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Cover Story

Patient Transformers

VBHC in Netherlands:

What problems could be solved? A report of interviews with 21 Dutch VHBC experts

Author: Dr Ton (AGJM) Hanselaar | Advisory Council member | Value-Based Health Care Center Europe | Amsterdam | the Netherlands

Author: Matthijs van der Linde | Senior programme advisor, Linnean Initiative | National Health Care Institute | Amsterdam | the Netherlands

Value-based healthcare (VBHC), aimed at improving patient outcomes without increasing costs, is becoming more and more important, as healthcare utilisation and costs continue to rise well above the cost of living. Many initiatives are now being taken to put value-driven care into practice, including in the Netherlands. The question, what problems could actually be solved by applying VBHC, has led to a series of interviews with Dutch VBHC experts. In this paper their insights and opinions are presented and discussed with the aim to provide caregivers, patient advocates, innovators and policymakers with an insight into the existing problems.

Key Points

- There is insufficient knowledge among healthcare providers about *what* and *who* is of value to the patient.
- There is an unfavourable economic business model.
- Healthcare is primarily organised from the perspective of the doctor and the care institution, not from the patient's perspective.
- The motivation and mutual trust of care workers are under pressure.
- There is little national cohesion in the collection of data and in the analysis of patient groups.
- Parties in healthcare are not specifically focussed on improving health outcomes that truly matter to the patients.

Introduction

As healthcare utilisation and costs continue to rise well above the cost of living, value-based healthcare has become an increasingly important concept (Porter and Lee 2015). The Value-Based HealthCare model (VBHC) aims to improve patient outcomes without increasing costs (see Appendix). The starting point is to achieve predetermined health values for and with patients, to be discussed with the patients in the doctor's office and among care professionals. Outcomes that are relevant to the patients are determined in a value ratio and measured in a structured way together with costs (Porter 2010). It encourages acceptance in healthcare practices to optimise the relationship between health gained and costs incurred. Many initiatives are now being taken to put value-driven care into practice, and it will inevitably lead to more research into how resources are deployed and spent (Brady et al. 2020). This concept is also catching on in the Netherlands. The nationwide programme Outcome-Based Healthcare, and the Dutch Linnean initiative, to which hundreds of people have now joined, try to further accelerate the transition to the VBHC system. But is it actually clear which problems can be solved with VBHC? Dutch VBHC experts give their insights and opinions on this in this paper.

Research Question

We have focussed on the question 'What are the problems in healthcare that can be eliminated by implementing the VBHC concept in practice?' With the answer to this

question, we aim to provide healthcare providers, innovators and policymakers who would like to start or have started a VBHC initiative, with an insight into the possible underlying problems, so that it can serve as a reference in their initiatives. But we also want to inform those who have not (yet) come into contact with VBHC with the answers to this question.

Methods

To identify the underlying problems, a series of semi-structured interviews were held in 2019 with 21 Dutch experts who are intensively involved in VBHC initiatives. The interviewees were approached by email and telephone by one of the authors (TH) in the period from May to June 2019. In three cases the questions asked were answered by email. The remaining 18 interviews were conducted by telephone. The duration of the telephone interviews varied from 40 to 90 minutes. The author (TH) wrote down the answers during the interview and then summarised them. Each interview was sent to the interviewee for approval and/or supplementation, after which it was recorded and saved. All interviewees agreed with these summaries, in some cases after certain clarifications.

The interviewees are healthcare administrators, patients, doctors, health insurers, business people working in the healthcare sector, researchers, consultants and winners of the VBHC Prize. All were familiar with the VBHC concept and had long-standing experiences with initiatives in this field. Some interviewees appreciated remaining anonymous in the report for reasons of their own. Hence, no list with the interviewees' full names has been included in this paper.

The answers to the questions were compiled afterwards and divided into a number of overarching categories. A total of 57 unique, distinctive answers were given. The categorisation was done on the basis of common denominators recognised and considered relevant by the authors. Given the small numbers of interviewees per professional group, no breakdown has been made by the background (director, consultant, etc.) of the interviewee.

During the interviews many examples were mentioned, some of which were an elaboration of a point made, some an example from practice. The answers, observations and opinions reflect those of the interviewees and do not have to match those of the authors of this paper.

Results

The results of the interviews show in summary the underlying problems as mentioned here. The results are presented in six overarching categories, each divided into specific problem topics.

1. Insufficient knowledge of what and who is of value to the patient

a. Not a good view of the (entire) patient
b. Limited knowledge about the effectiveness of treament for patients
c. The core of care, to help patients, has been reduced
d. Patients do not get the best doctor/care provider.

2. Skewed proportions

a. Patients are not seen as (equal) discussion partners
b. Limited commitment from the patients themselves
c. A doctor is still rather a 'God' than a 'Guide'.

3. An economically unfavourable picture

a. Discrepancy between economic input and outcome
b. No good knowledge of actual costs
c. Funding rewards Volume, not Quality.

4. Insufficiently informed patients and employees

a. Insufficient information hinders patients in their choices
b. No unambiguous language
c. Insufficiently informed healthcare workers.

5. Inadequate business operations

a. Disjointed, fragmented, scattered care
b. Blind spot for healthcare processes in doctors
c. Own interests
d. Moderate internal organisation
e. Lack of motivation, mutual trust; dissatisfied employees
f. Limited external coherence.

6. Limited learning and change ability

a. Inadequate focus on innovation, on improving care outcomes
b. Existing culture inhibits change.

Discussion

Since the 1990s, according to an analysis by BCG consultancy, the gap between healthcare expenditure and the disposable income of citizens has widened worldwide (Boston Consulting Group 2007). This also applies to the Netherlands. Healthcare institutions notice this through imposed spending ceilings and cutbacks. The traditional response of healthcare institutions to this is typically focussed on the short term, often on solving the financial issues through structural solutions, cutbacks and/or by performing more transactions. Due to growing external regulations, stricter bureaucratic procedures, and in the absence of a strategic course based on conviction, ambition and realism (which is recognisably carried out and guided during implementation), it is difficult to turn this tide (van Merode and Brouwer 2020). The patients do not seem to play a role in this traditional approach. Moreover, the enthusiastic caregivers, the inspired ones, often become frustrated and drop out. This interview study shows that, according to the experts consulted, there is much more going on.

Insufficient knowledge of *what* and *who* is of value to patient

There is insufficient knowledge among healthcare providers about *what* and *who* is of value to the patient. For example, care providers do not have a view of the (entire) patient. There is limited knowledge about the effectiveness of treatments for specific patients, but more for 'averages', which makes it difficult to distinguish between sensible and nonsensical care. Effectiveness and what is of value to patients are primarily defined from a clinical perspective, rather than from a patient's. The core of healthcare institutions, namely to help patients, is gradually slowing down. And patients do not vote by feet, neither they automatically get the best doctor, partly because it is hard to tell who the best doctor is.

Skewed proportions

There are skewed relationships between patients and healthcare providers. On the one hand, patients are not seen as an (equal) conversation partner by the care provider. On the other hand, patients themselves often show limited engagement. The much-described movement by the doctor from 'God' to 'Guide' has only started to a limited extent (Britnell 2013). The doctor is still considered as the great knowledge bearer. The consultation room is not yet a safe environment for patients to have an open conversation with the doctor in their role as partner-coach about the quality of care and their lives.

Economically unfavourable picture

This is due to a discrepancy between the resources we put into care (time, people and money) and the results, such as adequate diagnostics, treatment and achieved health outcomes. Both the World Health Organization (WHO) and the OECD estimate that up to 30% of the resources deployed are wasted on avoidable complications, unnecessary treatment or administrative inefficiency (WHO 2018). Healthcare providers and managers also lack good knowledge of the actual costs per care cycle of diagnostics, treatment and monitoring. This prevents the (rising) costs from becoming transparent and makes it possible for duplication of work to continue. Current financial flows focus on volume, not quality, and thus stimulate volume growth. It also indirectly creates a 'right' for physicians to determine treatment. It rewards bad treatments, pays for duplicates, and encourages over-treatment and unnecessary, but billable, transactions. After all, fewer treatments often means less income.

Insufficiently informed patients and employees

A lack of transparent, relevant information is a major problem because it prevents patients from choosing the healthcare provider or treatment that is best for their specific situation. It is precisely at the start of their illness that patients are often ignorant. Not being able to determine patient-relevant health outcomes deprives them of the opportunity to determine where they can best go. Data on outcomes for medical conditions are difficult to compare because data (infrastructure) are not interconnected and no unambiguous language is used. Furthermore, privacy regulations form another barrier to interoperability. To be able to deploy the best treatment process for each patient, care professionals need a clear understanding of treatment outcomes and experiences. Without that healthcare professionals miss opportunities to identify and monitor possibilities for improvement.

Inadequate business operations

Healthcare is characterised by inadequate operational management and is primarily organised from the perspective of the doctor and the care institution, not from the patient's perspective.

This has its roots in the classic image of the doctor who 'knows everything' and is personally involved in the care of their patients. Organising the care around the doctor was at that time logical. Today there are many more disciplines and sub-specialities, which results in fragmentation of the healtcare offering and less insight into the cohesion of care for the entire patient. Doctors have blind spots for care processes of their own patients, and for what happens outside their immediate speciality or outside the walls of their institution. This results in duplication of work, which is unnecessarily burdensome for all those involved. Doctors have their own interests, specialities, way of working, and specific wishes that do not have to be well-attuned to the value interest of the patient. The current structurally subordinate role of the nurses does not help with this (van Merode and Brouwer 2020). The enthusiasm in the workplace has decreased, partly due to the aforementioned fragmentation, to suboptimal and bureaucratic care. Employees are often not involved in the direction of their institution, in analyses of specific patient groups, in treatment considerations and improvement initiatives, which results in a decreasing sense of responsibility, accountability and changeability (Hanselaar 2020). Healthcare professionals have shown during the COVID-19 crisis that with focus, dedication and expertise they are able to realise major adjustments in the short term. There is capacity for change in healthcare, but little is used. Apparently, given the experiences during the crisis, addressing doctors and other care providers about their professional responsibility can be helpful in this respect.

There is little national cohesion in the collection of data and in analysis of patient groups. Joint benchmarks are struggling to gain ground. Exceptions such as Measurably

Better, (Meetbaar Beter) are limited in number. Partnership with the business community is still insufficiently available. The realisation that if a contribution from, for example, pharma is good for the patient, it can also be good for the pharma company, must still grow mutually. This is necessary to achieve better results together.

Limited learning and change ability

Parties in healthcare are not specifically focussed on improving the outcomes in healthcare. Academic medical research often does not look into applications or improvements in practice. Medical teams find it difficult to recognise and utilise their potential for improvement, as individuals or as a team. This and the limited application of innovations in healthcare are an expression of an internal organisation that is poorly aligned with patient value creation. Because there is no joint outcome perspective, there are no options for identifying improvement of outcomes and monitoring results. Only limited attention is paid to best practices. There is also little incentive to do this due to a limited R&D budget. The existing, ingrained culture in healthcare is difficult to change, both among healthcare professionals and patients. This could be partly out of fear of deterioration. It is in the nature of people, and it will not be very different in healthcare, to fight harder for the preservation of something than to acquire something new. Healthcare professionals often have a wait-and-see, sometimes lethargic attitude towards changes in culture and behaviour. In effect, the existing culture is more likely to inhibit change than to stimulate it.

Conclusion

With the overview presented here, we aim to provide care givers, innovators and policymakers who would like to start or have started a VBHC initiative, with an insight into the problems that play a role in healthcare. But we also want to inform those who have not (yet) come into contact with VBHC with the answers to the question about the type of problems that are identified in healthcare. According to the experts consulted, the aforementioned problems, challenges if you like, can be solved by applying the VBHC concept. By organising the activities for the patient well and in cohesion, with the aim of better outcomes for the patient, teams can create patient value. However, care is not currently organised like this, and this is at the root of the problems in care. Worse still, the rules and funding oppose this way of working. In a subsequent paper we will show which success factors according to these experts can help the implementation of value-driven care and which can make care for patients outcome-oriented and cost-conscious.

Conflict of interest

No conflict of interest reported. ■

Appendix

Value-Based Healthcare Model

The VBHC definition of value in healthcare is presented in a ratio:

value = outcomes / costs

In this value ratio, the numerator (outcomes) indicates condition-specific outcomes that are most important to patients, such as functional recovery and quality of life, while the denominator (costs) applies to the total expenditure for the entire care cycle (Porter and Teisberg 2006). Thus, if the results important to patients are not improved, the resulting value is low.

This definition applies to the entire care pathway, from primary to secondary and tertiary care, including post-hospital care for patients with a single disease or comorbidities. VBHC essentially wants to offer care for patients in such a way that (health) value for the patient is delivered in an acceptable proportion to the costs incurred (Kaplan and Anderson 2004).

The key VBHC concepts are:

- specific medical conditions/patient groups
- integrated multidisciplinary treatment teams
- (medical) leadership
- outcome measures
- patient-doctor relationship
- process design
- IT platform
- dashboard
- actual activities cost
- improvement initiatives
- bundled financing
- regional network relationships
- transparent information.

REFERENCES

Boston Consulting Group (2007) Health Care Regulation Across Europe. Available from iii.hm/15p4

Brady A et al. (2020) Radiology and Value-Based Health Care. JAMA, 324(13):1286-1287.

Britnell M (2013) From god to guide. Can patient-centred care become a reality in the NHS? The Guardian, 14 May. Available from iii.hm/15p5

For full references, please visit iii.hm/15p6