May 11, 2017

Call for action

Working Session with Prof. Porter on:

‘The Value Agenda for the Netherlands’

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AMGEN

THE VALUE AGENDA FOR THE NETHERLANDS
A call for action

VBHC Working Session | May 11, 2017

"*The Netherlands could become a leader in the field of Value-Based Health Care*", states Harvard Professor Michael Porter. During a working session held in Nijkerk on May 11, key challenges for large-scale implementation of Value-Based Health Care (VBHC) were identified and discussed by twenty-five decision makers in health care from the Netherlands.

This working session was organized by The Decision Group, Amgen and Medtronic to 'call for action' and formulate the key actions to collaboratively accelerate VBHC implementation in the Netherlands and improve value for patients.

The Value Agenda

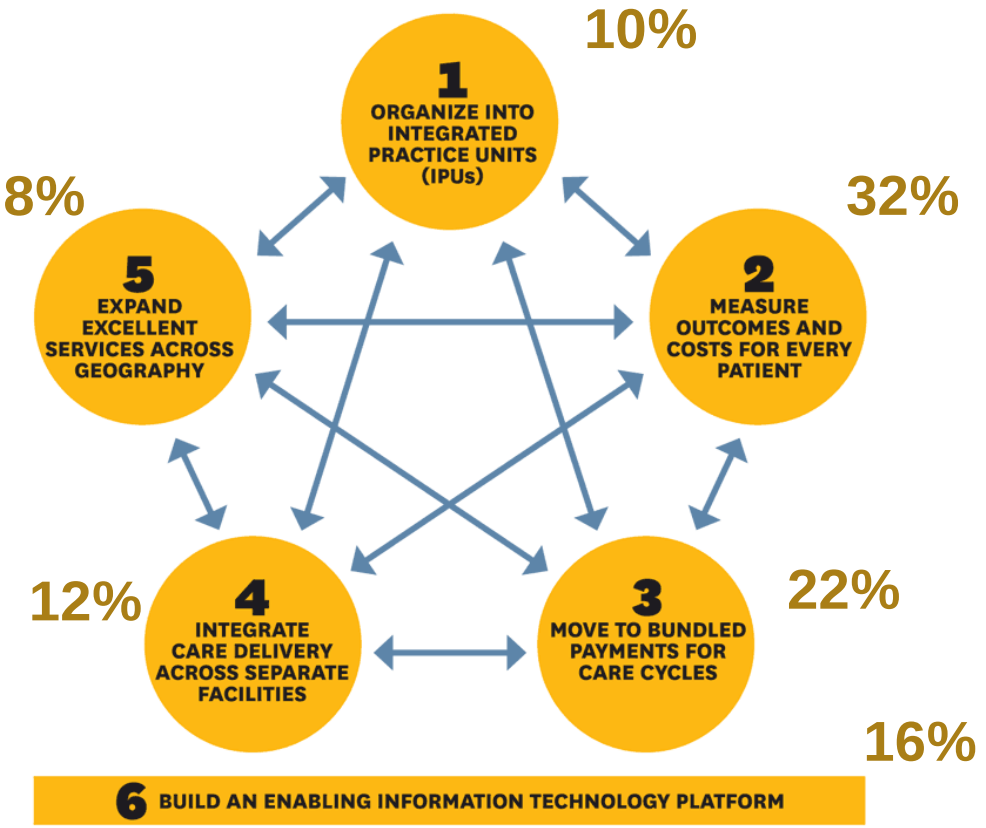
Prior to the working session, the components of Prof. Porter's Value Agenda that contain the biggest challenges for the Netherlands were identified by the attendees (see figure). A seventh component proved to be key for VBHC implementation: '*Change culture and stimulate leadership*', which was added to the Value Agenda.

The attendees and other leaders in health care identified over 60 key challenges in VBHC implementation that were categorized into the components of the Value Agenda. During a roundtable session, in which every table contained a balanced mix of stakeholders, the challenges were discussed to extract the key questions to discuss with Prof. Porter.

During an inspiring working session, an open and challenging discussion with Prof. Porter resulted in four key actions to accelerate VBHC implementation in the Netherlands, stated in this summary statement.

Input by attendees

Components of the Value Agenda that contain the biggest challenges for the Netherlands to accelerate VBHC implementation



Additional components for the Netherlands:

7 Change culture and stimulate leadership

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Call for Action I

Build VBHC leadership to help change the culture towards appreciation of value.

Cultural change is needed, both among health care professionals and patients. The current health care structure has been in place for a long time. Patients are used to going to the nearest hospital instead of choosing an institution based on its quality of care.

Professionals are often reluctant to adjust their working practices and are worried that reporting outcomes makes them look bad. When it comes to reporting outcomes, Prof. Porter stresses that a lack of reporting should be penalized, not bad outcomes. Learn as much as you can from the data and focus on improvement. The next generation of VBHC leaders must be immersed in this way of working early on and see that the resources are directed towards the VBHC way of working.

An important drive for change among health care professionals should be the acknowledgement that working in a VBHC-setting is more rewarding.
In Prof. Porter's experience, once the transition to integrated practice units (IPUs) has been made, no one wants to go back.

Call for Action II

Continue building IPUs across institutions with medical leaders as the dominant force and managers as enablers.

The most passionate clinicians should be the forerunners in their particular fields. Traditionally, medicine has been defined by departments, both in clinical practice and in teaching. The new centre of leadership should revolve around the innovative practice teams. To achieve this, clinicians have to become enthused about what they can achieve with IPUs for breast cancer patients, diabetics, et cetera.

Those who in the current situation only look after in-hospital patients, should be made responsible for out-patients as well. The separation between in and out is no longer relevant. This means breaking down barriers between primary, secondary and post-acute care. Get the patient involved. Primary care VBHC should be organized around subpopulations (patient segments) like fragile elderly with a heart condition and multi-morbidities.

The Netherlands has excellent examples of IPU's like Erasmus MC, Santeon, the network approach of ParkinsonNet, Diabeter, Meetbaar Beter and others (see for example the VBHC Prize Winners and Nominees of the last 4 year). Hospital administrators have the task to encourage and support such efforts. Prof. Porter has learned from experience: start with the people that are willing, support them. Don't go after the people that are opposing change.

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Call for Action III

Let the Dutch government enforce the use of outcome measures like ICHOMs minimum international set as an obligation, since no other stakeholder coalition seems to be able to overcome the interests.

The Netherlands, like almost all other countries, has the problem of: How to deal with different views among stakeholders on outcome data? In the Netherlands there is currently no owner for standardization of benchmark outcome data, Prof. Porter acknowledges. Standards have to be created, and preferably internationally adopted.

Where measurements are already in place, they are connected to specialisms, measuring outcomes that are relevant only to that area. The goal is to measure outcomes more broadly. For example, outcomes for diabetes go far beyond endocrinology.

Health care institutions can decide to adopt these standards on their own or it can be enforced by the government and insurance companies. The path of least resistance would be if the Dutch government were to adopt the ICHOM-standard as a minimum required set.

Call for Action IV

Move quickly to bundled payments for all care, away from the current mix of Fee For Service/DOT and capitation based payments, to break wrong incentives.

In Prof. Porter's experience, shifting the current fee-for-service reimbursement to bundled payment is an effective mechanism to break the barriers between specialisms. It starts a cultural change, as it creates an incentive for departments to work together in IPUs. In the United States, there has been an explosion of bundled payments in the past years.

In the Netherlands the current regulations/main agreements need to be changed to allow for P and Q negotiations between health insurance firms and the health care providers/VBHC leaders. Long-term (3 years) bundled payment contracts need to be set up allowing for concrete programs, led by VBHC leaders, to improve patient outcomes and patient journey costs. In these bundled payment contracts, risk sharing, shared savings, reasonable profit margins, relevant data sharing and the value based involvement of patients and other parties must be arranged.

A need for training boards of directors/supervisory boards on VBHC is needed to help these bodies orchestrate VBHC change inside and outside of their institutions. Prof. Porter and Prof. Van Eenennaam are embarking on this trajectory.

The extended report of the working session with Prof. Porter will be disseminated in the second week of July. The final report will include information about the continuation of this unique working session.

For more information, please contact Vincent Wiersma via: v.wiersma@thedecisiongroup.nl

The authors like to thank Harvard University Professor Michael Porter and his Harvard based team for their valuable input. Responsibility for the document rests with Prof. Fred van Eenennaam and his team. This summary statement is intended to generate and discuss action on bringing Value-Based Health Care to the next level in the Netherlands.

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