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CONFERENCE ABSTRACT

Towards population-based payment models in multiple-payer systems: the case of the Netherlands

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Introduction: The Dutch private multi-payer system is predominately paying providers on a fee-for-service basis, not incentivising efforts towards integrated care and prevention. Up to now, alternative payment models have not taken flight. Recent small-scale experiments in the Netherlands show substantial potential benefits of population-based payment models. Taking the Netherlands as an example, this study aims to analyse how such population-based payment schemes may be taken up more fiercely in systems running on the principles of managed competition.

Methods: PubMed and Medline were searched for international studies reporting on effects of introducing population-based payments compared to a control group. Quantitative results for both quality of care and healthcare utilisation were summarized and articles were qualitatively assessed to identify facilitators and barriers for implementation. Next, results of this review were presented to a panel of nine Dutch experts in the field of health policy to (1) validate and supplement findings from the literature review and (2) identify and determine processes to overcome barriers and enable further uptake of such payment schemes in managed competition systems.

Key findings: The literature search yielded 24 studies reporting on 10 international cases. Cases showed predominantly positive effects for both healthcare utilisation and quality of care. Identified challenges related to measuring quality, linking indicators to financial incentives, having an inappropriate data infrastructure to facilitate monitoring, and possible long-term financial instability for providers. Initiators of reforms and the degree of involvement of national policies and legislation differed, but the decentralised nature of healthcare systems in which these reforms were implemented seems to offer opportunities for small-scale experiments rather than radically reforming the entire healthcare system. The expert panel found that the Dutch system aligns with such a bottom-up approach. Payers and providers can initiate population-based payment systems to fit local needs, but should determine clear preconditions that focus on quality of care. Quality indicators tied to financial incentives, such as shared savings, might minimise risks of undertreatment. Upfront investments are needed to facilitate necessary data infrastructure and reforms might be encouraged through nationally set default options towards integrated payment systems, potentially reducing administrative burdens. Strong leadership, trust, and mutual understanding are paramount to overcome silos to integrate services across providers.

Conclusions: Several international examples of population-based payment reforms in multiple-payer systems have shown promising results in the last couple of years, but implementation is often

accompanied by various challenges. Successful experiments were often initiated bottom-up: payers and providers both have an active role in initiating such reforms, defining goals, and experimenting in local populations. Governmental bodies should have a facilitating rather than a directive role.

Implications: Whilst this paper used the Dutch healthcare system as their primary example, similar mechanisms and processes can act as a guide for the implementation of population-based payments in other multiple-payer settings. Policymakers in other multi-payer managed competition systems may therefore benefit from these insights to overcome barriers while transforming their healthcare systems through population-based payment schemes.