VBM and payment reform in Denmark

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Value based health care (Porter, Teismann etc)

Mix of different organizational and steering mechanisms: Overall philosophy is to track patient pathways, costs and outcomes. – *and to link outcomes to economic incentives.*

Specific recommendations:
- Building integrated care units
- Larger geographical areas (IPU - Integrated Practice Unit – can be distibuted networks)
- Bundling of activities – including post discharge results (readmissions, long term quality)
- Assessing costs and results for each patient
- Sharing risks b/n third party payer and delivery organization(s)
- Using patient reported outcome measures (PROMS) of various kinds
- Building an appropriate IT/data platform

Value based health care (Porter, Teismann etc)

Peformance measures at three levels:

Level 1: Health status achieved?
- Mortality rates, improved function, QALY etc

Level 2: Process
- How long is the process from diagnosis to cure?
- The impact of adverse events?
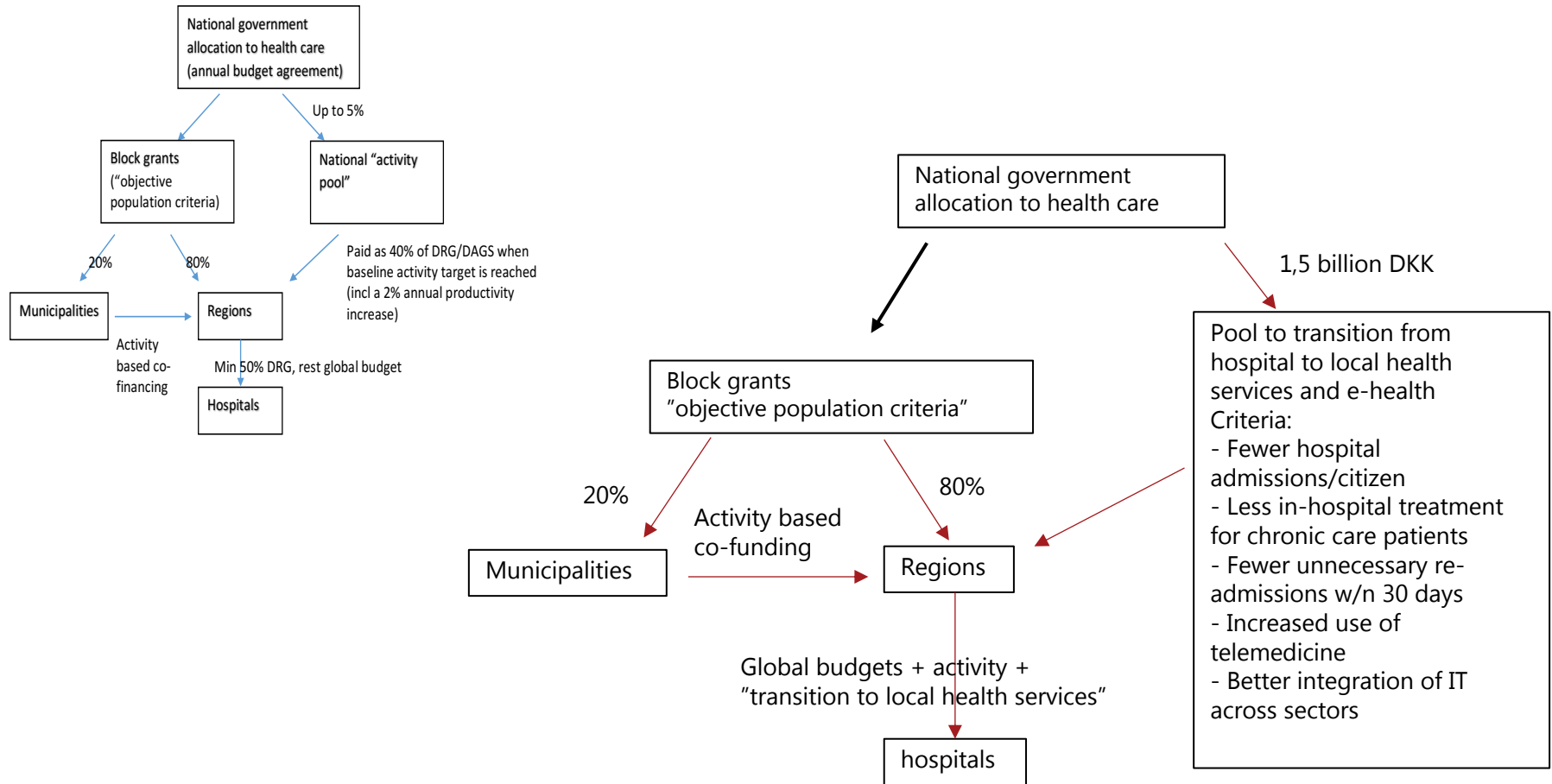- Patient perceptions of impact in terms of anxiety, pain, infections etc.

Level 3: Sustainability
- Long term effects. – Relapse, functionality etc

Highly relevant ideas, - *but*

- Many components are undefined, and must be developed further

- Requires very sophisticated data and analytical capacity to track complex pathways (multimorbidity) and long term outcomes.– selecting the right indicators is an issue (process, output, outcome – clinical and patient perspectives. – Short and long term)

- Still a "system centric" perspective - We need better approaches to integrate knowledge about the environmental and individual factors that influence outcomes

- How to develop a fair incentive scheme that adjusts for case mix and the interaction b/n environmental factors and individual level responses

- Any performance management scheme generates wanted and unwanted effects (gaming, distortion, tunnel vision etc)

Changing the payment scheme in Denmark – moving towards VBM?

National government allocation to health care (annual budget agreement)

Up to 5%

Block grants ("objective population criteria)

National "activity pool"

Paid as 40% of DRG/DAGS when baseline activity target is reached (incl a 2% annual productivity increase)

20%   80%

Municipalities   Regions

Activity based co-financing

Min 50% DRG, rest global budget

Hospitals

National government allocation to health care

1,5 billion DKK

Block grants "objective population criteria"

20%   80%

Activity based co-funding

Municipalities   Regions

Global budgets + activity + "transition to local health services"

hospitals

Pool to transition from hospital to local health services and e-health
Criteria:
- Fewer hospital admissions/citizen
- Less in-hospital treatment for chronic care patients
- Fewer unnecessary re-admissions w/n 30 days
- Increased use of telemedicine
- Better integration of IT across sectors

Based on agreement b/n Regions and Government in 2018

Technological and organizational solutions to support these aims will be in high demand:

- Monitoring and interpreting data (admissions, re-admissions, IT progress)
- Understanding organizational dynamics and motivational factors that create results
- Building and testing efficient implementation models that support the aims and avoid negative side effects
- Combining individual and environmental data to understand individual level responses that influence disease, health and well-being
- Providing IT solutions for integration of care. – work with health care organizations to implement in practice
- Support telemedicine and provide evidence for best solutions