The healthcare purchaser as a care chain orchestrator

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Summary

Policymakers expect healthcare purchasing organisations (in short: purchasers) such as health insurers and governmental bodies to fulfil an orchestrator's role in order to improve chronic care delivery. Particularly for chronically ill patients, there is often room for improving task division and collaboration between providers including general practitioners (GPs) and medical specialists in hospitals. Through the use of contracts, payment schemes and by facilitating projects and innovation, healthcare purchasers can steer providers towards better healthcare delivery. Practice and theory, however, show that healthcare purchasers, in both privately and publicly funded healthcare systems, struggle to orchestrate care chains: they instead often focus on their administrative task of controlling healthcare budgets. There is limited understanding of how decisions and purchasing strategies evolve in practice, and whether these can be explained by differences in healthcare systems. In response, this thesis aims to gain a better understanding of how healthcare purchasers' strategies are shaped by health policies, regulations and everyday practice.

Scientific foundation

Chronic care can be seen as a chain or network of care providers each involved in the delivery of different aspects of a patient's treatment. Patients require consultations, diagnostics and follow-up care from various disciplines such as GPs, hospital specialists and nurses, physiotherapists and community nurses. Research on concepts including integrated care, the Chronic Care Model and care pathways in general have established organisational preconditions that can contribute to better chronic care delivery and outcomes. A basic level comprising community, social and mental care is required to support chronically ill patients. Procedures need to be in place to facilitate coordination, professionals require frequent training, and supportive systems in terms of information technology, diagnostic devices, medication and medical supplies are essential. Although the way in which care chains should be organised is usually established in national care guidelines and protocols, how care is delivered in practice varies significantly, revealing considerable room for improving care delivery. It is widely acknowledged that, to achieve continuous improvement, the financing of care should reward providers and patients for pursuing better health outcomes within the available resources. Often, however, the financial incentives offered to the various providers can create tensions. For example, shifting services from one provider to another will lead to higher revenues for one care provider at the expense of the other. Healthcare purchasers have a key role in managing these financial incentives.

There are many ways to contract and pay for care services, which have been studied by economists and healthcare management researchers, and it is important that healthcare purchasers weigh the advantages and disadvantages of each payment system. A distinct payment for each care service provided may, for example, reduce waiting times but increases volumes, while an overall budget payment is known to have the opposite effect. In practice, payment systems may be blended to offer incentives for better care outcomes. Besides financial tools, purchasers have other means to steer healthcare delivery, for example through regulation, coercion and collaboration. From comparisons between healthcare systems, we know the benefits and downsides of such tools, and this provides an understanding of how one might improve healthcare purchasing regulation. Nevertheless, one observes that why purchasers choose particular tools in specific circumstances is often unclear and cannot solely be explained by the distinction between market- and government-based purchasing systems. Why, for example, are frequent tensions and conflicts between purchasers and providers reported in some countries or regions whereas, in other situations, collaboration and trust are more apparent?

In short, how the purchaser's challenging position in the care chain affects their purchasing approach remains only partly understood. A premise underpinning this thesis is that purchasers are embedded in a complex network of patients, providers and regulatory agencies who all have their own vested interests, goals and responsibilities in chronic care delivery. In this thesis, we aim to explain if and how a purchaser adopts an orchestrator's approach to purchasing by studying the health policy context and pressures exerted by a range of stakeholders.

How healthcare systems shape a purchaser's strategies and actions

In Chapter 2, we present a comparative case study between regions in England, Sweden (both publicly financed) and the Netherlands (insurance system). Healthcare purchasing organisations in these countries all have similar challenges with respect to aligning care providers and strengthening primary care. A qualitative, in-depth analysis of one region from each country shows that each healthcare purchaser has a different approach towards purchasing care for chronically ill patients. In the region in England, we saw a strong long-term vision, with the regional Clinical Commissioning Group (CCG) pursuing overall population financing with a fifteen-year contract. The CCG, which is managed by a GP council, has a strong clinical standpoint, close collaboration with care providers, but also sometimes a coercive style of managing the care chain. In the Netherlands, the largest health insurer in the region studied takes a

predominantly cost-focused and short-term perspective. Although the insurer is aware of the importance of achieving long-term improvements in citizens' health, the pressure of competition drives them towards keeping insurance premium rates competitive and affordable. Further, health insurers are also pressured by their subscribers to ensure relatively short waiting times. Experiments with innovative approaches are supported in the Dutch region, but mostly focused on initiatives by individual care providers and without a mechanism to expand them into wider use. The relationship between care providers and health insurers is more formal in the Netherlands than in England and it is also notable that there are frequent changes of personnel within the insurer. In the approach of the studied Swedish County Council (CC), the clinical and patient perspectives are key here with, for example, much attention given to the social causes of health problems. Patients have considerable freedom to choose between primary and secondary care providers and this limits the steering power of the CC. There is a large and expensive secondary care sector in the studied region and although the purchaser tries to stimulate primary care use through regulation and contracts this has only limited effects. Based on our comparison, we conclude that particularly whether competition between healthcare purchasers exists, the style of purchaser governance (clinical or managerial) and the degree of patient choice (high or limited choice for specialized care providers, presence of GP gatekeeper or not) play a major role in shaping the purchaser's strategies and actions. These three system characteristics determine the extent to which purchasers are strongly engaged in improving chronic care delivery, adopt a strategic lens aimed at short-term costs, as against long-term health benefits, and adopt a directive influencing style.

How stakeholder pressures shape a purchaser's institutional logics

Patients with Chronic Obstructive Pulmonary Disease (COPD) suffer from progressive respiratory distress and difficulty with physical exercise, often accompanied by psychological problems and addiction to cigarette smoking. Frequently, patients need emergency hospitalisation because of a pulmonary attack (exacerbation). Effective COPD treatment entails care from a GP, a pulmonologist, a physiotherapist, a dietician, a psychologist and home care. Adequate collaboration and task division between these different providers is essential, but difficult to achieve because of the differing personal needs of patients, different medical perspectives and sometimes conflicting financial interests between providers. As such, it is seen as desirable that the purchaser adopts an orchestrator's role. However, given the different goals and interests of the involved parties, we see that the purchaser is in a difficult position. In Chapter 3, we conducted a longitudinal, single-case study on a Dutch health insurer that was pursuing better chain-wide care delivery for patients with COPD. Using the theoretical lens of

institutional logics, we aimed for a better understanding of the logics that purchasers adopt as the basis for their purchasing strategy. Our assumption was that the purchaser would pursue a role of care chain coordinator, but also expected a strong urge to retain a role of budget controller. Based on our qualitative data analysis we have explained these roles by using the metaphors 'orchestrator's' and 'bookkeeper's' institutional logic (in short: logic). From 2015 until the present, we have followed a major health insurer in a Dutch province who, in collaboration with care providers, established multiple initiatives to improve COPD care. Partly as a consequence of public and government expectations, the health insurer started ambitiously by organising frequent meetings with providers, taking a chain-wide approach and offering a supportive shared savings contract. Interviewees reported that the initial phase of the collaboration developed positively and contributed to building mutual trust between parties. After this initial phase, where the orchestrator's logic appeared to dominate, the insurer fell back into their default bookkeeper's way of thinking. The insurer appeared to struggle to achieve consensus between care providers, appeared hesitant to realise a chain-wide, shared savings agreement and reduced its involvement. Looking back on events, we identified five types of pressures exerted by policyholders, providers and the government towards the insurer linked to: relationships with providers, need for cost control, uncertainty on care and cost outcomes and medical and public health demands. The intensity of each type of stakeholder pressure varied over time and, importantly, also interacted with each other, thereby explaining the institutional logic adopted by the insurer. For instance, an improving relationship between insurer and provider made it easier for the purchaser to deal with cost and uncertainty pressures. On the other hand, the insurer appeared less open to medical substantiation of improvement initiatives when under high financial pressures. Besides these externally driven explanations, the purchaser's own internal organisation in terms of collaboration, structure and capacity also played an important role. The insurer had separate departments for purchasing primary and secondary care, and there was only limited alignment between them. Moreover, contracting managers and directors offered little support to the policy advisors who were closely involved with setting up the initiatives. Finally, we saw a lack of medical knowledge and capacity to provide support within the insurer. This lack of intra-organisational alignment created a vicious cycle in how the purchaser responded to external stakeholder pressures. Hence, falling back into the bookkeeper's logic appears to have been inevitable.

Out-of-hospital coaching of patients with severe COPD

Chapter 4 evaluates the COPD home-coaching intervention that was the main intervention emerging from the insurer-provider collaboration presented in Chapter 3. The intervention aimed to reduce hospitalisations as a consequence of COPD-related pulmonary attacks. After a hospitalisation, patients were offered home coaching by an experienced respiratory nurse from the hospital. A goal of the coaching was to teach patients how to timely recognise worsening symptoms, improve their use of medication and strengthen their network of care professionals and informal carers. The expectation was that this would lead to fewer respiratory complaints, improved physical and mental wellbeing and, consequently, lower care costs. Earlier research aimed at case management and stimulating self-management for COPD patients had shown promising, albeit variable, results. After a stay in one of the four participating hospitals, patients received seven home visits, followed by three phone calls during the two years after discharge. In our study, the effects of the intervention were determined based on reimbursement data provided by the health insurer and validated questionnaires regarding respiratory distress, patient activation, mental wellbeing and nutritional status. The feasibility of implementing the home-coaching service was assessed based on questionnaire responses, cost-effectiveness, a Patient Reported Experience Measure (PREM) and a qualitative evaluation. Between June 2016 and May 2018, 170 patients (90 female) were enrolled in the study, with an average age of 69 years. During the study period, 12 (7,1%) patients declined to participate further and 44 (25,9%) patients died. Six months post-intervention (i.e. after leaving a period of hospitalisation), the surviving patients showed statistically significant benefits in terms of CCQ (clinical pulmonary status), PAM (motivation and self-awareness) and SNAQ (nutritional status)) scores compared to baseline measurements. This improvement was also found for CCQ, HADS (anxiety and depression) and SNAQ measures, 12 months post-intervention. Overall, 20% to 45% of patients showed a clinical improvement on at least one measure, six months and/or 12 months after start of the intervention. The average annual COPD-related hospitalisation rate for the 85 patients in the insurance data subset a year prior to the intervention was 2.39, and this had fallen to 1.92 one year after, indicating a 20% reduction in hospitalisation rate. The greatest reduction in hospitalisation rates was for patients with a historically lower hospitalisation risk, fewer respiratory symptoms, but with a high mental burden. Comparing data for one year before to one year after the intervention, a cost reduction of about €900 per patient per year was established after taking into account costs of coaching, physiotherapy and other additional costs. The response rate to the questionnaires was 87.1%. The PREM showed a positive assessment of the coaching (4.2 on a 1 to 5 scale) and the qualitative evaluation showed improvements in four

aspects of care: care giver–patient relationship, collaboration, self-management support and professional development. As reported by the participating coaches and patients, an important element of the coaching was the provision of attention, safety and trust, indicating a particular benefit for patients with a high mental burden. However, it appeared challenging to improve the physical status of patients with severe respiratory symptoms through support and education. Our findings are in line with studies conducted elsewhere in a primary care setting focussed on patients with less severe symptoms. We would stress the importance for COPD patients of timely support and attention. Moreover, the time provided for caregivers to receive disease management education enriched their work and enables professional development. Overall, the implementation of improved COPD care was shown to be both feasible and cost-effective, and should therefore be supported by healthcare purchasers. However, governments need to provide the right macro-incentives and policy context for long-term, widescale adoption.

Conclusions

The three studies presented provide a better understanding of what drives, enables or limits healthcare purchasers, how their behaviour can change over time and what purchasing means for society and the patient. First, we show how fundamental characteristics of public or private healthcare purchasing systems affect a purchaser's strategies and actions when managing chronic care. Purchaser competition, purchaser governance and patient choice appear to be key characteristics in determining a purchaser's engagement, strategic lens and influencing style. Second, when trying to improve task division and collaboration between chronic care providers, the purchaser is faced with multiple stakeholders with often different interests, goals and power. These stakeholders – care providers, insurance policyholders and the government – exert five types of pressures which explain the observed shifts in the institutional logics adopted by the purchaser. These are relationship pressures, cost pressures, medical demands, public health demands and uncertainty. Third, purchaser–provider collaboration can encourage the implementation and evaluation of chronic care improvement initiatives. Our evaluation and feasibility study of a home-coaching intervention for hospitalised COPD patients on return to their homes shows beneficial results in terms of health, wellbeing and costs. Purchasers nevertheless struggle to drive the structural embedment of such improvements into regular care provision.

A key insight derived in this thesis is that, although frequently addressed, it is not simply a matter of taxation versus insurance regulation that enables the best healthcare purchasing system. Other healthcare system characteristics, related to purchaser

competition, governance and patient choice, determine whether purchasers have sufficient influence, professional knowledge, responsibility and ability to coordinate the care chain and to guide patients through it. Policymakers and purchasers should regularly consider whether they are providing the best context for their health policy goals. We also show that the purchaser can itself create better conditions for pursuing improved task division and collaboration in the long run.

Naturally, the question as to whether fee-for-service, pay-for-performance, budget, bundled or population payment works better than the other alternatives is relevant. However, purchasers and providers also need to be willing to make new financial arrangements that require working collaboratively towards a fairer sharing of risks and the avoidance of possible perverse incentives. We have seen that, in many countries, there are experiments with new incentive schemes, but that these have not been implemented on a large and structural scale. Our research contributes to the healthcare purchasing literature by showing that it is important to create the appropriate context to enable purchasers to develop an orchestrator's role. Such a context involves the right macro-financial incentives for both purchasers and providers, and the availability of the necessary relational, financial and analytical purchasing tools. Using such tools and learning of their benefits and disadvantages is an important way ahead towards achieving the right care at the right place along care chains.

The COPD coaching initiative showed that, in practice, due to conflicting interests and viewpoints of the various providers and the purchaser, even with promising outcomes, it remains difficult to make structural agreements. Care improvement initiatives are often difficult to scale up and thereby prove to be unsustainable. We would stress that care chain improvement requires the establishment of an adequate organisation with the right financial incentives for all stakeholders and agreements on the rights and obligations of the different parties, both for the initial stages and into the future. Governments and policymakers should demand and facilitate the organisation of care chains based on current best practices, which are omnipresent within and beyond the field of COPD care.

Our study contributes to the healthcare management and purchasing literature by explaining how purchasers can potentially provide the preconditions necessary for adequate chain-wide chronic care delivery. For this to occur, health policy needs to support purchasers in their difficult position facing provider, citizen and government demands. Furthermore, purchasers themselves can and need to build the right organisation and knowledge to enable them to become care chain orchestrators.