

Centralization of care and quality of care

An insurers perspective on innovation



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Who we are

Zorgverzekeraars Nederland is the umbrella organization of health insurers in The Netherlands

Ambition 2025:

- sustainable care
- patient / individual centered
- care is delivered with compassion in an effective way in networks around the patient
- spending money wisely, economically and honestly in order to maintain solidarity



What matters from health insurers perspective?

Insurers primarily have a societal perspective. Three basic questions:

1. Is the care delivered insured care?
2. How is healthcare organized to obtain optimal quality and accessibility?
3. How do we keep costs manageable?

1 Insured care

Three conditions must be met according to Dutch law and regulations:

- **usual** care for the field or specialism
- **evidence** based and formal practice
- medically **necessary** for the patient


If not, insurers are not allowed to pay for it.

Challenges for innovation and evaluation:

- Providing adequate evidence
- Legislation that supports a learning system

Beoordeling stand van de wetenschap en praktijk

'Helpt ziekenhuiszorg is niet bewezen effectief'

15 apr 2019 · leestijd 2 minuten ·  bewaren

Margot Smits · Eric van der Hijden · Jacques van Limbeek · 07 oktober 2021 · 7 minuten leestijd

kosten en baten

Gangbare zorg is lang niet altijd verzekerde zorg

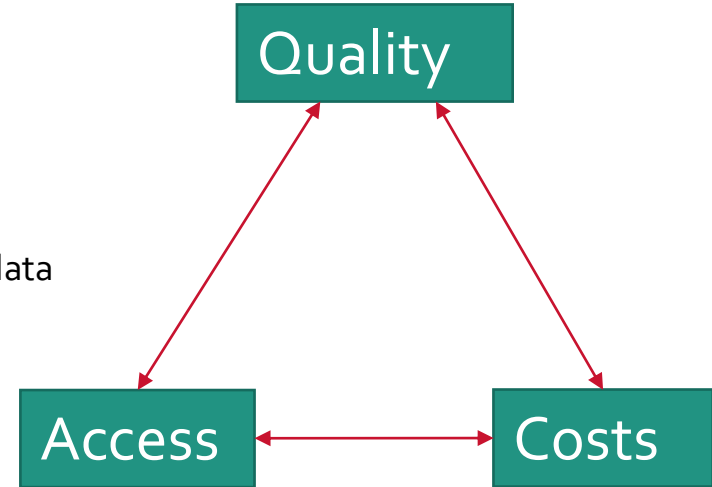
De 'stand van wetenschap en praktijk' verdient meer aandacht

2 Optimal organisation

Balance between: quality, accessibility and costs.

What is optimal organisation? E.g.:

- **Patients**
 - Good access to healthcare
 - Adequate process, outcomes and experience
- **Healthcare providers** improve their service:
 - Accumulate experience, learn from each other and from data
 - Quality, efficiency, proper use
- **Societal level:**
 - Healthy population
 - Capacity management, focused investments



Optimal organisation: data show that volume matters

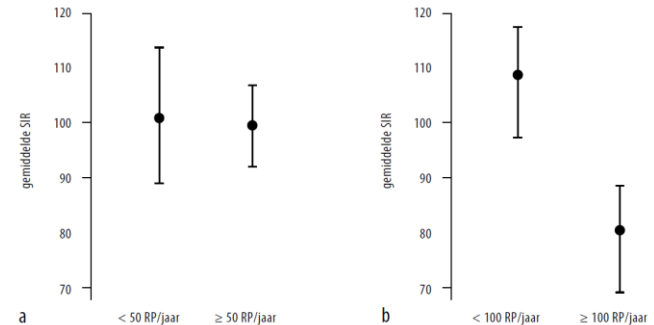
- **Incontinence** is a common and unpleasant complication after radical prostatectomy (RP).
- 1 or more incontinence pads per day are claimed for **26% of RP patients**, 12 – 15 months after RP, which indicates incontinence.
- In hospitals that perform **more than 100 RPs a year**, patients are significantly less likely to suffer from incontinence.

Hoe vaak incontinentie na radicale prostatectomie?

INCIDENTIE BEPAALD OP BASIS VAN DECLARATIE INCONTINENTIE MATERIAAL

Maïke H.J. Schepens, Cathelijne M.P. Ziedses des Plantes, D.M. (Rik) Somford, Judith A. van Erkelens, Ruben G. Cremers, Sytske de Vries, Katja K.H. Aben, René Hoekstra, Jozette J.C. Stienen, Bart P. Wijsman, Martijn B. Busstra en Jacques van Limbeek

NED TIJDSCHR GENEESKD. 2018;162: D2294

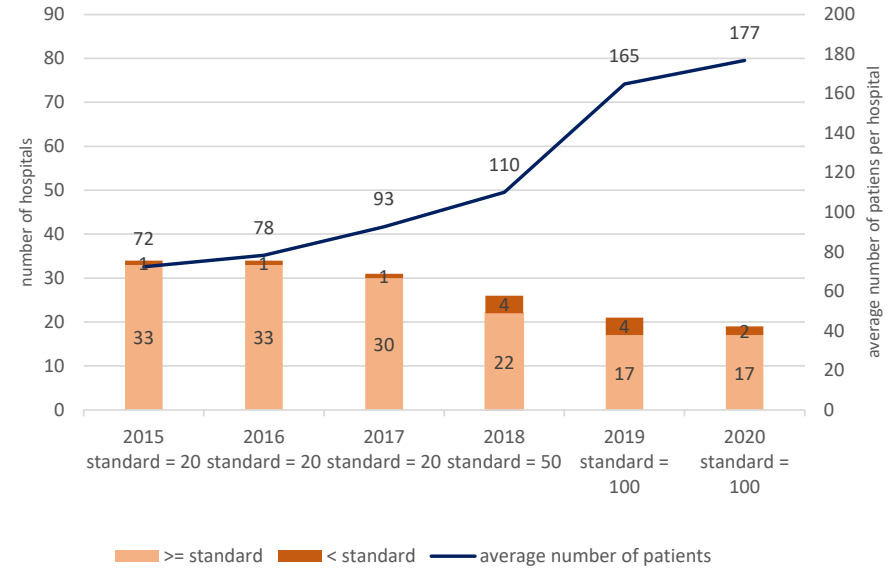


FIGUUR Verschil in de kans op incontinentie na radicale prostatectomie – uitgedrukt in gestandaardiseerd incidentieratio (SIR) – tussen ziekenhuizen met een laag operatievolume en met een hoog operatievolume. De SIR is de verhouding tussen het werkelijke aantal en het verwachte aantal incontinentie patiënten x 100. Weergegeven is de gemiddelde SIR met 95%-betrouwbaarheidsinterval voor (a) ziekenhuizen met < 50 versus ≥ 50 radicale prostatectomieën (RP) per jaar; en (b) ziekenhuizen met < 100 versus ≥ 100 RP per jaar.

Optimal organisation: developments

- **Volume standards** per hospital for RP increased from a minimum of 20 in 2017 **to 100 in 2019**.
- Average number of **patients treated** with RP in hospital **increased to 177** in 2020
- Treatment is in 2020 **concentrated in 19 hospitals**, of which 17 conform to the new volume standard.

Development of number of hospitals and average number of patients treated with radical prostatectomy versus volume standards



3 How do we keep costs manageable?

There is a big **societal challenge**:

- **Aging population** will increase number of patients
- **Lack of staff**: no more people available, staff overburdened
- **Healthcare budget** is not allowed to increase any further.

**We need to treat more patients,
with the same (shrinking) staff and budget.**



Main challenge



3 How do we keep costs manageable?

Innovation and the societal challenge

- **Cost-increasing** innovation does not match available budget and staff. E.g. expensive medicines, advanced tools, time consuming treatment, digital care as something extra.
- **Moral dilemma:** more expensive or time-consuming treatment for patient A means no treatment for patient B.
 - Who wants to be patient B?
 - Who decides that patient A is more important than patient B?
 - Which patients will not get treatment to pay for innovation for others?

3 How do we keep costs manageable?

Major challenge is that we need innovations that

- are good for **patients**
- limit **staff** burden
- and reduce **costs**

Only innovations that meet all these criteria contribute to a solution for the societal challenge.

How to enhance implementation?

Challenges for implementation / scale-up of promising innovations

- 'not invented here' syndrome
- Tailormade versus one size fits all
- Across different domains of care
- The law does not allow to pay for innovations not yet scientifically proved to be effective

How can we help each other?

Wrap up with regard to manifest

Keep the societal perspective in mind:

- Make sure the requirements for insured care are met
- Make sure the organization of care is optimal
- Make sure innovation contributes to the societal challenge