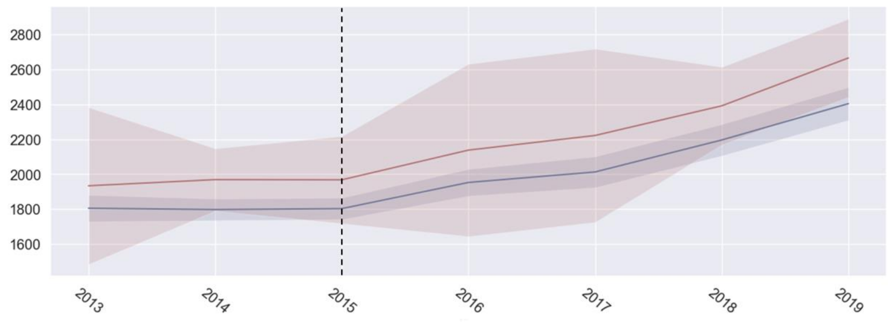


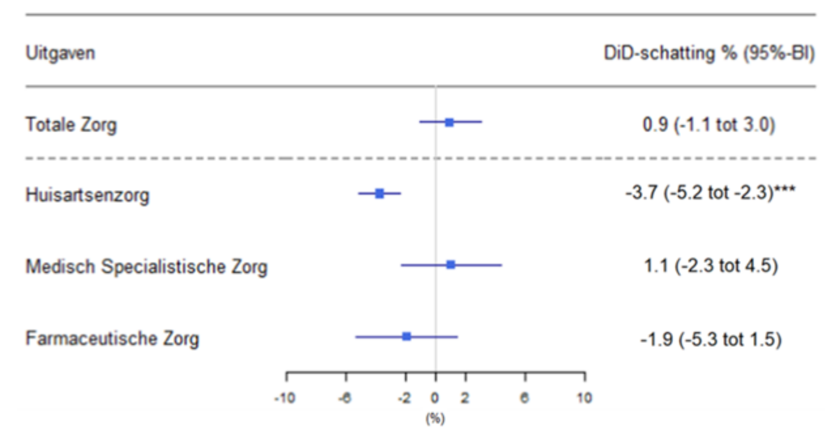
Source:
Scheefhals et a., in preparation

Current projects (II)

Commissioned by:
Ministry of Health, Welfare and Sport

Population-based funding for GPs (i.e. 'consultloos abonnementstarief')



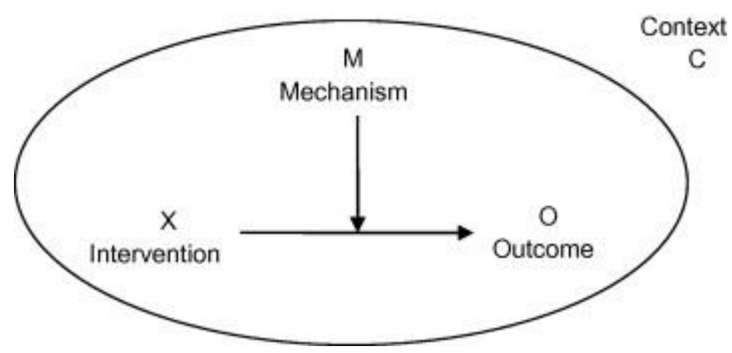


Source:
Steenhuis et al., in preparation, Faiq et al., in preparation

Current projects (III)

Commissioned by:
ZonMw

Research project BUNDLE: a realist evaluation approach within 7 different APM contracts



Current projects (IV)

Commissioned by:
Stichting Phoenix

Vernieuwde hartfalenzorg: aanneemsom voor hartfalenzorg (Rdgg-DSW)

Populatiebekostiging kan een eind maken aan inkoopcircus

Elk jaar maken zorgaanbieders en zorgverzekeraars opnieuw afspraken met elkaar. Deze manier van bekostigen moedigt niet aan om te investeren in een slimmere organisatie van zorg of preventie. Maeke Stumpel van Zorgvuldig Advies schrijft over hoe het Reinier de Graaf Gasthuis en zorgverzekeraar DSW het anders aanpakken.

Current projects (V)

APMs and their role in decarbonization of the health care system

1 East 75th Street
New York, NY 10021
212.606.3800
commonwealthfund.org

June 30, 2022

Jeroen Struijs
Associate Professor
LUMC Health Campus The Hague
Leiden University Medical Center
jeroen.struijs@rivm.nl

Dear Jeroen,

On behalf of The Commonwealth Fund, I am pleased to inform you that your proposal "An Untouched Opportunity: Value-based Purchasing to 'Green' the Health Care System" has been selected for funding through the Harkness Senior Fellow Small Grant Program.

in collaboration with:

Commissioned by:
Commonwealth Fund, NYC

Concluding Remarks

- Provider-led entities which assume financial risks are still in their early stages…
- Translating of provider incentives differs between settings
- Knowledge base is growing supporting the potential of payment reforms as a strategy toward more value-based health care delivery
- Joy of the workforce is too often neglected: design in cocreation to maintain support
- Real outcome-based payment models still in its infancy

Interested?

coursera
education for everyone

Browse > Health > Healthcare Management

Offered By Universiteit Leiden The Netherlands

Population Health: Alternative Payment Models

★★★★★ 4.9 9 ratings

Jeroen Struijs

BUNDLE.

Expertisecentrum Alternatieve Bekostiging

[BUNDLE - Expertisecentrum Alternatieve Bekostiging in de Zorg: LinkedIn]