The future of social care in The Netherlands: effectiveness of population-based financing

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ABSTRACT:

On 1 January 2015 the new Law on Social Support (Wmo) was introduced in The Netherlands. This law made the municipalities responsible for an important part of the care for their citizens. The municipalities are free to purchase and arrange this care in the way they want.
Where the old system used payment per hour of care, the municipalities can now introduce forms of payment for results. This paper analyses one form of payment for results: population based financing.
In a system with population based financing, a care provider receives a fixed payment for supplying a certain population with a certain type of care. This form of financing can stimulate innovation and efficiency but can create monopolistic care suppliers, municipalities without any influence on the spending of their budget and patients without choice.
This paper identifies the risks associated with the introduction of population based financing as mentioned in theory. Furthermore, the tender documents and contracts of four municipalities that chose to introduce population based financing are analysed to identify counter measures against the presence of the identified risks.

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Keywords

Wmo, purchasing of care, population based financing, capitation, healthcare.

8th IBA Bachelor Thesis Conference, November 10th, 2016, Enschede, The Netherlands.

1. DESCRIPTION OF THE TOPIC

On 1 January 2015 parts of the care for people The Netherlands moved from the AWBZ (General Law on Exceptional Health Expenses) to the Wmo (Law on Social Support). This is the case for:

- Support with being self-reliant
- Support with participation
- Protected living and shelter
- Support of caregiving
- Client support

The transition includes two important changes. First of all, the care that was part of the AWBZ was the responsibility of the national government. The parts that moved to the Wmo became the responsibility of the municipalities. The municipalities have a high degree of freedom in contracting their own partners to supply the care.

Second, the budget for the care that was moved from the AWBZ to the Wmo will gradually be decreased by 25-40%, depending on the type of care. The municipalities have the responsibility to take care of their citizens while reducing the expenses.

Municipalities use different models to organize their new responsibilities. These models include the contractual relation between the municipality and the care provider / supplier. The way of funding is an important aspect in the new contracts with care suppliers as it defines both the effectiveness assessment criteria and the roadmap towards the reduction of the expenses. Uenk (2016) defines three different funding strategies:

PxQ (price times quantity) or fee for service financing is characterized by payment per hour of care delivered by the care provider. In most cases, the municipalities define the hours and type of care to be delivered on client level and the contracts define the rates per hour. As this was the way of financing that used for AWBZ care before the transition, most municipalities (still) use this form.

In case *Result* or *performance based financing* is used, care providers are paid for reaching goals on individual level, for example a yearly amount per client with a certain indication. They have (more) freedom in deciding how to reach the goals. This way, the care providers have more chance to innovate and find more efficient ways of reaching the results.

Population based financing is based on giving a care provider the responsibility to take care of a certain (subset of the) population, for example a city or district. Usually a care supplier receives a fixed amount per member of the population. The care supplier has the responsibility to give the right type of care to the right people, and has a financial motivation to stay within budget. Municipalities usually include systems in the contract that create incentives to deliver good care. This is a form of result based financing, but with a different approach. In result based financing, the results are usually measured per client. With population based financing the results are measured per population.

According to KPMG Plexus (2013-2) population based financing works best when there is a preventive or regional character or when it is hard to diagnose well, because in these cases it is either hard to define a specific treatment or to allocate costs to a specific treatment or patient.

For Wmo-care, municipalities can use district teams. KPMG Plexus (2013-2) states that population based financing fits well to district teams with a high degree of freedom in deciding who receives which care, and which help is needed to provide this. They have and maintain contact with the clients in the district and have the freedom to supply whatever they see needed. The district teams can also use this freedom to invest in making the whole district better, for example by setting up facilities where people can meet and help each other, or by giving courses to teach people to care instead of doing this for them.

Secondly, there is a motivation to take preventive measures. If the payment is not based on the treatment, the care provider can invest in projects that avoid costs in the future. If the decease does not occur, no costs will be made to cure it.

Third, if one (coalition of) care provider(s) is responsible for a whole district, it is easier to make agreements with other entities in the district, like general practitioners, district nurses and social organizations, and create an integrated offer with these other social services.

Fourth, the care provider has a clear benefit from the work of caregivers within the direct circle of the client, as well as volunteers, and will be motivated to assist and support them. Fifth, there is a motivation to innovate. Where the old AWBZ system had a motivation for Supplier Induced Demand (SID), the system of population based financing creates an advantage of doing things more efficient. Shifting to population based financing gives a strong motivation for innovation because the care provider benefits financially from the increased efficiency.

These points are mainly beneficial for the customer, in case of the Wmo the municipality, because they aim to increase efficiency and ultimately lower costs. If done properly, however, delivering the same level of care in a more efficient way should not be disadvantageous (and can even be advantageous) for clients.

All these benefits come with potential risks and problems. The aim of this paper is to identify the risks of implementing population based financing, like underproduction and the creation of too powerful care suppliers and limited competition, and see how municipalities who actually implementing or have actually implemented population based financing deal with these.

2. METHODOLOGY

The research question that is to be answered in this paper is: *"How do care providers and municipalities in The Netherlands try to avoid and control the problems that occur with population based financing? "*.

To get to this answer, first the first sub-question will be answered: *"What problems can occur when using a population based financing model?"*. In chapter 3 the problems will be identified using literature research.

These results will be used to answer the second sub-question: *"How are the problems that can occur when using a population based financing model addressed and avoided in the contracts between care suppliers and municipalities?"*. The answer to this question will be given based on an analysis of the tender documents and (where available) contracts between care suppliers and municipalities.

As background for answering the first sub-question, scientific and professional articles were found with an exploratory search method using backtracking and association.

Backtracking means that theory is searched using theory that was found before. As starting point, the key articles of Eijkenaar & Schut (2015) and Pomp (2013) were used, as well as a collection of articles published by Telgen and Uenk, the supervisors of this thesis. Sources in these articles were analysed for being relevant to this thesis, following a tree structure. When a path resulted in a relevant article, the path was followed. When not, I took one

step back and followed another path. This was done until there were no relevant articles left to be found.

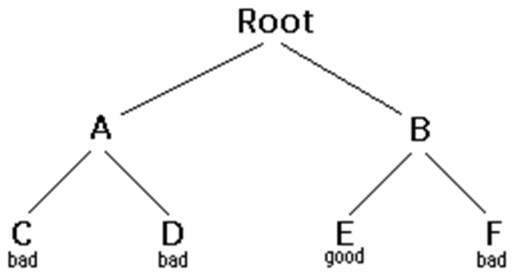

Figure 1: The tree structure used for backtracking.

Another method used for the theoretical analysis is association. This principle comes from psychology and goes back as far as Plato. In the sense used here, it means that relations between articles and theories are discovered. This approach is used because the field of research is not well defined as-such. This thesis rather tries to combine existing fields and therefore needs related research from different scientific fields.

The theoretical analysis resulted in formulating 14 "fields of concern" regarding population based financing, in three categories (market, municipalities and patients). These fields of concern are displayed in Figure 2 on the horizontal axis.

The simplified result of this theoretical analysis, only indicating which source is linked to which part of the paper, is displayed in the theoretical framework in Figure 2, on the vertical axis.

In chapter 3 the first sub-question is being answered by describing the 14 fields of concern and formulating risks. Each of the concerns results in one clear risk.

	General			Market						Municipalities			Patients				
	Definition of population financing	Examples in The Netherlands	Examples abroad	Limitation of competition between care providers	The role and position of sub-contractors	Dependence of subcontractor on contractor	Dependence of municipality on contractor	Adequate pricing	Long-term contracts	Limits the coordinating role of municipalities	Monitoring by municipalities	Exchange of information	Referring patients to other (higher) segments of care	The accessibility of care	The quality of care	Freedom of choice of patients	Happiness of patients
Berwick at al. (2008)														•	•		
CPB (2015)				•				•	•	•	•		•		•	•	•
Drewes et al. (2014)		•															
Eijkenaar & Schut (2015)	•		•	•		•	•	•	•			•	•		•		•
Gevel, van de (2013)											•			•	•		
Hildebrandt et al. (2010)			•					•				•	•		•		
Kleef, van et al. (2014)				•				•					•	•	•	•	
KPMG Plexus (2012)		•						•									
KPMG Plexus (2013)					•			•		•	•	•	•	•	•	•	
KPMG Plexus (2013-2)	•	•		•			•	•			•	•	•		•	•	
McClellan et al. (2013)			•					•							•		•
Pomp (2013)	•	•	•	•	•			•					•				
Telgen & Uenk (2015)								•									
Telgen (2015)										•						•	
Telgen et al. (2014)									•								
Telgen et al. (2014-2)				•		•				•						•	
Uenk (2016)									•								
Uenk (2016-2)				•	•	•		•		•						•	
Veurink (2015)												•					
Zorgvisie (2015)									•								

Figure 2: Theoretical background

In chapter 4 the analysed municipalities are introduced. The four municipalities each have different tenders, different ways of contracting and different priorities. These are described in this chapter.

In chapter 5 the second sub-question will be answered by analysing contracts between municipalities and care providers and tender documents. For each municipality the tender documents and contracts were studied to find out how they (plan to) deal with the defined risks. The extent to which the risk is avoided is graded on a 0-5 scale to get a comparable overview.

In chapter 6 the research question will be answered, and some last remarks are made.

3. POPULATION BASED FINANCING IN THEORY

This chapter has the aim to answer the first sub-question: *"What problems can occur when using a population based financing model?"*. In this chapter 14 concerns (in three categories) of using a population based financing models will be identified and described.

Two different forms of population based financing can be distinguished in theory: shared savings and capitation (Pomp, 2013).

In a model with shared savings the budget holder agrees with the care provider about sharing the benefits of improvements compared to a certain benchmark. Within this framework there are different ways of sharing the (financial) risk. If the care provider only receives a bonus for making certain improvements, all risk remains with the budget holder. In case of a bonus/malus system where also a part of the budget can be cut in case of achieving below expectations the risks are shared between budget holder and care provider.

Shared savings cannot fully be seen as population based financing because the care provider has a lower degree of risk. It can however be used to share savings in a next line of care.

When capitation is used, the financial risks shift to the care provider. They receive a fixed budget for a certain population for a certain period. This budget can be adjusted or set based on the characteristics of the population, but key is that the costs or benefits resulting from different budgeted and actual costs are taken by the care provider.

To have benefits from population based financing both aspects are needed. The care provider needs to benefit from improvements to be motivated to invest in improvements. The share of the care provider in the benefits of innovation should exceed the sum of the costs of improving and the lost incomes due to the lower production that results from the improvement, minus the costs savings that might already have resulted from the improvement. At the same time, the care provider needs to take a certain risk to be motivated to stay within budget. The incentives for staying within a set budget should exceed the benefits of overproduction.

Eijkenaar & Schut (2015) describe several examples of population based financing abroad, in the United States, United Kingdom and Germany. The example closest to the situation in The Netherlands has started in Germany a few years ago: Gesundes Kinzigtal. The approach of Gesundes Kinzigtal is characterized by a focus on investing in health and the quality of care, offering preventive programs and stimulating a healthy lifestyle, and coordinate the network of care suppliers. This all leads to a more integrated approach with a focus on prevention and caring, rather than curing, as well as increased care after a treatment took place.

A noteworthy difference with the Wmo in The Netherlands is that most of the benefits are in the next part of the chain. In the case of Gesundes Kinzigtal that is still in the interest of the health insurers participating in the project; they benefit from a decrease

in hospitalization. In case of the Wmo in The Netherlands, however, this benefit is not so obvious. The municipalities benefit from cost savings and will see the advantage of an increased quality of life of the patients, but not necessarily have an incentive to lower the costs for 2nd line care (in Wlz or Zvw institutions). To create this incentive, shared savings agreements can be used.

Moving the risks to the care provider imposes some new risks that should be taken into account when contracting.

3.1 Market

An important factor to consider when deciding about the use of population based financing is the market. Within this category, six potential risk factors are defined based on theory. These factors are related to the position of the municipalities and the care providers on the market for care. This includes the pricing.

3.1.1 Limitation of competition between care providers

There are two general forms that can be used when applying for a population based financing contract: an organization can apply alone, or in a consortium or coalition with other care providers, if the municipality allows this. To take responsibility for a (geographical) area, care providers need to be of considerable size. To be able to take the risk and administration that comes with a population based financing contract the care provider also needs to have a substantial organizational power and funding. This makes it hard for small, local organizations to engage in such agreements.

Municipalities using population based financing contract one or a small number of care providers. The only chance for the other parties is to become sub-contractors of the contracted care provider.

Risk: Only large organisations are able to engage in population based financing contracts.

This is a problem because it will lead to small (local) organisations leaving the market and large organisations becoming monopolies, leading to a limited choice in future tenders.

3.1.2 The role and position of sub-contractors

If a care provider does not have the size, knowledge or experience to apply for a certain contract, one contractor can make agreements with several sub-contractors and share the task. The care provider applying for the contract will take the risk and is the direct partner of the municipality, but can delegate parts of the tasks to parties.

These other parties can either be too small to take the role of contractor, for example an independent therapist or a local day-care centre. They can also have a different specialization, this is the case when sub-contracting a cleaning organization to keep the houses of clients clean, or a taxi company for the transportation of clients.

A contractor can be motivated to involve sub-contractors so to share financial and capacity risks. But on the long run it is doubtful this motivation remains; it might be more interesting to enlarge the own organization (or acquire smaller organizations) to avoid sharing profits.

Risk: Contractors are not motivated to keep the sub-contractors involved on the long run.

This is a problem because being a sub-contractor is the only way to participate in population based financing contracts as a small organisation. This could lead to small organisations leaving the market and large organisations becoming monopolies, leading to a limited choice in future tenders.

3.1.3 Dependence of sub-contractor on contractor

In a market model with only a few (usually even only one) contractor, there is a high dependency of the sub-contractors on this contractor. For the municipalities, this contractor is the only party at the table. As long as they deliver the agreed upon results, it is the choice of the contractor whether or not to use sub-contractors. Even when contractors use sub-contractors on the short run, only long-term agreements between the contractor and the sub-contractor can guarantee that the sub-contractor stays in business.

Eijkenaar & Schut (2015, p. 26) define two risks for sub-contractors in the secondary market. First of all, there is a risk of exploitation. The secondary market of subcontractors hired by the contractor is a monopsony. The contractor can set decide about the price because the sub-contractor has no alternative.

The second risk is substitution. The contractor will only use the services of sub-contractors when the own resources are optimally used. For example, a contractor needs a treatment for a client who needs help with structuring his or her days. When the contractor has excess capacity in a group therapy class, they will be more likely to use this than hiring a sub-contractor who offers individual care.

Risk: The market for sub-contractors is a monopsony, leading to exploitation and substitution of sub-contractors.

This is a problem because it could lead to sub-contractors leaving the market and large organisations becoming monopolies.

3.1.4 Dependence of municipality on contractor

When a municipality contracts only one (or a small number of) contractor(s), there is a risk that the dependency of the municipality on this contractor grows.

On the short run the municipalities might not have alternatives if things do not go as expected. There is no secondary infrastructure or supplier; the whole budget is allocated for the contractor. Even though the contracts might allow the municipalities to apply discounts in case certain quality criteria are not met, this does not necessarily allow them to take immediate action towards the citizens.

On the longer run, the other parties on the market might disappear or be bought by the contractor. When the contract ends, there is a chance that less parties are available for future contracts. This could have a negative effect on the price (Eijkenaar & Schut, 2015 p. 26) and on the choice the municipality has.

Population based financing could ultimately lead to health care providers merging to powerful monopolists, not leaving the municipalities much choice in later tenders.

Risk: Population based financing could eliminate competitors of the contracted care supplier.

This is a problem because it could lead to less choice in future tenders.

3.1.5 Adequate pricing

The pricing of population based financing is a complicated matter. The old financing system (under the AWBZ) was based on PxQ, which means that the price is set, but is multiplied by the actual quantity of care provided to get the total payment a care provider received.

The core principle of population based financing is that care providers receive a fixed amount per citizen per year, to achieve certain pre-determined goals. But in order to make sure that the care provider does not only focus on costs, it is usually combined with financial incentives for quality and achieving certain results. Another option is to include a certain shared savings agreement to give an incentive to reduce care that is not included in the

population based financing. An important difference with the other financing models is that population based financing is based on results for the whole population, not on individuals.

Gesundes Kinzigtal works with a shared savings model, which does not fully qualify as population based financing. In this system, the care provider does not get a fixed budget, but a reward based on the realized savings compared to the previously used system.

Risk: Population based financing could lead to a focus only on costs.

This is a problem because there are other factors that are important as well, like the well-being of patients and the priorities of the municipalities.

3.1.6 Long-term contracts

A discussion point is the desirable length of the contracts between municipalities and care providers. According to CPB (2015) long term contracts are important to make the care providers willing to invest. If investments lose value after a contract ends, this value has to be depreciated during the length of the contract. Also in a less monetary way, contractors are more likely to invest in innovation and prevention when they know it is for a longer period.

Zorgvisie (2015) states that it is a risk when the contracts are long-term or even open-end because it could exclude other care providers and are a "grey area" considering EU procurement law.

Risk: Engaging in too long (or open end) contracts can close the door for other care providers.

This is a problem because other care providers do not get the chance to offer care in the municipality, and because the municipality does not see what other parties have to offer.

3.2 Municipalities

The second category of risk factors is called municipalities. The three identified risks in this category are related to the role of the municipality in the contracting of the care supplier(s) as well as in the day-to-day operations.

3.2.1 Limits the coordinating role of municipalities

Most municipalities introduced so-called district teams to decide what clients received which (Wmo) care. PPRC (2015) reasons that it could be beneficial to outsource the district teams. That way the municipalities don't need to acquire the competences to make those decisions themselves. The main risk with this, however, is that team members connected to care providers can have interest in taking decisions that are beneficial for their organization, leading to overproduction (or: Supplier Induced Demand; SID). The downside of outsourcing the district teams is that the municipalities miss the chance to coordinate the care given to their citizens.

Uenk (2016-2) sees that most municipalities want to make a move towards a focus on results in contracts. But they see a different role for themselves: some want to increase their role as coordinator, others want to outsource this coordinating role to a contractor. Furthermore, Uenk states that the role of the political field in the choices of the municipality have been very limited. It is not unlikely that if the municipality councils get a bigger role in the Wmo related decisions, they also demand a more coordinating role of the municipalities in the district teams.

Risk: Municipalities give away the chance to represent their citizens and organize care in line with their policies.

This is a problem because giving municipalities the chance to decide about Wmo budgets is one of the goals of the Wmo. The municipality council is elected to represent the citizens and might not get the chance to do so.

3.2.2 Monitoring by municipalities

The municipalities have the duty to make Wmo care available to their citizens. They don't have the capacity to deliver this care themselves, and therefore outsource this to care providers. This gives them the responsibility to monitor the achievements of these care providers. According to CPB (2015) the monitoring role should always remain with the municipalities.

Adequate monitoring of the results is not only important to see if the municipality meets the legal requirements, but is in most cases also the basis for deciding whether or not the care provider met the pre-determined criteria for delivering care as well as the criteria for receiving bonuses. Therefore, it is important that the municipality and the care provider agree beforehand on the way of monitoring.

Risk: Municipalities are not able to properly monitor whether the care given meets the legal and contractual requirements.

This is a problem because municipalities need to make sure the care providers do what is agreed and all legal requirements are met.

3.2.3 Exchange of information

Using population based financing creates a different form of subordination than municipalities were used to. The Wmo gives municipalities the legal obligation to supply care to their citizens who need it, but district teams and care providers decide who receives what care. This puts some pressure on the information flows. You do not only need the right IT systems, but you also need to define properly what information is needed (KPMG Plexus, 2013 p. 37). The municipalities will need enough information to ensure their responsibilities are taken care of and the care providers deliver the care they promised, but at the same time the care providers should have enough freedom to arrange the care in the best way and not spend too much time on reporting. According to Veurink (2015) the municipalities and care providers need to invest in IT systems that communicate well with each other and other parties.

Risk: Municipalities and care providers will not have access to the right information at the right moment and lose resources on inefficient exchange of information.

This is a problem because all parties need to have the right knowledge to make decisions.

3.3 Patients

Maybe the most important stakeholder in the Wmo care are the patients receiving the care. They should receive the right care at the right time. The literature describes five risks within this category.

3.3.1 Referring patients to other (higher) segments of care/cure

The care the municipalities are responsible for mainly covers the first line. When a population based financing project only includes first line care, so called non-integral population based financing the care providers have an incentive to refer patients to (costlier) second line care as soon as possible (Pomp, 2013).

To solve this, contracts can contain quality criteria to avoid referring based on financial motives. Another option is to either use integral population based financing, where the population based financing also covers the second line of care, or create a system of profit sharing for savings in the next line of care.

In an integrated system there is also the chance that patients are referred too late because the 1st line care provider is too motivated to avoid referring the patient (Pomp, 2013). If the 2nd line care provider can cure the patient at lower expenses, referring is efficient.

Risk: Care providers can be stimulated to refer people to second line care prematurely.

This is a problem because the (societal) costs will raise if patients are receiving second line care when first line care would have been adequate.

3.3.2 The accessibility of care

The old financing model used for AWBZ care had an incentive for overproduction (or: Supplier Induced Demand; SID). The care supplier got paid per hour of care and was motivated to produce as many hours as possible. In a system with population based financing there is an incentive to minimize costs by making as few hours as possible (underproduction), and to produce the remaining care at the lowest possible costs. According to Gevel (2013) and Pomp (2013) this creates the risk that care providers cut costs on the quality of care or by not accepting complicated or expensive patients. If the care provider decides who receives which type of care, there is an incentive to accept as few people as possible.

Risk: Population based financing can stimulate care providers to not accept patients.

This is a problem because patients should receive adequate care.

3.3.3 The quality of care

According to the supporters of population based financing models, an important benefit is the potential increase of the quality of care. According to Gevel (2013) this is achieved through a focus on prevention and offering more suitable care.

Just shifting the responsibility to the healthcare providers is unlikely to improve the quality of care. That is why contracts in the United States include financial incentives for quality (Pomp, 2013). KPMG Plexus (2013) confirms this need for quality requirements in contracts.

Care providers will be motivated to take preventive measures when they share in the benefits of savings on 2nd line care. This requires an integrated or shared savings system.

Important is the choice of the municipality between taking a role as coordinator and outsourcing this role (Uenk, 2016-2).

Risk: Population based financing can lead to a lower quality of care.

This is a problem because lowering the quality of care offered to patients is generally seen as unacceptable.

3.3.4 Freedom of choice of patients

The choice of the financing model influences the freedom of choice of patients. In a PxQ or payment per client model, patients can have a (limited) choice from different care providers. In a population based financing model the municipality most likely makes this choice for them (CPB, 2015). The choice could be even more limited when the contractor prefers using own capacity over the offer of sub-contractors.

Patients can, however, have a role in the decision making of the municipalities. Telgen (2015) states that patients, when trained properly, can give valuable input in the process of purchasing care. The municipality councils are losing this representative role.

Risk: Patients can have a limited freedom of choice.

This is a problem because it could lower the satisfaction and lead to a limited flexibility regarding differentiation in patients' needs.

3.3.5 Satisfaction of patients

A factor that is not always easy to measure, but has a clear social (and political) benefit is the satisfaction of patients. Results are not the only factor that influences the happiness. Information, customer service, and the simple kindness of the care providers can be of equal importance. McClellan et al. (2013) state that not only the quality, but also the experience of patient care is crucial for an accountable care system like population based financing.

The satisfaction of patients can be a risk in population based financing models because the patients depend more on a (commercial) organisation than in a system with a more central role for the municipality. This organisation might feel less pressure to increase satisfaction than an open, public institution like a municipality.

CPB (2015) suggests the use of the Consumer Quality Index to operationalise the satisfaction.

Risk: Patients can feel unsatisfied about the care.

This is a problem because the Wmo aims to give the right care to the right people, and the municipalities want to offer the best for their citizens.

3.4 Conclusion

The purpose of this chapter was to answer the first sub-question: *"What problems can occur when using a population based financing model?"*. The conclusions from each category form the answer to this question.

3.4.1 Market

1. Only large organisations are able to engage in population based financing contracts.
2. Contractors are not motivated to keep the sub-contractors involved on the long run.
3. The market for sub-contractors is a monopsony, leading to exploitation and substitution of sub-contractors.
4. Population based financing could eliminate competitors of the contracted care supplier.
5. Population based financing could lead to a focus only on costs.
6. Engaging in too long (or open end) contracts can close the door for other care providers.

3.4.2 Municipalities

1. Municipalities give away the chance to represent their citizens and organize care in line with their policies.
2. Municipalities need to properly monitor whether the care given meets the legal and contractual requirements.
3. Municipalities and care providers will not have access to the right information at the right moment and lose resources on inefficient exchange of information.

3.4.3 Patients

1. Care providers can be stimulated to refer people to second line care prematurely.
2. Population based financing can stimulate care providers to not accept patients.
3. Population based financing can lead to a lower quality of care.
4. Patients can have a limited freedom of choice.
5. Patients can feel unsatisfied about the care.

4. THE MUNICIPALITIES

This aims to answer the second sub-question: *"How are the problems that can occur when using a population based financing model addressed and avoided in the contracts between care suppliers and municipalities?"*. The question is answered using a combination of tender documents and the contracts between municipalities and care providers (including support

documents). From four municipalities the tender documents were analysed, from three also the contract.

4.1 Rijnstreekgemeenten

The first analysed tender is from the "Rijnstreekgemeenten": Alphen aan den Rijn, Kaag en Braassem and Nieuwkoop. The analysis is based on the collective tender documents of the three municipalities, as well as the contract between Alphen aan den Rijn and the foundations behind *Tom in de Buurt*, the coalition that was contracted for Wmo care.

The tender aims to find one supplier or coalition for the Youth Law, Participation Law and Wmo related care. The municipality of Alphen aan den Rijn, responsible for 80% of the total budget of the tender, led the coalition.

The municipalities contracted a coalition named *Tom in de Buurt*[1]. The contract only comprises social participation, which is the biggest part of the Wmo care. The contract has a duration of 4 years and can be prolonged by the municipalities with two years. The contract can be ended prematurely after two years in case the pre-determined criteria are not met or in case of substantial changes in laws or budget. With the contract, an extensive list of Key Performance Indicators (KPI's) is agreed upon, as well as two types of accountancy reports[2].

4.2 Lelystad

The second analysed municipality is Lelystad. The analysis is based on the tender documents and the framework contracts. The municipality of Lelystad made different tenders for the different laws they got responsibility for. The municipality aimed to contract one supplier per city district. An interesting difference with the other municipalities is that the supplier will only get the task to coordinate the household assistance; the household assistance itself is purchased in a different tender.

Lelystad is paying a fixed amount per citizen, and using a bonus/malus system based on the performance of the supplier.

Lelystad takes the control of who receives which care in their own hands by controlling the district teams. The care supplier receives a fixed payment based on historical use of populations with comparable characteristics, and can negotiate about this amount if the number of patients differs more than 5%.

4.3 Hollands Kroon

Hollands Kroon is a municipality with only 48,000 inhabitants spread over 22 villages and a large area. After earlier tenders of parts of the Youth Law and Wmo care, the suppliers continued pretty much in the same way as they did before. Therefore the municipality aimed to create a system- and culture change towards equal partnerships with suppliers. The municipality and this partner should together make a transformation happen. Hollands Kroon aims to contract one partner and has a long-term perspective. The tasks start on 1 July 2016.

Hollands Kroon signed an agreement with Incluzio, part of the large facility services organisation Facilicom group. The contract includes the youth law and Wmo, and starts as planned on 1 July 2016. The initial duration is 2.5 years and can unlimitedly be prolonged with 1 year at a time.

Currently Hollands Kroon has their own district teams and an administrative office together with Schagen. From the start of the new contract, the current district team members will be moved to Incluzio and Hollands Kroon will stop the cooperation with Schagen to let the administrative part go to Incluzio as well.

4.4 Emmen

Emmen formed a coalition with the municipalities Borger Odoorn and Coevoorden. They want to use the years 2015 and 2016 for transition towards a better model, but want to introduce population based financing from the beginning.

Emmen wants to limit the use of professional services and lower the price paid for care. When contracting, the focus will be on regional cooperation, quality and the involvement of the current care supplier.

5. THE RISKS IN PRACTICE

The tender documents of the municipalities were analysed for the risks defined in Chapter 3.

The aim of this chapter is to define whether the contracts and tender documents cover the defined risks. To do so in a comparable way, the following raking was applied:

0 points: Nothing is done to avoid the risk, or the risk is not mentioned.

1 point: Little is done to avoid the risk.

3 points: The supplier has to report about the risk. Something is done to avoid the risk, but the risk remains.

4 points: The supplier has to report about the risk, and take action. Something is done to avoid the risk, the risk became smaller.

5 points: The supplier has to report about the risk, take action to avoid the risk, and not doing so has serious consequences. The risk is avoided.

An overview of all scores is displayed in Figure 3.

5.1 Market

5.1.1 Only large organisations are able to engage in population based financing contracts

5.1.1.1 Rijnstreekgemeenten

The Rijnstreekgemeenten do only accept applications from single suppliers or coalitions of suppliers, and don't allow suppliers to only make an offer for a part of the care. They do, however, not expect that one party will be able to offer all care needed without either using subcontractors or forming a coalition. After signing the contract, the municipalities will only act as buyers and give the suppliers all space to do what is needed to supply the care. The tender documents don't describe a role for suppliers who are not part of the tender contract or coalition, nor mention the supplier field after the end of the contract.

Contrary to the tender, the Rijnstreekgemeenten did contract one coalition (*Tom in de Buurt*) for only Wmo care. This coalition consists of four organisations plus four sub-contractors who operate together. The contract is long term; if all parties are satisfied up to six years. The contract does not allow for adding (or removing) partners of the coalition.

Score: 1 point[3]

5.1.1.2 Lelystad

Lelystad has divided the city in four districts. For each district, one supplier will be contracted. Each supplier can be contracted for a maximum of two districts. This gives more suppliers the

[1] The coalition *Tom in de Buurt* consist of four foundations: Stichting Kwadraad, Stichting Participe, Stichting Gemiva-SVG Groep and Stichting Kwintes. They execute the tasks together with 4 sub-contractors.

[2] COS 3000 Assurance report and COS 4400 Report of findings.

[3] Even though Tom in de Buurt was contracted for only Wmo care, the tender document only allowed suppliers for a wide range of care. Based on this requirement, the tender was only open for large organisations. Therefore, only 1 point is given.

chance to have a role and gives the municipality the chance to compare their performance.

Score: 4 points

5.1.1.3 Hollands Kroon

Hollands Kroon aimed in the tender to contract one partner who will organize the care. They came to an agreement with Incluzio, part of the Facilicom group. Incluzio will set up a separate entity for the care in Hollands Kroon, but this remains part of and led by the large Facilicom group.

KPI 9 states that Incluzio will use a major share of the budget for purchasing care. This could mean that smaller parties will have the chance to be a sub-contractor. This gives smaller parties the chance to stay in business, but they are dependent on Incluzio.

Score: 1 point

5.1.1.4 Emmen

The municipality of Emmen contracts suppliers per region instead of for the whole area covered by the coalition. This could potentially give more suppliers the chance to deliver services.

Score: 3 points

5.1.1.5 Conclusion

All municipalities prefer contracting a limited number of large organisations. Only the Rijnstreekgemeenten allow coalitions of suppliers to apply, but require each of the partners in these coalition to meet the requirements for organizational and financial stability. Lelystad is the only one who does not allow one care supplier to be responsible for the whole city, and sees it as beneficial to be able to compare the performance of different suppliers.

We see that only in Hollands Kroon a large party got the contract. In the Rijnstreekgemeenten a coalition of smaller organisations won the tender, and in Lelystad and Emmen the suppliers are contracted for smaller districts. The Rijnstreekgemeenten show that it is also for smaller parties possible to be contractor, but this coalition is still of limited size. Entering or leaving the coalition is not easy.

The average score is 2.25, but with a wide spread.

5.1.2 Contractors are not motivated to keep the sub-contractors involved on the long run

5.1.2.1 Rijnstreekgemeenten

In the tender documents of the Rijnstreekgemeenten, tenderers are expected to operate either in a coalition or with sub-contractors. The municipalities signed a contract with a coalition of four suppliers. The contract states that the contractor needs permission before using sub-contractors. The evaluation documents state that there are four sub-contractors involved in Tom in de Buurt. Both the tender documents and the contract state that the supplier (coalition) is the only contract partners of the municipalities, and don't describe the position of the sub-contractors, nor the continuity of their involvement over the years.

Score: 1 point

5.1.2.2 Lelystad

Lelystad specifically states in the tender document that they want to contract one party per district and do not regulate the arrangements with sub-contractors. The contract states that it is allowed to use sub-contractors, but under responsibility of the contractor.

Score: 1 point

5.1.2.3 Hollands Kroon

Hollands Kroon did not set any rules or requirements for sub-contractors in the tender. The contract specifically allows the use of sub-contractors after informing the municipality.

KPI 9 states that Incluzio spends a large part of the budget on purchasing care. To achieve this, they need to involve sub-

	Market						Municipalities			Patients					
Topic	Limitation of competition between care providers	The role and position of sub-contractors	Dependence of subcontractor on contractor	Dependence of municipality on contractor	Adequate pricing	Long-term contracts	Limits the coordinating role of municipalities	Monitoring by municipalities	Exchange of information	Referring patients to other (higher) segments of care/cure	The accessibility of care	The quality of care	Freedom of choice of patients	Happiness of patients	
Problem	Only large organisations are able to engage in population based financing contracts.	Contractors are not motivated to keep the sub-contractors involved on the long run.	The market for sub-contractors is a monopsony, leading to exploitation and substitution of sub-contractors.	Population based financing could eliminate competitors of the contracted care supplier.	Population based financing could lead to a focus only on costs.	Engaging in long (or open end) contracts can close the door for other care providers.	Municipalities give away the chance to represent their citizens and organize care in line with their policies.	Municipalities need to properly monitor whether the care given meets the legal and contractual requirements.	Municipalities and care providers need to exchange the right information in an efficient way	Care providers can be stimulated to refer people to second line care prematurely.	Population based financing can stimulate care providers to not accept patients.	Population based financing can lead to a lower quality of care.	Patients can have a limited freedom of choice.	Patients can feel unsatisfied about the care.	*Average*
Rijnstreekgemeenten	1,0	1,0	0,0	3,0	5,0	3,0	1,0	5,0	5,0	4,0	5,0	5,0	0,0	5,0	*3,1*
Lelystad	4,0	1,0	0,0	5,0	5,0	3,0	4,0	5,0	4,0	4,0	5,0	5,0	0,0	5,0	*3,6*
Hollands Kroon	1,0	3,0	3,0	1,0	1,0	1,0	1,0	4,0	4,0	3,0	5,0	5,0	0,0	4,0	*2,6*
Emmen	3,0	0,0	0,0	4,0	3,0	n/a	3,0	n/a	n/a	3,0	3,0	4,0	0,0	4,0	*2,5*
Averages	*2,3*	*1,3*	*0,8*	*3,3*	*3,5*	*2,3*	*2,3*	*4,7*	*4,3*	*3,5*	*4,5*	*4,8*	*0,0*	*4,5*	
	2,2						*3,8*			*3,5*					

Figure 3: Table of scores for risks and municipalities

contractors, also on the long run. KPI 10 secures a certain level of satisfaction of the sub-contractors.

Incluzio will be forced to use sub-contractors on the long run. That does, however, not mean that these have to be same parties for a long term. Therefore we can't say the risk is fully avoided.

Score: 3 points

5.1.2.4 Emmen

Emmen contracts parties for small areas and did not describe the option for sub-contractors in the tender documents.

Score: 0 points

5.1.2.5 Conclusion

None of the municipalities stimulates the use of sub-contractors to give small players a role in the field. They all prefer to have one (legal) partner and leave this partner the choice to do it alone or with others.

The average score is 1.25, but Hollands Kroon raises the score by being the only municipality with KPIs regarding sub-contractors.

5.1.3 The market for sub-contractors is a monopsony, leading to exploitation and substitution of sub-contractors

5.1.3.1 Rijnstreekgemeenten

In the case of the Rijnstreekgemeenten, the role of sub-contractors is not described. There are also no protective measures to keep them involved.

Score: 0 points

5.1.3.2 Lelystad

Lelystad made no other arrangements for sub-contractors in the contracts than mentioning that it is allowed to use them.

Score: 0 points

5.1.3.3 Hollands Kroon

Incluzio has freedom to use sub-contractors, they only have to inform the municipality about this.

KPI 10 assures satisfaction of chain-partners and sub-contractors, but does not guarantee the long-term involvement and fair pay of individual sub-contractors.

Score: 3 points

5.1.3.4 Emmen

Emmen contracts parties for small areas and did not describe the option for sub-contractors in the tender documents.

Score: 0 points

5.1.3.5 Conclusion

None of the four municipalities took any measures to ensure the continuity of relations with sub-contractors. This means that the formulated risk is a valid one.

The average score is 0,75 with Hollands Kroon raising the score as the only one with KPIs regarding sub-contractors.

5.1.4 Population based financing could eliminate competitors of the contracted care supplier

5.1.4.1 Rijnstreekgemeenten

The Rijnstreekgemeenten state in their contract with Tom in de Buurt that the municipalities can prematurely end the contract if the pre-determined criteria are not met or significant changes in the laws or budgets occur. Besides this safety clause, the municipalities are dependent on the contractor. The coalition behind Tom in de Buurt exists of four parties, which does leave the option to form different coalitions including some of the current partners for a next tender.

Score: 3 points

5.1.4.2 Lelystad

Lelystad made a different strategic choice and contracts care suppliers per district. They don't allow one supplier to be responsible for more than two of the four districts. This gives space for other suppliers on the market, and the chance to compare.

Score: 5 points

5.1.4.3 Hollands Kroon

Hollands Kroon aims to build a long-term relation with one partner. The contract does include measures in case of problems with achieving the goals, but not to keep other or local care suppliers active.

The competitors do have the chance to take a role as sub-contractor. Their satisfaction is monitored using KPI 10. This is, however, not a satisfying solution for the problem because their role is limited and dependent.

Score: 1 point

5.1.4.4 Emmen

Emmen aims to contract more than one party for the different districts, and allows consortia. They prefer constructions with a role for the current and small suppliers.

Score: 4 points

5.1.4.5 Conclusion

The chances for competitors depend on the size and number of contractors. Only in Hollands Kroon a large party won the tender, so this concern is only valid in this municipality.

The average score is 3.25. Rijnstreekgemeenten, Lelystad and Emmen score higher than Hollands Kroon because they give space for coalitions of smaller parties.

5.1.5 Population based financing could lead to a focus only on costs

5.1.5.1 Rijnstreekgemeenten

The Rijnstreekgemeenten and Tom in de Buurt made an extensive list of KPI's to create a focus on quality and satisfaction besides costs. This list includes measurements and requirements for self-supportiveness, access to services, and customer satisfaction. Not meeting the KPI-criteria can ultimately lead to termination of the contract.

Score: 5 points

5.1.5.2 Lelystad

Lelystad keeps the district teams in her own hands. Therefore, a focus on costs could in the case of Lelystad only occur in the execution, not in the indication.

Score: 5 points

5.1.5.3 Hollands Kroon

Incluzio will set up a separate entity for the care in Hollands Kroon. Profits in the entity will be used for investments in better care in Hollands Kroon or to lower the costs for the municipality. KPI 9 describes that funds are divided between the district team and purchasing care. Article 15 of the contract states that the budget will be cut by a small percentage each year.

This does guarantee that most of the money is actually used for care, but this does not fully avoid the risk of a focus on costs. Both the uncertainty of the population and the budget cuts require a certain focus on cost levels.

Score: 1 point

5.1.5.4 Emmen

Emmen aims to lower costs by cutting on price and amount of professional care. Quality is also described as an important factor.

Score: 3 points

5.1.5.5 Conclusion

All municipalities included the quality and accessibility of care in some way in the requirements or KPI's, and somehow try to avoid too much focus on costs. However, the actual checking is in all cases reactive: the municipalities require reports from the care suppliers.

The average score is 3.5.

5.1.6 Engaging in long (or open end) contracts can close the door for other care providers

5.1.6.1 Rijnstreekgemeenten

The Rijnstreekgemeenten signed a 4-6 year contract with Tom in de Buurt that can only be ended prematurely if the KPI's are not met or in case of substantial changes in laws or budgets.

Although it is no open end contract, the contract is long-term, which means that it will take long before other parties get the chance to become supplier.

Score: 3 points

5.1.6.2 Lelystad

The contracts of Lelystad all cover a small part of the care and have a duration of 2-5 years. These are (potentially) long term contracts.

Score: 3 points

5.1.6.3 Hollands Kroon

The contract between Hollands Kroon and Incluzio is signed for 2.5 years, but is in fact open-end because it can be prolonged without a limit.

The risk of discouraging investments is avoided by engaging for a minimum duration of 2.5 years. The risk of closing the door for other care providers is eminent because the parties can extend the duration contract indefinitely without having a new tender.

Score: 1 point

5.1.6.4 Emmen

Emmen sees the years 2015 and 2016 as a transition period, and wants to get experience to introduce a new system per 2017. Emmen prefers to keep the current suppliers involved in the new contracts. The plans regarding contracts from 2017 are not known.

Score: N/A

5.1.6.5 Conclusion

Rijnstreekgemeenten and Lelystad engaged in contracts that can (if prolonged) last up to 5-6 years. This period is very long and drastically limits the chances for other suppliers to make a competing offer. The most extreme situation is Hollands Kroon where the contract is in fact open-end.

The average score of the three scored municipalities is 2.3.

5.2 Municipalities

5.2.1 Municipalities give away the chance to represent their citizens and organize care in line with their policies

5.2.1.1 Rijnstreekgemeenten

In the tender documents of the Rijnstreekgemeenten the role of the municipalities is described clearly. They contract a supplier according to the set requirements and will keep track of the performance via indicators proposed by the supplier. This aim is effectuated in the contract with Tom in the Buurt, that refers to a comprehensive list of KPI's and accountancy reports, but does not try to influence the day-to-day operations. The municipalities will take a reactive role.

Score: 1

5.2.1.2 Lelystad

Lelystad will keep a coordinating role by not letting the district teams be part of the tender. The municipality will organize these teams, not the supplier. The supplier will, however, make the choices regarding the execution.

Score: 4 points

5.2.1.3 Hollands Kroon

Hollands Kroon has a focus on building a good, equal relationship, but at the same time wants to give the have a limited role in the actual execution of the tasks. The district teams that used to be under direct control of the municipality will be moved to Incluzio.

KPI 4 gives Hollands Kroon the right to define "themes" Incluzio should have a social impact on. KPI 8 encourages citizens to take initiatives against certain social problems. This shows that Hollands Kroon does want to influence some aspects, but does not prefer to have a coordinating role.

Score: 1 point

5.2.1.4 Emmen

Compared to the other municipalities, Emmen describes the desired situation in more detail. This gives the impression they want to be more involved in the actual care supplied to the citizens. They also state that the budgets (and budget cuts) should be allocated to the specific fields they are received for, which also limits the "freedom" of the supplier.

Score: 3 points

5.2.1.5 Conclusion

The role of the municipalities after the contracting phase differs. All municipalities want to give the care provider a lot of freedom in doing their tasks. Only Lelystad stays involved in the decisions about which client receives care by maintaining a strong position in the district teams.

The average score is 2.25, with Lelystad and Emmen scoring higher.

5.2.2 Municipalities need to properly monitor whether the care given meets the legal and contractual requirements

5.2.2.1 Rijnstreekgemeenten

The Rijnstreekgemeenten formulated a comprehensive list of KPI's the care providers have to report about. Furthermore, the contract requires the contractors to supply accountant's reports. If these requirements are not met, a part of the financial compensation will not be paid. Not meeting the requirements could ultimately lead to termination of the contract.

Score: 5 points

5.2.2.2 Lelystad

Lelystad keeps control of the district teams, and asks the suppliers to report in client level. They keep full control over the access of the care, but let the care supplier take care of executing.

Score: 5 points

5.2.2.3 Hollands Kroon

Hollands Kroon and Incluzio made a list of KPI's that will be reviewed and updated yearly. Incluzio needs to make a yearly budget and include a risk paragraph. Incluzio needs provide

quarterly reports, and has to report problems with executing their tasks right away.

Score: 4 points

5.2.2.4 Emmen

The methods Emmen uses for monitoring are not described in the tender documents.

Score: N/A

5.2.2.5 Conclusion

All municipalties formulated KPI's and listed documents they want to use for monitoring. This is a reactive approach.

The average score of the three scored municipalities is 4.7.

5.2.3 Municipalities and care providers need to exchange the right information in an efficient way

5.2.3.1 Rijnstreekgemeenten

The Rijnstreekgemeenten receive every quarter a report from Tom in de Buurt reflecting on the KPI's. Furthermore, there is a yearly report and the accountant's reports.

The information needed as well as the consequences of not supplying it are well specified in the contract and attachments.

Score: 5 points

5.2.3.2 Lelystad

Lelystad requests a large amount of information on client and organizational level. The contract states what has to be delivered at what time in the year. Given their choice to keep the district teams as a responsibility of the municipality, this high amount of exchanging information is needed. This does create some inefficiency.

Score: 4 points

5.2.3.3 Hollands Kroon

Hollands Kroon supplies an IT system that Incluzio will use for all patient data. Furthermore, there are quarterly reports about the status of the KPI and reports regarding finances and problems. This gives the impression that the information flow is properly organized.

Score: 4 points

5.2.3.4 Emmen

Emmen wants to let the supplier be in charge of the district teams and indication process. The methods Emmen uses for monitoring are not described in the tender documents.

Score: N/A

5.2.3.5 Conclusion

Rijnstreekgemeenten and Lelystad describe clearly what information they expect. They have a different approach: Lelystad needs information on client level because they stay involved in the district teams.

Hollands Kroon supplies the IT system to the care supplier. It seems unclear why the municipality needs this information because both the decision making and the execution are in hands of the care supplier. On the long term it could be a good choice to let the municipality own the data because this could ease a transition to a new supplier.

The average score of the three scored municipalities is 4.3

5.3 Patients

5.3.1 Care providers can be stimulated to refer people to second line care prematurely

5.3.1.1 Rijnstreekgemeenten

In the tender document, the Rijnstreekgemeenten required an integrated approach among the three laws the municipalities are responsible for (Youth Law, Participation Law and Wmo) and expect to save costs and increase quality and efficiency this way. The tender document does not describe or value the influence on higher segments of care that are outside the scope of this tender. The contract, however, only covers the Wmo care. There is a KPI that focusses on using general services instead of specialist services, but besides this no focus on avoiding the referring of patients.

Score: 4 points

5.3.1.2 Lelystad

Lelystad keeps the tenders small: per "law" and per district, and keep the district teams in their own hands. They do require a plan for cooperation with other care providers and other segments of care.

Score: 4 points

5.3.1.3 Hollands Kroon

Hollands Kroon does want to build a relation with one supplier for all fields of care the municipality is responsible for, but has no KPI's or other incentives looking at other forms of care.

KPI 1 ensures every patient gets adequate care, but does not go against referring to Wlz or Zvw care.

Score: 3 points

5.3.1.4 Emmen

Emmen wants to limit professional care within the Wmo field as well as increase the incomes by raising the financial contributions of care receivers.

Score: 3 points

5.3.1.5 Conclusion

The Rijnstreekgemeenten have the most integrated approach when it comes to the different types of care the municipalities are responsible for, but none of the studied municipalities take measures against referring to second line care in a too early stage.

The average score is 3.5 points.

5.3.2 Population based financing can stimulate care providers to not accept patients

5.3.2.1 Rijnstreekgemeenten

The Rijnstreekgemeenten have a KPI about the availability and accessibility of care. This makes this one of the points Tom in de Buurt has to report on and shows the municipalities see this as an important point.

Score: 5 points

5.3.2.2 Lelystad

Lelystad solved this using their different approach of not letting the supplier decide who receives care. The municipality keeps in control of the district teams that decide about acceptance of patients.

Score: 5 points

5.3.2.3 Hollands Kroon

The contract between Hollands Kroon and Incluzio includes a clause that states that patients indicated by the district team or the municipality cannot be refused. KPI 1 ensures that every citizen who asks for care receives adequate care within a decreasing number of days.

Score: 5 points

5.3.2.4 Emmen

Emmen wants to save on costs by lowering the amount of professional care. This increases the chance of referring to second line care.

Score: 3 points

5.3.2.5 Conclusion

All municipalities tried to solve this problem in a different way. Lelystad has the most reliable situation because they do not outsource the district teams. The other municipalities will need continuous monitoring on this aspect.

The average score is 4.5 points, with Emmen as only one without full score.

5.3.3 Population based financing can lead to a lower quality of care

5.3.3.1 Rijnstreekgemeenten

The Rijnstreekgemeenten wrote in the tender document that they see quality as main criterion for selection. This is reflected in the choice of selection criteria where the price accounts for 10% and the other 90% is divided among seven quality indicators. During the contract, the municipalities monitor the achievements using quality criteria (as part of the KPI's) that are proposed by Tom in de Buurt. Two of the three municipalities in the coalition are also using an Impact on Participation and Autonomy measurement and require the supplier to make adjustments to the offering according to the outcomes of this measurement.

Score: 5 points

5.3.3.2 Lelystad

Lelystad keeps being involved in the district teams and has in this way a direct influence on the care supplied. They also implement a bonus/malus system, with direct financial consequences of over- or underperformance.

Score: 5 points

5.3.3.3 Hollands Kroon

Hollands Kroon aims to create a culture change and stimulate innovation. Quality is an important factor in both the ambitions and the selection criteria. The municipality wants to create an equal partnership to maintain good contact with the supplier.

KPI 2 ensures that for most of the patients the goals will be reached. KPI 5 measures the satisfaction of patients with the care supplied to them. KPI 7 aims to create an increase in this patient satisfaction.

All these measures together should adequately avoid the risk.

Score: 5 points

5.3.3.4 Emmen

Emmen sees quality and satisfaction as important selection criteria.

Score: 4 points

5.3.3.5 Conclusion

The general picture is that all municipalities see quality as a crucial factor. They all use it as an important factor when selecting the care supplier. The involvement after signing the contract differs. Lelystad wants to stay involved in the district teams and have a direct influence. All municipalities use KPI's to measure the performance and have some financial consequences attached to this.

The average score is 4.75 points.

5.3.4 Patients can have a limited freedom of choice

5.3.4.1 Rijnstreekgemeenten

In the Rijnstreekgemeenten, all Wmo care is offered by Tom in de Buurt. Patients can choose if they want to participate in certain activities like social meetings. There is no alternative provider.

Score: 0 points

5.3.4.2 Lelystad

Lelystad contracts a care supplier for each region, and therefore the patients have no alternative to choose from.

Score: 0 points

5.3.4.3 Hollands Kroon

Incluzio will be responsible for both the district teams and the actual care in Hollands Kroon. The patients will not have alternative suppliers to choose from. This is not mentioned as a risk or problem.

Score: 0 points

5.3.4.4 Emmen

Emmen aims to contract a care supplier per district. This means that the patients will not have freedom of choice.

Score: 0 points

5.3.4.5 Conclusion

In all cases the only freedom the patients have is that they can talk with the district teams about possible options. In all cases there is no second supplier to choose from.

All municipalities scored 0 points.

5.3.5 Patients can feel unsatisfied about the care

5.3.5.1 Rijnstreekgemeenten

The Rijnstreekgemeenten have a KPI about the client satisfaction. This makes this one of the points Tom in de Buurt has to report on and shows the municipalities see this as an important point.

Score: 5 points

5.3.5.2 Lelystad

The satisfaction of patients is included in the bonus/malus incentives in the contract between Lelystad and the care suppliers.

Score: 5 points

5.3.5.3 Hollands Kroon

The contract between Hollands Kroon and Incluzio includes several KPI's that are related to this concern: KPI 2 ensures that for most of the patients the goals will be reached. KPI 5 measures the satisfaction of patients with the care supplied to them. KPI 7 aims to create an increase in this patient satisfaction.

All these measures together should adequately avoid the risk.

Score: 4 points.

5.3.5.4 Emmen

Emmen listen customer satisfaction as important factor for the selection of care suppliers.

Score: 4 points

5.3.5.5 Conclusion

All municipalities see patient satisfaction as important and took measures to motivate the care supplier to take this into account.

The average score is 4.5 points.

6. CONCLUSIONS

In this chapter the research question will be answered: *"Do care providers and municipalities in The Netherlands manage to control the problems that occur with population based*

financing?". This will be done based on the answers of the sub-questions given in the last chapters.

The first sub-question was *"What problems can occur when using a population based financing model?"*. This is answered in chapter 3 by formulating 14 concerns in three categories.

The second sub-question was: *"How are the problems that can occur when using a population based financing model addressed and avoided in the contracts between care suppliers and municipalities?"*. This is answered in chapter 5 by analysing and grading which actions four municipalities took to avoid the risks.

6.1 Market

Chapter 5 shows that over the whole category the municipalities did not take many measures to avoid the risks.

Only Lelystad and Emmen do not prefer to contract one (likely large) organisation. The other two don't see this as a risk, but as a benefit.

Hollands Kroon is the only municipality that took measures in the field of sub-contractors. Keeping sub-contractors involved is not something the municipalities see as important; they only focus on the contractors.

Also the length of the contract is not perceived as a risk by the municipalities. All municipalities engaged in long-term or open end contracts, or in contracts that can be prolonged without a new tender.

The lack of measures over the whole market category could lead to large organisations becoming monopolies on the long run. If more municipalities contract in this way, small players will leave the market, not leaving choice and competition in future tenders.

6.2 Municipalities

The scoring in Chapter 5 shows a mixed result. The risks related to monitoring and information exchange scored considerably higher than the one regarding the coordinating role of municipalities.

Two of the four municipalities don't see any role for themselves after contracting the supplier. This is an interesting conculsion because this means they miss the chance to organise the care in line with their policy and to represent the citizens.

The monitoring and information exchange is perceived as more important: all available contracts describe this. IT systems and procedures and KPIs have to ensure the information flows.

The differences are clear: where Lelystad goes as far as being in control of the acceptance of patients, the others see it as more important to give freedom to the suppliers. By doing so, they are likely to miss out on a potential coordinating role.

6.3 Patients

The results on the risks related to patients are mixed as well. None of the municipalities sees the risk regarding freedom of choice for patients. All analysed municipalities made the choice to only offer the services of one care supplier to their citizens. Whether the contracting is done per city or per district, in all cases an individual citizen is not able to make any choices. This is not the case with other funding methods where more parties are contracted and receive a compensation per treated patient or hour.

The quality of care is seen as important in all cases. All municipalities have some system to ensure this.

6.4 The analysed municipalities

Given the fact that every risked is scored per municipality and these data is put in a matrix, it is tempting to calculate an average score of each municipality. However, a couple of remarks have to be made. First of all, the different risks might need to get different values based on importance. It is not within the scope of this research to rank the relative importance of each risk. Second, it can be a policy decision of the municipality to neglect certain aspects, as part of their role of setting the outlines of the care for their citizens. This could lead to a low score on certain fields, but does not have to mean that a contract is "bad".

6.4.1 Rijnstreekgemeenten

The municipalities generally scored low on the market related risks and high on the patient related risks. They did take care of many risks, but not all.

Recent findings in the quarterly and annual reports of Tom in de Buurt confirm this conclusion. Tom in de Buurt is a coalition of four organisations, and uses four sub-contractors, but is in fact a new organisation. In the annual report they state they had to invest a considerable amount of time in defining its role and the relations and cooperation with other parties.

The annual report shows that in Q3 of 2015 the costs of CVV (collective transportation; not part of the population based financing care) raised, resulting in an investigation into the relation with the cuts of Tom in de Buurt on Wmo transportation.

The annual report states that Tom in de Buurt introduced a stricter policy regarding patient transportation. Only patients that can't transport themselves will get transportation from Tom in de Buurt. This resulted in the impression that Tom in de Buurt stopped with patient transportation and gave patients the feeling that they lost something they were entitled to. Tom in de Buurt states that every complaint regarding this is solved.

6.4.2 Lelystad

Chapter 5 shows that Lelystad is the municipality that took best care of avoiding the risks. The difference with the others is mainly on the market related risks.

The contract of Lelystad has two specific characteristics. First of all, they don't contract one party but see value in having different parties in different parts of the city. Second, they keep the district teams in their own hands, not giving away the coordination and the decisions about access to care to the care supplier. These two aspects seem to contribute to a higher score.

6.4.3 Hollands Kroon

Hollands Kroon shows a mixed result. The only risks that are avoided well are on quality and accessibility of care.

Hollands Kroon made the clearest policy choice. They wanted to sign a contract with one party and give a high degree of freedom. This choice has resulted in low scores on the related risks.

6.4.4 Emmen

Emmen did not get rated on all risks because from this municipality the final contract was not available. Therefore, some information needed to evaluate these points was missing.

A clear difference between Emmen and the other municipalities is that Emmen takes two years for the transition. They want to introduce a new system based on all experiences per 2017.

6.5 Some critical remarks

Although this paper gives an interesting overview of the risks of population based financing in theory and practice, it is good to make some remarks.

First of all, the average scores are calculated with the estimation that all risks are equally important. The policy decisions made by municipalities are not taken into account. There is also no correction applied for risks on overlapping fields.

Second, this paper only describes four municipalities. Although this number is enough to get a good overview of the theory and

practice, it cannot be said with certainty that these four can represent all other municipalities in case of generalizing the results.

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