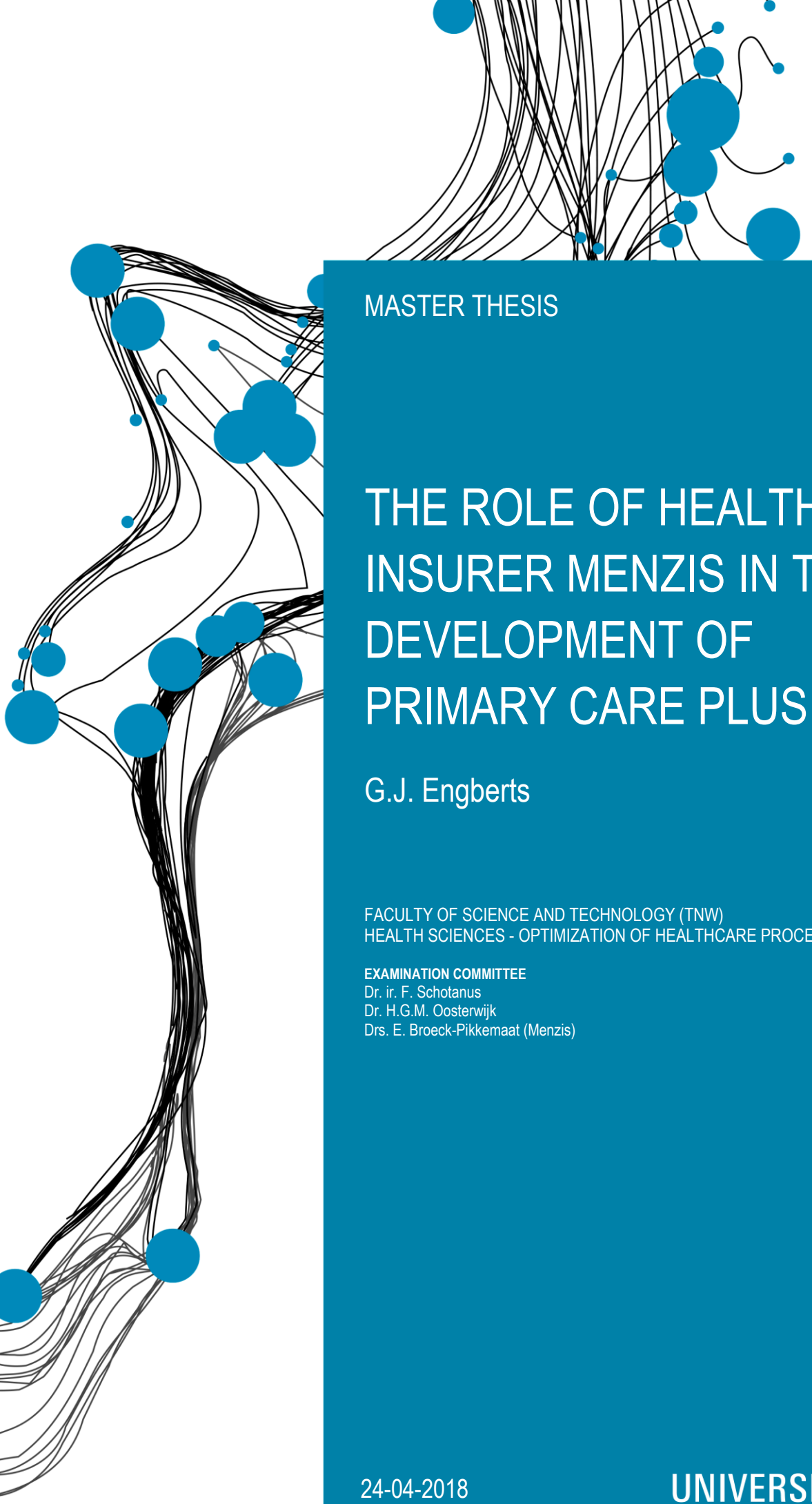

MASTER THESIS

THE ROLE OF HEALTH INSURER MENZIS IN THE DEVELOPMENT OF PRIMARY CARE PLUS

G.J. Engberts

FACULTY OF SCIENCE AND TECHNOLOGY (TNW)
HEALTH SCIENCES - OPTIMIZATION OF HEALTHCARE PROCESSES

EXAMINATION COMMITTEE
Dr. ir. F. Schotanus
Dr. H.G.M. Oosterwijk
Drs. E. Broeck-Pikkemaat (Menzis)

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THE ROLE OF HEALTH INSURER MENZIS IN THE DEVELOPMENT OF PRIMARY CARE PLUS

A study to the best suitable role for health insurer Menzis in the development of Primary Care Plus

Master thesis

University of Twente - Master Health Sciences

G.J. Engberts - S1507400

g.j.engberts@student.utwente.nl

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Preface

This study was carried out on behalf of health insurer Menzis, from September 2017 till April 2018 in order to complete my Master Health Sciences at the University of Twente. Because I did my Bachelor thesis at a hospital in Twente, I experienced one side of the care field. For that reason I also wanted to get to know the health insurance 'world'. I already knew the innovative subject of Primary Care Plus because of 'Blauwe Zorg' in Maastricht. When I heard that Menzis had a master assignment for Primary Care Plus in Twente, I knew that this would be my chance for a nice Master thesis assignment.

This report would not have been possible without the effort and support of several people. First of all I would like to thank my supervisors of the University of Twente, Fredo Schotanus and Herman Oosterwijk for providing my thesis of feedback and for the interesting discussions about this subject. Next to that I would like to thank my supervisors of Menzis, Evelien Broeck-Pikkemaat for her support during my assignment and Olivier van Noort for providing my thesis of English linguistic feedback. At last, I would like to thank all interviewed respondents because without their participation and input this study could not have been successfully conducted.

I hope you will enjoy reading this thesis.

Best regards,
GertJan Engberts

Enschede, April 2018

Abstract

Background

Dutch healthcare is facing the challenge of changing demand for care, keeping healthcare expenditures in control and an expected staff shortage. This implies that changes in the healthcare system need to be made in order to create sustainable healthcare. A frequently mentioned solution is substitution of secondary to primary care. The practical appearance is called Primary Care Plus (PCP) (in Dutch: anderhalvelijnszorg). The Dutch Ministry of Public Health, Welfare and Sport expects an active role of health insurers regarding substitution of care. Experiences so far teach that among other things local conditions influence the success of PCP. Because health insurer Menzis is the largest health insurer in the region of Twente, it is closely involved in the development and procurement of PCP in the region of Twente. At the moment there are a number of PCP projects in Twente. However Menzis does not know what role it should take in the further development of PCP.

Method

In this qualitative explorative study a literature research has been conducted. In addition, five representative experts, four employees with a multidisciplinary management function of (PCP) practices and all eight involved stakeholders for PCP in Twente have been interviewed. Based on the results and on two problems which Menzis experiences as most important, two scenarios for the development of PCP with two different roles for Menzis were drafted. These scenarios were presented to employees of Menzis in a regional meeting and provided feedback of the employees was taken into account. All results were plotted in an adjusted version of the Rainbow Model of Integrated Care of Valentijn (19) in order to indicate how the results relate to each other.

Results and discussion

A health insurer can take different roles in (the development) of PCP, namely a facilitating, stimulating or a directing role. Next to that are different incentives, appropriate to these roles, identified which could be used in the development of PCP. For instance, profile strengthening innovations (stimulating role) or selective procurement (stimulating and directing role). The most suitable role for a health insurer depends on its context and subject. For instance, sustainable local cooperation, market share of a health insurer or type of intervention in which a health insurer wishes to interfere. Although, no ideally organized setting for PCP exists, seven enablers are identified which could be used. In addition, sixteen success and failure factors are identified, of which 'A common vision and ambition' is experienced as most important by the visited practices. 'Healthcare professionals have to give form and content to a PCP initiative' and 'Invest in building a solid trust relation between involved stakeholders' are ranked as second and third.

Furthermore, normative enablers (the extent in which work values, mission etc. are shared) are considered to be of more importance than functional enablers (the extent in which support and back-office functions are coordinated) in the development of PCP. All roles of the involved stakeholders of PCP in Twente are identified, these stakeholders provided eight opportunities, eight risks and eight needs for (the development of) PCP. Interestingly, the found opportunities, risks and needs could also apply to other regions in the Netherlands because it has many similarities with the found enablers and success and failure factors. For example, the need 'A clear, common vision is needed in order to know where to work towards to in PCP' is in line with previous mentioned success factor. Although, specific contextual factors cannot always be generalized, for that reason contextual factors remain important for (the development) of PCP.

Based on the drafted scenarios, we advise that Menzis should start with taking a directing role in the development of PCP in the region of Twente. Because the starting point of the directing role will give Menzis best opportunity to respond to potential reconsideration of stakeholders opinions and to the context of the care field. Menzis could give PCP in Twente direction by means of multiple incentives, most importantly: salary guarantee for medical specialists, appointing an external, independent facilitator and (financial) incentives to stimulate healthcare professionals to create PCP ideas.

Conclusion

Three different roles are suitable for Menzis in the development of PCP, namely a facilitating, stimulating or directing role. But the context of the care field, in which Menzis wishes to develop PCP, is important (almost leading) for determining its role.

Samenvatting

Achtergrond

De Nederlandse gezondheidszorg staat voor de uitdaging om de veranderende zorgvraag, de zorguitgaven en het verwachte personeelstekort onder controle te houden. Dit betekent dat er veranderingen in de gezondheidszorg moeten plaatsvinden om een duurzame gezondheidszorg te creëren. Een veelgehoorde oplossing is substitutie van tweedelijnszorg naar de eerste lijn. De praktische uitwerking hiervan heet Primary Care Plus (PCP) (anderhalvelijnszorg). Het ministerie van VWS verwacht een actieve rol van zorgverzekeraars bij substitutie van zorg. Ervaringen tot nu toe leren ons dat onder andere lokale omstandigheden het succes van PCP beïnvloeden. Omdat Menzis de grootste zorgverzekeraar is in de regio Twente, is zij nauw betrokken bij de ontwikkeling en inkoop van PCP in Twente. Op dit moment zijn er een aantal PCP projecten in Twente. Menzis weet echter niet welke rol het in zou moeten nemen bij de verdere ontwikkeling van PCP.

Methode

In dit kwalitatieve, verkennende onderzoek is een literatuuronderzoek uitgevoerd. Daarnaast zijn vijf experts, vier medewerkers met een managementfunctie van (PCP) praktijken en alle acht betrokken stakeholders voor PCP in Twente geïnterviewd. Op basis van de resultaten en op basis van twee problemen die Menzis als belangrijkste ervaart, zijn twee scenario's opgesteld voor de ontwikkeling van PCP met twee verschillende rollen voor Menzis. Deze scenario's zijn in een regio-overleg van Menzis gepresenteerd en zij hebben de scenario's van feedback voorzien. Alle resultaten van dit onderzoek zijn geplot in een aangepaste versie van het Regenboogmodel voor geïntegreerde zorg van Valentijn (19), om te bepalen hoe de resultaten zich tot elkaar verhouden.

Resultaten en discussie

Een zorgverzekeraar kan verschillende rollen innemen in (de ontwikkeling van) PCP, namelijk een faciliterende, stimulerende of een regisserende rol. Daarnaast zijn verschillende prikkels in kaart gebracht die passen bij de rollen en die kunnen worden ingezet bij de ontwikkeling van PCP. Bijvoorbeeld, profiel versterkende innovaties (stimulerend) of selectieve inkoop (stimulerend en regisserend). De meest geschikte rol voor een zorgverzekeraar is afhankelijk van de context en het onderwerp. Bijvoorbeeld, duurzame lokale samenwerking, het marktaandeel van de zorgverzekeraar of het type interventie waar een zorgverzekeraar zich in wil mengen. Alhoewel er geen ideaal georganiseerde PCP setting bestaat, zijn wel zeven randvoorwaarden voor PCP in kaart gebracht. Daarnaast zijn er zestien succes- en faalfactoren geïdentificeerd, waar 'Een gemeenschappelijke visie en ambitie' als belangrijkste werd ervaren door de bezochte praktijken. 'Zorg professionals moeten vorm en inhoud geven aan een PCP initiatief' en 'Investeer in het opbouwen van een solide vertrouwensrelatie tussen de betrokken stakeholders' werden als tweede en derde gerangschikt.

Door deze ranking kan worden gesteld dat normatieve randvoorwaarden (de mate waarin werk waarden, missie etc. zijn gedeeld) van groter belang zijn dan functionele randvoorwaarden (de mate waarin ondersteuning en backoffice-functies zijn gecoördineerd) in de ontwikkeling van PCP. Alle rollen van de betrokken stakeholders van PCP in Twente zijn geïdentificeerd, de interviews resulteerden in acht kansen, acht risico's en acht behoeften voor (de ontwikkeling van) PCP. Het is interessant dat de gevonden kansen, risico's en behoeften ook van toepassing kunnen zijn op andere regio's in Nederland, omdat het veel overeenkomsten vertoont met de gevonden randvoorwaarden en succes- en faalfactoren. Bijvoorbeeld, de behoefte 'Een duidelijke, gezamenlijke visie is nodig om te weten waar naar toe te werken in PCP' komt overeen met voorgenoemde succesfactor. Alhoewel specifieke contextuele factoren niet altijd kunnen worden gegeneraliseerd, blijven contextuele factoren belangrijk in (de ontwikkeling van) PCP.

Op basis van de opgestelde scenario's is ons advies dat Menzis moet beginnen met het aannemen van een regisserende rol bij de ontwikkeling van PCP in de regio Twente. Omdat het uitgangspunt van de regisserende rol voor Menzis de beste mogelijkheid biedt om te reageren op mogelijke heroverwegingen van meningen van stakeholders en de context van het zorgveld. Menzis kan PCP in Twente richting geven door middel van meerdere prikkels, voornamelijk: loongarantie voor medisch specialisten, het aanstellen van een externe, onafhankelijke facilitator en (financiële) prikkels om zorgprofessionals te stimuleren om PCP-ideeën te creëren.

Conclusie

Drie verschillende rollen zijn geschikt voor Menzis bij de ontwikkeling van PCP, namelijk een faciliterende, stimulerende of regisserende rol. Maar de context van het zorgveld, waarin Menzis PCP wil ontwikkelen, is belangrijk (bijna leidend) voor het bepalen van zijn rol.

Table of contents

1. Introduction

This chapter will describe the background of this study, the objective and the reading guide for this thesis. It explains why this research needed to be conducted and what goals needed to be achieved with this study.

1.1. Background

A monthly health insurance premium of approximately €100,- and a deductible around the €385,- will be unthinkable for Dutch citizens if healthcare trends of the past 10 years will continue to 2040. The healthcare expenditures are expected to be doubled in 2040 to 174 billion euro if this trend continuous (1). In this scenario, people in 2040 will make a greater appeal to healthcare, this is caused by demographical developments, technological progress and a changing view on illness and health. The Dutch healthcare is facing the challenge of the changing demand for care and keeping the healthcare expenditures in control. (2)

According to a report of the Dutch government, about the control of the healthcare spending, there will be three main tasks in order to control the public health expenditure. 1; Care must return to the core. 2; Care needs to be provided at the right place. 3; All stakeholders in healthcare need to contribute to the control of the public health expenditure. (3) This means that changes in the healthcare system need to be made in order to create a sustainable health care.

In the context of the changing healthcare demand and the rising healthcare costs healthcare providers, insurers and experts discuss more and more about “Value Based Health Care” (VBHC) and “Triple Aim”. Starting point here is quality, accessibility and affordability of healthcare on the long term. Porter introduced VBHC, which aims to maximize the value of care for the patient and to reduce the healthcare costs. (4) Another way of improving healthcare is stated by Berwick in three objectives, called the Triple Aim: 1. Improving the experience of care; 2. Improving the health of populations; 3. Reducing the costs of healthcare. (5) The core of this is that all involved stakeholders need to take responsibility for the three aims. The value for the patient has a central position in this and continuous improvement of care is the goal. (2)

In order to realize VBHC, the Triple Aim and to keep the healthcare manageable a structural approach is needed, a frequently mentioned solution for this is substitution of healthcare. The practical appearance of substitutable care products from secondary care to primary care is called Primary Care Plus (PCP) (anderhalvelijnszorg). The Dutch Ministry of Public Health, Welfare and Sport expects an active role of health insurers regarding substitution of care. Health insurers can promote substitution with tariffs and (integral) primary care procurement, by strengthening the gatekeeper function and trying to prevent duplications of care purchases. (6)

Experience so far teaches that local conditions influence the success of PCP. (2) An example of a PCP collaboration is Blauwe Zorg – Stadspoli in Maastricht in cooperation with health insurer VGZ. Medical specialists hold two-week consultations for patients with non-acute disorders. The specialist examines the patient and gives after maximal two consults advice for further treatment by the patient’s own general practitioner or for further reference to secondary line. (7) Because Blauwe Zorg has been set up in a demarcated local setting with sustainable collaborations between general practitioners and medical specialist, this is seen as the starting point for a successful PCP setting. (2)

Health insurer Menzis is the largest health insurer in the region of Twente. For this reason it is closely involved in the development and in the health procurement of PCP in Twente. At the moment there are a number of PCP projects in the region of Twente. However Menzis does not know what role it should take in the development of a PCP.

1.2. Objective

The aim of this study is to get insight in the possible roles which health insurer Menzis could take in the development of PCP in the region of Twente. Important steps to achieve this goal are:

1. identification of suitable roles for a health insurer in an ideally organized PCP setting,
2. identification of the opportunities for improvement of the current PCP in the Netherlands,
3. identification of the current state of PCP in Twente and
4. identification of different scenarios with different roles for health insurer Menzis in the development of PCP in Twente.

Menzis endorses the theory of VBHC and the Triple Aim and therefore it wants to take a role in this. For this reason Menzis wants to know which role it could take in the development of PCP in Twente and how it can give direction. Menzis wants to give the healthcare providers some handles regarding the development of PCP. For this reason the following research question is stated:

"What role could health insurer Menzis take in the development of Primary Care Plus in order to realize equal or improved quality of care at lower costs?"

In this context it will give insight how health insurers can give direction in PCP and what the involved stakeholders in the region Twente should take into account regarding the development of PCP. The research question will be substantiated with the four following sub-questions:

1. What role could a health insurer take in an ideally organized PCP setting?
    a. How should PCP ideally be organized according to literature?
    b. How should PCP ideally be organized according to experts?
    c. What are suitable roles for health insurers regarding PCP?
2. What opportunities for improvement does the current PCP in the Netherlands have?
    a. What types of PCP exist internationally as well as in the Netherlands?
    b. What 'care products' are according to literature well substitutable to a PCP setting?
    c. What works well and what problems are faced regarding the current PCP settings?
3. What is the current state of PCP in Twente?
    a. What are the roles of the involved stakeholders in Twente in the interference of the organization of PCP?
    b. Which opportunities and risks does Twente have regarding PCP?
    c. Where do the involved stakeholders need support regarding the (further) development of PCP in Twente?
4. What (possible) role could health insurer Menzis take in the development of PCP in Twente?
    a. How can Menzis give direction to PCP in Twente by means of incentives?
    b. What should the involved stakeholders take into account regarding the development of PCP in Twente?

1.3. Reading guide

This thesis is divided in eight chapters in order to answer above formulated research questions. In Chapter 2 the literature review will be presented, literature and theory related to this study will be described. In Chapter 3 will the methodology be given, it will describe step by step how this study is performed and why. Chapter 4 consists of enablers for PCP, suitable roles for a health insurer in PCP and incentives which a health insurer could use in a certain role. Chapter 5 describes the opportunities for improvement for PCP in the Netherlands, it provides among others a ranking of success and failure factors. Chapter 7 presents two possible scenarios with two different roles for Menzis in the development of PCP in Twente. The last chapter, Chapter 8, includes the discussion and conclusion of this study, which gives answer to the stated research question.

2. Literature review

Previous chapter provided the problem identification and the research question, with its corresponding sub-questions. In this chapter the existing literature and theories which are related to PCP will be described. By means of the reviewed literature, outcomes in this research might be explained.

Paragraph 2.1 will give more information and the definitions of PCP and substitution. Paragraph 2.2 explains the Rainbow Model of Integrated Care (RMIC) of Valentijn, Paragraph 2.3 introduces the Rainbow Model for Primary Care Plus (RMPCP), adapted from the RMIC of Valentijn. The RMPCP will be the conceptual framework for this thesis. Paragraph 2.4 will describe the roles of involved stakeholders in PCP and Subparagraph 2.4.1 introduces the participation stairs. Paragraph 2.5 describes incentives in healthcare and Paragraph 2.6 the different types of PCP. Paragraph 2.7 describes the advantages and disadvantages of PCP found in literature. At last, explains Paragraph 2.8 the success and failure factors of PCP and substitution.

2.1. Primary Care Plus

Definition PCP

PCP is care that is being offered by medical specialists and/or general practitioners (GPs), delivered in primary care and funded from the primary care financial framework (2). PCP is based on two basic principles: adjustments in the organization of care and behavioural change of both healthcare providers and patients (8). PCP is care at the interface of complex or chronic primary care and non-acute and low complex secondary care (9). It combines accessibility of primary care with specific knowledge and diagnostics of secondary care (10). The GP keeps in control and remains responsible for the patient in PCP (11, 12).

Substitution

In practice substitution means replacement of current, relative simple care and resources from secondary to primary care (13), while maintaining the same target group and preventing that these patients need secondary care in the future (2, 14, 15). Substitution also occurs in social domain, where care is replaced to the municipalities, and self-management is also a form of substitution (13).

Substitution has two approaches. The first approach implies preventing care to be delivered in secondary care, the GP gatekeeper system can be seen as the most important exponent of this policy. The second approach assumes the reverse, namely referring patients, as soon as possible, back from secondary to primary care. This policy is less crystallized, because terminating care in secondary care and referring back to primary care is not clearly protocolized (14).

Substitution of care answers multiple goals, namely:

- Cost-reduction by means of efficiency gains, cost-effectiveness and savings in order to keep the healthcare affordable (2, 16).
- Keep and/or make care accessible and approachable (2, 16).
- Stimulating of self-management and self-care of the patient (2, 17).
- Providing care closer to the patients home (2, 17, 18).
- Knowledge exchange between primary and secondary care, by means of organizing more personalized and approachable consultation between healthcare professionals (2, 17, 18).

For more information and background about substitution see Appendix I.

2.2. Rainbow Model of Integrated Care

Figure 2.1 visualizes the Rainbow Model of Integrated Care (RMIC) of Valentijn (19) combined with the Triple Aim principles of Berwick (5). The RMIC provides a synthesis of current knowledge and theories on integrated and primary care into an overarching theoretical perspective. Valentijn provided a theory which supports how integration efforts (system, organizational, professional and clinical) act at different levels (macro, meso and micro) can be explained from multiple stakeholder perspectives (policymakers, managers, professionals and patients). The comprehensive RMIC is organized into three main categories, namely scope (person-focused vs. population-based), type (clinical, professional, organizational and system) and enablers (functional vs. normative). 'Hard' functional (e.g. IT, financial incentives) and 'soft' normative (e.g. cultural values) enablers are both essential for encouraging widespread implementation of integrated care. The RMIC visualizes that integrated care can be pursued at various levels within a system to facilitate the comprehensive, continuous and coordinated delivery of services for populations and individuals. For more information about the RMIC and definitions of the integration types see Appendix I.

The role of cooperation in the development of integrated primary care is essential, because several interpersonal conditions play a role at the start and in the development of integrated care initiatives. These interpersonal conditions are relationship dynamics, mutual gains, process management and organizational dynamics (shared control). Valentijn showed that an increase in relationship capital, over time, was related with a successful development of integrated primary care. For this reason it is suggested that in the development of integrated primary care initiatives, that trust-based governance mechanisms (i.e. relationship dynamics and mutual gains) are more important than control-based mechanism (i.e. process management).

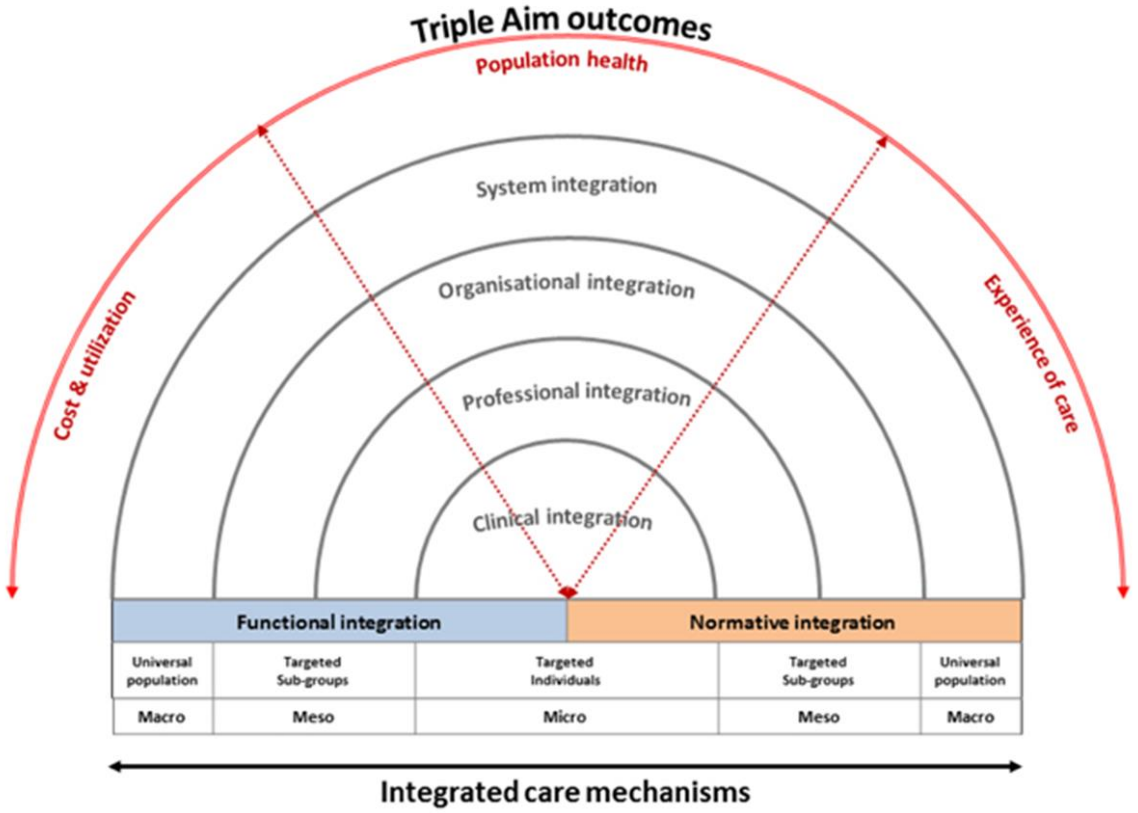

Figure 2.1: The RMIC, a three-dimensional value perspective on integrated care (5, 20).

Next to that is concluded that in achieving collaborative advantage of an integrated care initiative, the interpersonal collaboration conditions involved in the development of integrated care are essential. Valentijn identified three subgroups of (dis)similarity integration mind-sets between stakeholders, namely a 'united integration perspectives (UIP)' subgroup, a 'disunited integration perspectives (DIP)' subgroup and a 'professional oriented integration perspectives (PIP)' subgroup. The different subgroups had various effects on the interpersonal conditions in a project, see Appendix I for these results.

The RMIC emphasizes that the development of integrated care should start with an analysis of the needs and system requirements, this in order to explore the best suitable integration strategy. Valentijn states that in the future the challenge will be to explore the best suitable integration strategy to achieve better health outcomes at lower costs. The development of integrated care in a primary care context has design and management limitations. This because no stakeholder (i.e. financier, government) has the ultimate authority or resources to control the health, social, political and economic system that influences people's health and well-being. One single stakeholder is not able to manage the complexity of the entire system (21). And for this reason the behaviour of involved stakeholders can usually be more easily influenced than controlled (21, 22).

2.3. Rainbow Model of Primary Care Plus

The RMIC of Valentijn is adapted to a conceptual framework, the Rainbow Model of Primary Care Plus (RMPCP), see Figure 2.2. The RMPCP is simplified to a more self-evident model and will be used in this thesis, in which PCP integration efforts will be plotted to make clear how these PCP efforts act at different levels. During this thesis will the results from this study, for instance the roles, incentives, types and success and failure factors, be plotted in the RMPCP.

The Triple Aim outcomes, the different levels (macro, meso and micro) and the target groups (universal population, targeted sub-groups and targeted individuals) which were integrated in the RMIC are removed in the RMPCP. This because these facets caused, at first sight, confusion to the author and will not directly be used or applied on PCP in this thesis. The different integration types are moved from the rainbow to the blocks below the rainbow, this to make space to plot the PCP integration efforts. At last, the functional and normative integration is changed to functional and normative enablers, because both support and link system, organizational, professional and clinical integration (23). The word 'enabler' makes it, according to the author, more clear that it's about preconditions for the different types integration. Next to that, functional and normative enablers are moved below the different integration types, this because the enablers form the basis and support the different integration efforts, for that reason is also a line in the rainbow drawn to make a clear distinction between both.

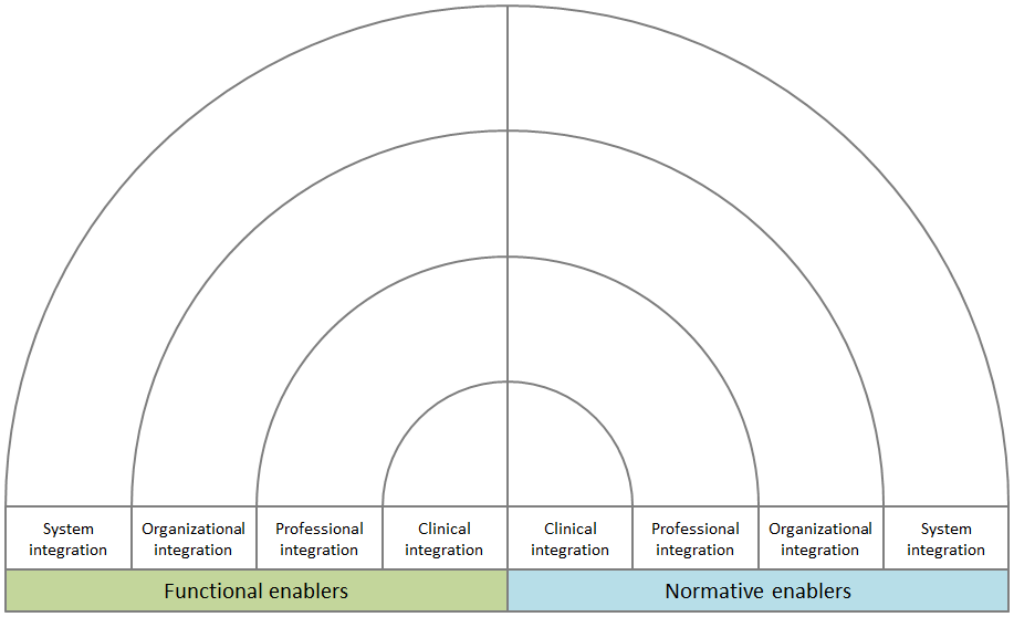

Figure 2.2: The RMPCP adapted from RMIC (19)

2.4. Roles of involved stakeholders

This paragraph describes the roles of the main stakeholders in PCP (health insurer, primary care and secondary care). In Table 2.1 an overview is given of the possible roles per stakeholder, how this stakeholder can contribute to PCP and what possible risks per stakeholder may be faced.

Table 2.1: Roles of involved stakeholders

	Health insurer	**Primary care**	**Secondary care**
What role?	In most PCP initiatives different: directing (13), controlling (24), leading (25), stimulating, supporting or facilitating role (2).	Gatekeeper (25-28), head practitioner (17), coordinating or directing role.	Treatment and diagnosis of high complex care (25).
How to substitute care/ opportunities?	- Long term (regional) procurement policy (13, 17), with selective procurement(2, 17), multi-year financing and preservation of innovation as incentives (29). - Pre-conditions: a business case and intended cost reduction (29). - Sharing successful initiatives and giving (small initiatives a chance (13).	- Taking over care activities of medical specialists (2). - Joint or one-off consultation medical specialist.	- Substituting care activities to primary care (17). - Joint or one-off consultation with GP.
Possible risks?	Supplementation of 'unlocked' substituted care due to fee-for-service funding (17).	Directing role: GP is not educated for management tasks (25). Expected staff shortage (30-32).	Substitution agreements concern hospital part and honorarium part independent medical specialists (17).

Figure 2.2: The RMPCP adapted from RMIC (19)

Health insurer

The role of, and cooperation with a health insurer is in most substitution projects different, this is caused by the fact that the role of a health insurer depends on contextual factors (6, 17). Contextual factors are for instance sustainable local cooperation (2, 25), willingness to cooperate (25), market share of a health insurer, present knowledge and competences in PCP (17, 33), coordination on location (17), type of medical intervention (34). For that reason health insurers are also still searching for an appropriate role (29). Literature suggests that health insurers could take different roles, namely: a directing (13), controlling (24), stimulating, supporting, facilitating (2) and in case of a dominant health insurer a leading role (25).

Literature also suggests how health insurers can take this role or how health insurers can make substitution happen. For adequate substitution of care a long term procurement policy of the health insurer is important (17). Also multi-year financing, a sound business case, cost reduction and preservation of innovation has been experienced as successful in the cooperation of substitution agreements (29). Next to that, health insurers could be more active by making concrete substitution agreements, among others by regional care procurement (13), involving and cooperating with GPs, medical specialists and the hospital in an early stage in substitution agreements (17) and to give substitution innovations a chance, even at small scale (13).

Health insurers can steer a region of healthcare providers to innovate in a certain direction by sharing successful practice examples of other regions, in order to determine whether this example can be applied in their region (13). Another way of giving substitution direction is by purchasing certain care activities only in primary care and not in secondary care (2). At last should health insurers try to manage or prevent, in case of fee for service funding and substitution of secondary to primary care, supplementation of the 'unlocked' care, this because fee for service funding has a volume incentive (17).

Primary care

Primary care delivers an important contribution for people living longer at home (13), where the GP has a gatekeeper function to secondary care (25-28). When a GP takes certain care activities over of the medical specialist, the GP needs to be qualified and competent (2). In order to catch up the extra care activities, GP could make use of (more) physician assistants (35-41). In case of PCP the GP remains clinically in charge of the patient and remains the head practitioner (17). The gatekeeping and coordinating role of the GP will be strengthened by PCP, because cooperation and communication between specialist and GP will be intensified (9). Unfortunately it is questionable if the GPs are able to take the director role, this because GPs are not educated for this management task (25). But given the expected staff shortage of 7,4% to 9,1% in 2022, it will be questionable if primary care can handle PCP (30-32). For that reason one needs to work towards labour or timesaving solutions.

Secondary care

Secondary care concerns all care wherefore a referral is required from primary care, so care which cannot be diagnosed or treated in primary care (25). Secondary care can substitute care by substituting care activities to primary care. Secondary care roughly exists of the hospital and the medical specialists working in the hospital. And for this reason it is hard to make substitution agreements, because these agreements concern both hospital part as honorarium part of the independent medical specialists (17). The agreements of the honorarium of independent medical specialists concern a maximum, because of the fee-for-service funding. But because of this agreement, health insurers experience this as an impeding factor for substitution because medical specialists are still able to derive their honorarium maximum (17). At last, substitution of secondary to primary care has consequences for the hospital, because when hospital care will not be supplemented then the hospital needs to shrink (2, 17, 25).

2.4.1. Participation stairs

Interestingly, if one looks at abovementioned roles, one can see conformity between the possible roles of a health insurer and government. This might be caused by the fact that the old health insurance funds (in Dutch: ziekenfonds) became implementation bodies of a public law, the health insurance funds became in 2006 under the Health Insurance Act, health insurers. Another reason might be that the health insurance premium can be seen as a tax, resulting in about the same role as the government has.

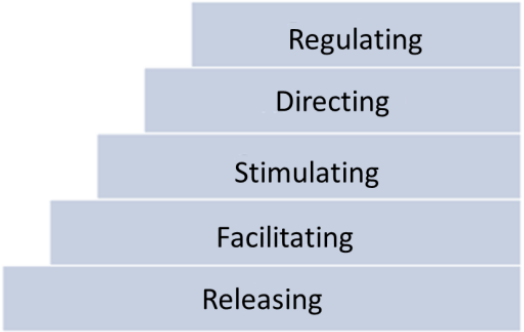

Figure 2.3: The participation stairs (42)

Depending on the context and the needs of the involved stakeholders, government or a health insurer needs/wishes to adopt another role. The Dutch Council for Public Administration (CPA) introduced a '(government) participation stairs', where stepwise the roles for government are described when adopting another role, see Figure 2.3.

The participation stairs consists of five steps, namely: releasing, facilitating, stimulating, directing and regulating, see Appendix I for definitions of each step. Per subject and situation (context dependent) one needs to determine and make explicit what role they see for their authority (government/health insurer). Because the roles are context and subject dependent an ideal or best role does not exists for an authority. But the regulating role will, even after a made change of role, remain an instrument which can be used. Giving space to the vitality of society (care field) is more likely if the authority climbs the participation stairs as little as possible (42).

2.5. Incentives in healthcare

This section describes briefly the financial incentives (FI) and non-financial incentives (NFI). Literature states that the right incentives for both GPs and medical specialists are required in order to realize substitution of care, because potentially negative consequences for either GPs or medical specialists could harm the relationship between both and it could prevent substitution of secondary to primary care (17, 26). Additionally, a balance of FI and NFI is likely to be most effective (43-46) and for both types of incentives applies that incentives should be matching with contextual factors. When Menzis knows what role it could take in the development of PCP, it might use incentives to give to healthcare providers and professionals direction. Literature states multiple incentives for PCP, see Table 2.2.

Table 2.2: Financial and non-financial incentives

Financial incentives (FI)	Non-financial incentives (NFI)
1. FI can be adjusted to influence provider treatment decisions (47-49), e.g. salary or revenue guarantees (2, 6, 17, 25, 50) or a FI can lead to a decrease of referrals and to an increase of performed GP services (26, 51, 52).	1. In developing NFI the values and goals of the healthcare system, local and personal norms and values, and contextual circumstances should be well matched to the performance objectives (44, 53).
2. Different payment approaches can lead to different types of behaviour (49), e.g. lump sum agreements could prevent supplementation (17), Multiyear financing/long term contracts (29) or selective procurement (17, 25).	2. Preservation of/profile strengthening innovations (13, 29, 54).
3. Alignment of financial incentives for GPs and medical specialists to motivate both for substitution (26).	3. Determining a long term procurement policy for a region (17).
4. FI need to be adjusted to the characteristics of recipients and to the context in which they practice. Therefore, FI cannot be generally structured in order to improve quality of care (49, 55).	4. NFI should be aligned with guidelines, causing intrinsic motivation (6).
5. Too low fees for substituted care activities, could lead to a risk for its progress (2, 29).	5. Laying down a basis for a facilitated setting (29) for instance support in drafting a business case or cost savings calculations.
6. A mix of FI, rules and monitoring efforts will result in the desired provider behaviour (47-49).	6. Public-ranking or benchmarking healthcare providers' performance (43, 45).
7. FI need to be devoted to measurement and monitoring activities and the greater the cost of monitoring activities, the less likely that the use of FI will be cost-effective (49).	

2.6. Types of PCP

This section describes the different types of PCP in the Netherlands and internationally. PCP exists of different types and these are often combined. For example, joint consultation can be offered in a regional PCP centre or joint consultation can be used as an eHealth application. See Table 2.3 for the description of both international as Dutch PCP types.

In addition to Table 2.3, three articles state that the number of performed services by a GP is associated with a decrease in referrals (14, 24, 51), another article found no association (26). For GP duo practices (significant) and GP group practices (not significant) applies that less patients were referred compared to GP solo-practices (6). These results could be applicable for substitution of low complex interventions, (specialist) outreach clinic and GPwSI.

Table 2.3: Description of PCP types

PCP type	Description
Substitution of low complex interventions	Low complex secondary care interventions, in which no specific capital-intensive infrastructure is required, can be performed closer to patients home. It involves minor surgery in general, removing atheroma, stitching of wounds etc. This type of PCP is also known as substitution of secondary to primary care (56).
(Specialist) outreach clinic (regiopoli's)	A (specialist) outreach clinic can be described as a primary care setting in which a medical specialist (plus eventually his team) provides outpatient diagnostics or treatment services for patients who would otherwise be referred to secondary care (57, 58).
eHealth	Cooperation between primary and secondary care can be supported and promoted by eHealth applications. eHealth can be used to prevent a referral (12), as an aid to refer purposefully, for referring back from secondary to PCP or primary care and to facilitate and support inter collegial consultation about joint patients of GP and medical specialist. The use of eHealth applications can significantly facilitate substitution of care (2).
Joint consultation	From 2015, NZa made it possible to declare "Joint or one-off consultation" (in Dutch: Meekijkconsult) with a medical specialist or other experts in healthcare. Aim must be to prevent a referral to secondary care and to be able to refer purposefully. The GP remains the main practitioner during the joint consultation (2).
Diagnostics nearby	Low capital-intensive diagnostic tools in-house (for example ultrasound) or PCP in cooperation with primary care diagnostics centres are examples of diagnostics organized near to patients home. This diagnostics will be organized to be able to offer a complete diagnosis nearby (11).
Primary care beds	When people can no longer live at home because of a medical necessity, a temporary admission to a primary care accommodation should be possible (18). An example of this is primary care beds, (in Dutch: Eerstelijnsverblijf bedden, ELV), where people can temporarily recover after a hospital admission under the responsibility of the GP (13).
GP with a Special Interests (GPwSI) (NOVO-care)	A GPwSI is a GP with complementary training and expertise in a specific clinical area who takes referrals for assessment or treatment of patients that may otherwise have been referred to secondary care. A GPwSI may also provide enhanced service for patient groups with specific conditions (59).

2.7. (Dis)advantages of PCP

This section provides the found advantages and disadvantages of PCP in literature, see Table 2.4. The main advantages of PCP are an improvement of the (experienced) quality of care and PCP is supposed to reduce or at least not to increase healthcare costs. The main disadvantages of PCP are that due to the current funding system, PCP is difficult to finance and PCP will in case of joint consultation not be cost-effective without an efficient planning. The (dis)advantages are pointwise and abstract given, for more information and explanation for the (dis)advantages see Appendix I.

Table 2.4: Advantages and disadvantages of PCP

Advantages PCP	Disadvantages PCP
1. PCP improves the (experienced) quality of care (9, 10, 25, 50, 57, 60-66).	1. PCP could lead to immoderate medical consumption and over-diagnosis (10, 70).
2. PCP is supposed that health outcomes of the population (non-acute, low complexity complaints) will be the same (9).	2. Due to the current funding system, PCP is difficult to finance (14, 50) and/or care will be double declared (17, 24, 72).
3. PCP has no influence on the level of safety and equity of care (9).	3. Joint consultation will not be cost-effective without an efficient planning/use of time (50, 60, 61, 71, 73-75).
4. PCP is supposed to reduce or at least not to increase healthcare costs (10, 57, 60-62, 64, 66-71).	4. In case of a new PCP centre, could PCP lead to increased healthcare costs (10, 61, 69).
5. PCP is supposed to improve the effectiveness of care (9).	5. No national blueprint is available for PCP (6, 17).
6. Healthcare professionals have more knowledge about each other's qualities (9, 24).	

2.8. Success and failure factors

This section describes the success and failure factors for both PCP and substitution. When health insurer Menzis knows what role it could take in the development of PCP, it should take the success and failure factors of PCP and substitution into account. The factors are divided in four subheads, namely: a common vision and ambition, organization of PCP, healthcare professionals and financing of PCP. The extended argumentation for below standing factors is included in Appendix I.

A common vision and ambition

A common vision and ambition forms the basis for a PCP cooperation, this should regularly be monitored on its progress (29, 50). The interests of all stakeholders should be taken into account, so a win-win situation could be created (19, 25). Next to that, one should invest in building a solid trust relation between the involved stakeholders and healthcare professionals (5, 29, 50, 76).

Organization of PCP

Literature states that some form of organization seems to be important, for instance an administrative consultative body (2, 25, 50). Beside, a leader at an administrative level and a leader at healthcare professional level are crucial (5, 29, 50, 76) and an external, independent project manager or integrator is recommended (26, 29, 50). Literature also states that the process of substituting care should be designed carefully, so implementers can keep up the pace (10, 25, 50). Cooperation in substitution of care should be facilitated with 'flanking policy', such as staff support, training, information exchange and develop common ICT (6, 50) and there needs to be (municipal) governmental support (25). At last, specific for joint consultation, a sufficient adherence area should be created (50, 60, 73-75).

Healthcare professionals

Healthcare professionals have to give form and content to a PCP initiative, in which they for instance agree on diagnostics and sharing of information (29, 50). Another important factor is that healthcare professionals will make clear agreements about their contribution in PCP, so no differences in job interpretation need to occur (77). At last GPs should be able to perform PCP services (6, 17, 26).

Financing of PCP

At the moment there is lack of a clear funding system for PCP (6, 12, 13, 25). Therefore, the risk exists that the budgetary framework for GP care might be exceeded (17). Beside, substitution concerns for secondary care both hospital cost part and honorarium part of the independent medical specialist working in a hospital, for that reason substitution might have financial consequences for both (17). Fee-for-service funding has a volume incentive, in a regulated market a health insurer needs to prevent or manage supplementation of substituted care (17, 72). For this reason financial preconditions are essential for good cooperation, causing substitution of care (29). When using incentives for this, these should be aligned between primary and secondary care (26). Ideally a funding system should be created for PCP, independent of the baffles of healthcare and in which money follows care (8).

3. Methodology

This chapter explains the methodology of this research. The study was executed from September 2017 until March 2018. It took place in the region Twente of the Netherlands. To find answers to the stated research question, with corresponding sub-questions, a qualitative explorative approach was chosen. This research design is most suitable due to the explorative research questions and PCP is a relative unexamined subject and little is known about the role of a health insurer in it.

3.1. Literature research

In this research a literature research is conducted. The literature research started with the Dutch words "anderhalvelijnszorg" and "substitutie" and the English words "primary care plus" and "substitution (of secondary care with/to primary care)". The literature research was conducted in public databases of NZA (Nederlands Zorgautoriteit), ZN (Zorgverzekeraars Nederland), NIVEL, RIVM (Rijksinstituut voor Volksgezondheid en Milieu), VWS (Ministerie van Volksgezondheid, Welzijn en Sport), RVS (Raad voor Volksgezondheid en Samenleving), ZonMW, NWO (Nederlandse organisatie voor Wetenschappelijk Onderzoek), Google Scholar and FindUT. At last was also searched with Google. Only the first 200 searching results, filtered on relevance, were included for the first inclusion round. Based on appropriateness of the title of the searching results, literature has been in or excluded for further examination. The abstracts of the included results have been read to determine whether it was applicable for this research, a second inclusion round was performed. After the second inclusion round, duplicates have been excluded. The provisionally included literature has been read and snowball searching has been applied. Because the subject of this research was relative unexamined and snowball searching method could provide faster results than a systematic searching method, has been chosen for this method.

During snowball searching, has been searched for well-fitting titles, which were in line with the subject of this research. Keywords in the snowball searching method were "substitution" in combination with "hospital/secondary care and primary care/general practice", "integrated primary care", "specialist/outreach clinic" in combination with "primary care/general practice" and "joint consultation". The abstracts of the included snowball searching results have been read to determine whether the snowball searching literature was applicable for this study, a second inclusion round on the snowball searching results was performed. Reasons for exclusion (not found, not useful or already included) have been reported and the included snowball searching literature has also been read. The provisionally included literature and the snowball searching literature together resulted in the included literature of the literature research. The literature research aimed to give answer on sub-question 1a "How should PCP ideally be organized according to literature?".

3.1.1. Results literature research

This section describes the total numbers of results of the literature research and its snowball searching method. In Figure 3.1 one can see the used searching strategy as described in previous section with its corresponding searching results. In Table 3.1 one can see the results per inclusion round, per search term and the total numbers of included literature. In Table 3.2 one can see the snowball searching results and the reasons for exclusion per search term.

The included literature is used in writing the literature review. Because of the relative unexamined subject of this research, literature could not provide an ideally organized PCP model or theory. Multiple types of PCP have been found in literature and described in Paragraph 2.6.

Table 3.1: Literature research results per inclusion round

Searching terms	Searching results	Included based on title	Included based on abstract	Included after reading	Snowball searching results	Included literature
Anderhalvelijnszorg	96	14	6	5	1	6
Substitutie/substitution	1058	95	37	29	12	41
Primary Care Plus	937	9	6	3	13	16
Total	2091	118	49	37	26	63

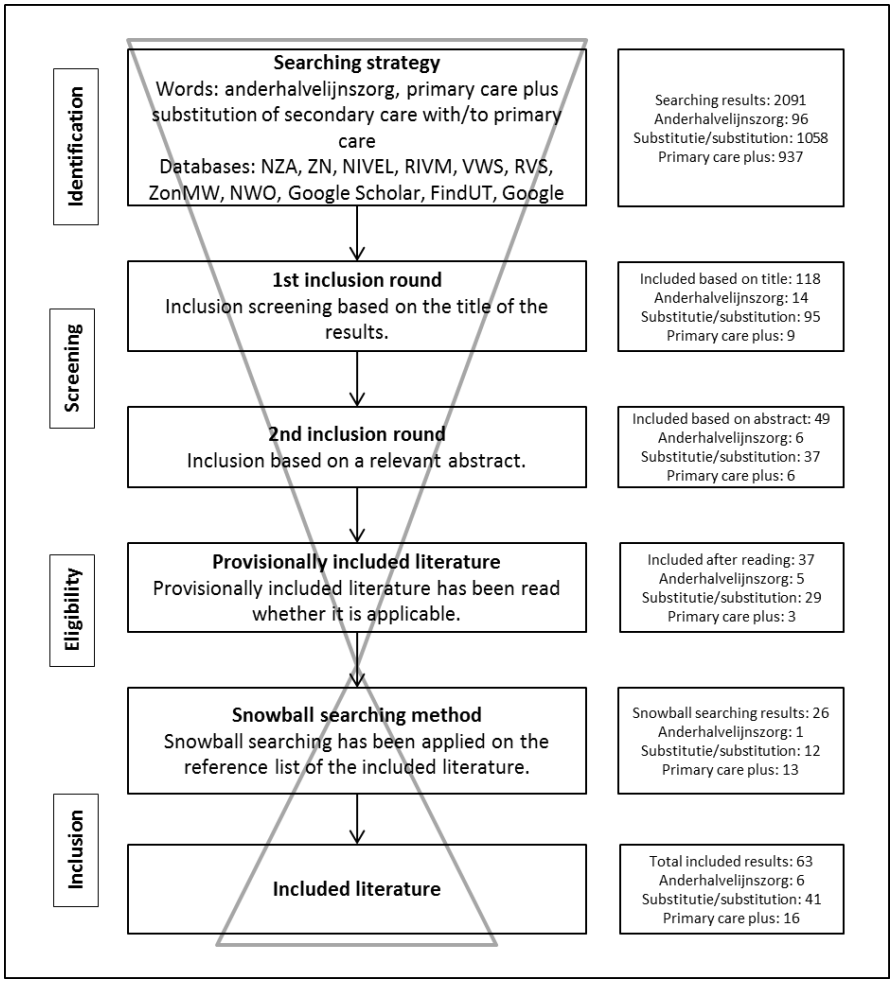

Figure 3.1: Searching strategy and searching results

Table 3.2: Snowball searching and exclusion results

	Provisionally snowball searching results	Reason exclusion Not found	Not useful	Already included	Snowball searching results
Anderhalvelijnszorg	6	1	4	0	1
Substitutie/substitution	32	2	4	14	12
Primary Care Plus	35	0	9	13	13
Total	73	3	17	27	26

3.2. Interviews experts

In addition to the literature research, interviews about an ideally organized PCP have been conducted. Five experts on PCP have been approached and asked if they would like to be interviewed on behalf of this study. The experts were dr. P.P. Valentijn, dr. M.A. Bruijnzeels, dr. G.J.C. Schulpen drs. J.E. de Wildt and drs. P. Offringa. In Appendix II more information about the experts and their background is given, the backgrounds of the experts is the reason why these experts were selected. The interviews were semi-structural in order to ask profound questions about their vision of an ideally organized PCP in a greenfield situation and what roles the involved stakeholders should have. A week before the interview the interview schedule has been e-mailed to the respondent, the interview schedule is included in Appendix III. The interview has been transcribed in summary. Based on the transcribed interviews and found literature a draft model of an ideally organized PCP is drafted. This model is sent to the experts and they were asked to review this draft model, four out of five experts provided the draft model of feedback. The provided feedback is taken into account in drafting the scenarios, this because the draft model is not included in this report but the general principles of it are. The interviews with the experts aimed to give answer on sub-question 1b “How should PCP ideally be organized according to experts?”.

3.3. Practical visits

Next to the previous methods, three practices in the Netherlands have been visited and interviewed and one practice in the Netherlands has been interviewed by telephone. In this report the four practices will be described as the 'visited practices'. There has been chosen for the longest running PCP practice, Sûnenz in Drachten, the shortest running PCP practice, health centre in Oostburg, a similar region as Twente where a PCP takes place, first line centre Tiel (ECT Tiel) and an interesting PCP practice, academic health centre Thermion in Lent. There has been chosen for this interesting PCP practice because health centre Thermion in Lent has a partnership with Radboudumc Academic General Practitioner Network, we hoped that this would lead to interesting results.

An employee with a multidisciplinary management function, who has general knowledge about the organization of the practice, has been interviewed, see Appendix II for the respondents and their backgrounds. A week before the interview the interview schedule has been e-mailed to the respondent, the interview schedule is included in Appendix III. After the practical visit the interview has been transcribed in summary, sent back to the respondent and the respondent has been asked to review the transcribed interview so possible adjustments could be made. All respondents reviewed their transcribed interview.

During the interviews the visited practices are asked to make a ranking of found success and failure factors of PCP and substitution in literature. The rankings of all four practices have been processed in Microsoft Excel. Based on the given rankings, an average has been calculated. Based on these averages an initial ranking has been made. Thereafter the lowest and highest deviation from average has been calculated. From all these deviation values is the average deviation (AD) calculated and could the deviations from the average deviation be mapped. Based on these data could be determined which factor with which practice deviated. The deviating factors have been examined in more detail and explanations for these deviations have been described. Factors which were not applicable for a practice, but which were ranked, have been excluded in the ranking of factors. For this reason a new average has been calculated, which resulted in a new ranking. The practical visits aimed to give answer on sub-question 2 "What opportunities for improvement does the current PCP in the Netherlands have?".

3.4. Interviews stakeholders PCP in Twente

In order to get more insight in the roles of different stakeholders in Twente, hospitals ZGT and MST, care federations of general practitioners THOON and FEA and at last Menzis were interviewed. During the interviews three new stakeholders came forward, namely: Medical Staff boards of ZGT (Coöperatie Medisch Specialisten (CMS)) and MST (Medisch Stafbestuur) and a network organization, Zorgnetwerk Zenderen. Employees of these organizations who are responsible for PCP or substitution of care were also interviewed, for more information about the respondents see Appendix II. The interview was transcribed in summary after the interview, sent back to the respondent and the respondent has been asked to review the transcribed interview so possible adjustments could be made. All interviewed stakeholders reviewed their transcribed interview. See Appendix III for the interview schedule. The interviews with the stakeholders in Twente aimed to give answer on sub-question 3 "What is the current state of PCP in Twente?'.

3.5. Scenarios PCP Twente

In order to get more insight in the main problems of Menzis in PCP, the researcher presented in a 'region meeting' of employees of Menzis the provisionally results, the possible roles for a health insurer and the RMPCP. The employees were a senior healthcare purchaser, program, region and project managers in the east of the Netherlands. Based on the presentation the employees in the meeting were asked what problems they experience regarding PCP in Twente and which two problems they experienced as most important. Based on the outcomes of this meeting, two scenarios with two different roles for Menzis were drafted.

In another region meeting the two drafted scenarios were presented and an initial advice for the role of Menzis in the development of PCP in Twente is given. The employees were asked to provide these scenarios of feedback. The provided feedback is taken into account in drafting a new version of the scenarios, resulting in two widely supported scenarios within Menzis. The drafted scenarios for PCP in Twente aimed to give answer on sub-question 4 "What (possible) role could health insurer Menzis take in the development of PCP in Twente?".

3.6. Plotting of results in RMPCP

In order to get more insight in how results from this study act at different levels, the results were plotted in the RMPCP, as described in Section 2.3. This section describes how the results are plotted in the RMPCP figures. In the legend below the figure is made clear which colored oval stands for a result. Different ovals are plotted in the figure, due to different results. The results are plotted for functional and normative enablers and at the same time for system, organizational, professional and clinical integration. If an oval hits a line between two integration levels or between the two enablers, then this implies that this oval applies to both.

The place of the oval in the bow of the RMPCP means nothing. If for instance a result is plotted higher than another result, then this does not mean that this result is of more importance. This because this study did not focussed on the importance of results relative to each other. The same applies to the size of an oval. There is difference between the sizes of some ovals, this could be because of the text in the ovals or because some results apply to multiple integration levels and for that reason they a bigger to hit the different bows/integration levels. Again, the size of the ovals does not mean that a result is of more importance. An example some fictional results are plotted in Figure 3.2.

Example of plotted result in the RMPCP

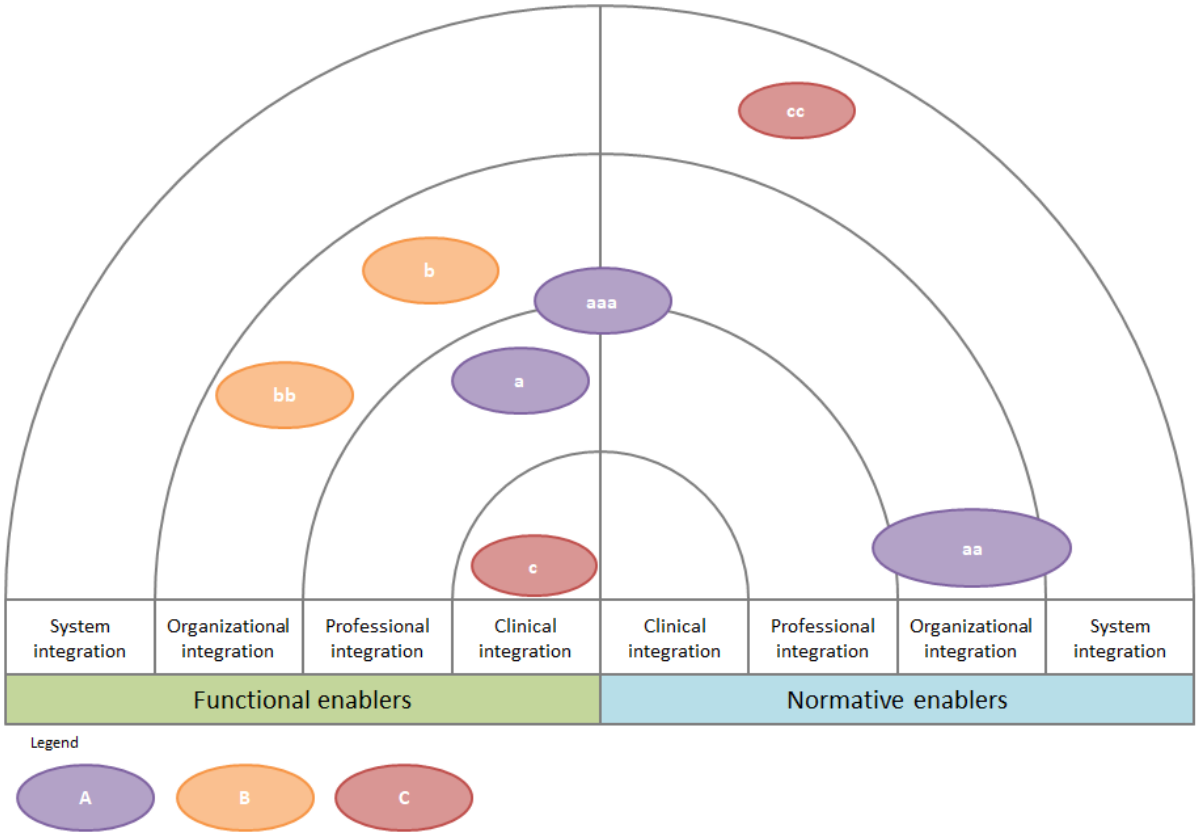

Figure 3.2: Example of plotted results in RMPCP

Result a is plotted as a functional enabler and for professional integration. Result aa is plotted as normative enabler and for professional, organizational and system integration, for that reason is this oval bigger than result a. result aaa is plotted as functional and normative enabler and for professional and organizational integration. The oval of result aa is bigger than ovals a and aaa, this does not mean that result aa is of more importance. Results b and bb are both plotted as a functional enabler and for organization integration. Result b is plotted higher than bb, this does not mean that result b is of more importance then result bb. Result c is plotted as functional enabler and for clinical integration. Result cc is plotted as normative enabler and for system integration.

4. The role of a health insurer in an ideally organized PCP

This chapter discusses seven suggested enablers which emerged from the expert interviews. Additionally, the suitable roles and its appropriate incentives which emerged from the interviews and found in literature will be discussed and plotted with each other. At last, results from this chapter will be plotted with the integration types and enablers of the RMPCP and will be visualized in the RMPCP figure. This chapter will give answer to sub-question 1, "What role should a health insurer take in an ideally organized PCP setting?".

4.1. Enablers for an ideally organized PCP

This section describes how PCP should ideally be organized according to five interviewed experts. The used method for the interviews can be found in Method, Chapter 3. See the appendix for background information about the experts, the used interview scheme and a summary of the transcribed interviews.

Enablers for PCP

Interestingly, four out of the five experts would not directly organize PCP. These four experts would rather work towards population-oriented working/funding, the principals of PCP could be seen as an intermediate form towards this. Their visions of an ideally organized healthcare are described in Appendix IV. One expert, dr. G.J.C. Schulpen, did have a vision about an ideally organized PCP, for that reason his vision will be further explained in this section.

According to Schulpen should PCP ideally be organized as it is in Maastricht (Blauwe Zorg/Stadspoli), in Maastricht they work with two different models of PCP. Firstly, joint consultation of a medical specialist in a GP practice. GPs are bundled in groups of three and a medical specialist visits them once every four or six weeks, together they consult patients that would otherwise have been referred. GP remains main practitioner and medical specialist is consultant, GP is responsible for performing the medical specialist advice. After a year the bundled GPs change of specialty to work towards a new learning curve. This is qualitatively and cooperatively good working model. With joint consultation, 85% of patients can be treated in primary care. Although a disadvantage of this model is that no large patients groups can be served, for that reason a second model is developed, Stadspoli.

The principles of joint consultation are in Stadspoli translated to a volume model, here GP and medical specialist do not consult the patient jointly but as it were parallel to each other. The volume model can be described as an one-off consultation of a medical specialist in an independent city outreach clinic. The medical specialist is allowed to consult a patient once and then needs to formulate an advice to the GP. For Stadspoli applies that 80% of one-off consulted patient can be treated in primary care.

Fortunately, from the five expert interviews did appear seven general enablers for an ideally organized PCP. An overview of the enablers is given in Table 4.1.

1. *An independent outreach clinic should have a sufficient adherence area.*

An independent outreach clinic requires a sufficient adherence area, this can be determined by the frequencies of referrals to a specialism.

2. *A funding system where money follows care.*

The experts indicated that an ideally organized healthcare can only succeed if it has a funding system where money follows care, and here lies a task for the health insurer and government.

3. *The GP remains first point of contact for the patient and gatekeeper for specialist care.*

The experts believe that healthcare, should be organized and reasoned from the patients perspective. According to the experts, it is for the patient most desirable if the GP remains the first point of contact and gatekeeper, reasoned from a generalist paradigm. One expert stated "*one should never touch the gatekeeper function of the GP, scientific research shows that this prevents a lot of referrals*".

4. *Substitution of low complex, simple specialist care to generalist care.*

The experts believe that when it is possible to substitute (expensive) low complex, simple care, where specialist facilities are not needed, to a cheaper, generalist infrastructure, then this should be done. The experts also believe that when a patient does not belong in the specialist paradigm, it should be referred back to the generalist paradigm. In other words, substitution of care.

5. *The experts would not create a new echelon between generalist and specialist care, the experts suggested to look across the healthcare lines. For this reason one should organize a regional, integrally organized healthcare, with more cooperation between both paradigms.*

The experts believe that PCP implicates that a new echelon between primary and secondary care will be created and this is according to the experts not desirable. They state that there is already a gap between

generalist and specialist paradigms due to the legal framework and the funding system. The experts believe that one should look more across the healthcare lines. For this reason all the experts believe that healthcare should be integral, per region organized. And according to the experts is more cooperation and integration between organizations desirable, without creating a new echelon.

6. *Professional integration by means of joint or one-off consultation of a medical specialist, causing a shift from specialist expertise to generalist paradigm.*

At the moment that generalist paradigm is no longer sufficient, the experts believe that expertise from specialist paradigm should be provided in the GP practice, known as joint or one-off consultation of a medical specialist. This is a typical example of professional integration, where specialist expertise is moved in order to prevent (unnecessary) referrals. In line with this, GPs should have the ability to a low threshold medical specialist advice. Although, one expert gave as feedback that enabler 6 would not succeed with only professional integration. This because he believes that clinical integration on micro level, professional and organizational integration on meso level and system integration on macro level is needed. He stated that more integration per level seems to have more effect on clinical and costs outcomes.

7. *The place where PCP will be provided is leading for its success.*

From the interviews appeared that the PCP place is leading for its success. Because when a one-off consultation will be done in hospital then both patient and medical specialist are hard to detach from hospital thinking/routine, this because hospital facilities are within reach. Although, one-off consultations in a GP practice does neither work, because this reduces the referral threshold for GPs in the same practice and colleague GPs have difficulty referring their patient to a competitor GP practice. For that reason one has chosen in Maastricht for an independent city outreach clinic where medical specialists can do one-off consultations.

Enablers plotted in the RMPCP

The PCP enablers are plotted in Table 4.1 with the integration types of the RMPCP. In the most left column the PCP enablers are indicated, divided among the two different enabler types, functional and normative. In the four right columns are the four different integration types indicated, system, organizational, professional and clinical integration. The PCP enablers are plotted (indicated with 'X') with the different integration types.

The intention was to make a draft model of an ideal organized PCP, but based on one ideal PCP vision one cannot draft an ideal organized PCP model. For that reason the seven enablers for PCP which appeared from the interviews could be taken as a guideline for a new PCP initiative. In Table 4.1 one can see that a distinction is made between the different types of enablers. Three enablers are indicated as functional enablers and four enablers as both functional and normative enablers. No enabler was applicable as a normative enabler. All seven enablers are plotted with the four types of integration of the RMIC.

The seven enablers are all applicable as functional enablers because all include the coordination of key support functions such as quality improvement, strategic planning, information management, human resources or financial management (78, 79). Four enablers are applicable as functional and normative enablers. Normative enablers are less tangible compared to functional enablers but essential to facilitate collaboration and ensure consistency between all integration types, for instance shared mission, vision, values and culture (19). No enabler, as given in Table 4.1, is applicable as normative enabler, because these did not result from the interviews with the experts.

Table 4.1: Enablers plotted in the RMIC

PCP enablers	Syst. intgr.	Org. intgr.	Prof. intgr.	Clinic. intgr.
Functional enablers				
1. An outreach clinic should have a sufficient adherence area.		X		
2. A funding system where money follows care.	X			
3. GP remains first point of contact and gatekeeper.		X	X	
Functional and normative enablers				
4. Substitution of low complex specialist care to generalist care.		X	X	
5. Organize a regional integrally healthcare, with more cooperation.		X	X	
6. Professional integration by means of joint or one-off consultation.			X	
7. The place where PCP will be provided is leading for its success.		X	X	
Normative enablers				
None.				

Enabler 1 is applicable to organizational integration because it refers to the extent in which organizations coordinate services, in this case a sufficient adherence area for an outreach clinic, across different organizations. Enabler 2, a funding system where money follows care, is applicable to system integration

because it refers to the alignment of rules and policies drafted by the NZa. Enabler 4 is applicable to organizational and professional integration because it refers to the extent in which organizations and professionals coordinate services, in this case substitution of low complex specialist care to generalist care, across different organizations and disciplines. In substitution of care are both organizations and healthcare providers involved, for that reason are both organizational and professional integration applicable. Enabler 6 is plotted as professional integration because this implies joint or one-off consultation. But one expert gave as feedback that enabler 6 would not succeed with only professional integration, although this enabler is only applicable to professional integration because it refers to the extent in which professionals coordinate services across various disciplines.

4.2. Suitable roles for a health insurer and incentives in PCP

This section describes, according to the interviewed experts, what roles a health insurer could take in PCP. Next to that it describes incentives found in literature and suggested by the experts. Furthermore, we will describe the plotted roles and incentives for a health insurer in the RMPCP and we will describe the possible incentives per health insurer role in PCP.

The experts believe that the role of the health insurer is keeping healthcare affordable and accessible. Next to that could a health insurer, according to the experts, take a pro-active, facilitating, stimulating or directing role. The experts indicate that the health insurer should lay down a basis, so healthcare providers get motivated/stimulated to cooperate in this facilitated setting. The health insurer should also dare to experiment with care projects and funding models. In case of a dominant health insurer, it should, eventually together with one or two other health insurers, determine a policy for a region so one policy for one region will be created. Furthermore, the experts indicate that transparency in costs and quality data could be an incentive for both health insurer and healthcare provider. Selective procurement is also an incentive/a way to substitute care, but the experts indicate that this incentive must ensure that primary and secondary care will move towards each other, by means of good cooperation between both.

Other incentives are focused on contract types, such as long term contracts of minimal five years, by means of this hospitals can get 'a long landing strip' to substitute care or to let shrink the hospital(budget). In line with this can the health insurer give the hospital its guarantee that it will not go bankrupt. Shared savings contracts are also indicated by the experts, where the shared savings can be used for hospital profile strengthening innovations, by means of this it continues to specialize. Another suggested incentive comes from Blue Cross Shield, here is an innovative project/initiative a three-year experiment. A potential cost reduction will benefit the healthcare provider, when it is not cost beneficial this will be the risk for the health insurer. After the experiment the healthcare provider needs to make a decision if it wants to continue with the project, but being responsible for financial gains or losses (two-sided model).

One expert suggested another way for consciously controlled shrinkage of the hospital, namely paying of the mortgage costs for not using a department. By means of this will disappear the production incentive to meet the financing obligations of the bank. This might cost the health insurer for example 10% of costs for not using a hospital department, but saves 90% of healthcare costs. At last, when all of the foregoing does not work, a health insurer could threat to approach to third parties outside the region, such as diagnostic or independent treatment centres, causing competition in the region.

Suitable roles for a health insurer plotted in the RMPCP

The possible roles which are suggested by the experts and found in literature are presented in Table 4.2 and divided among the two enabler types. The different roles are plotted with the integration types of the RMPCP. Because health insurers want to develop the principles of PCP in healthcare, Menzis anyway, the releasing role is not suitable for a health insurer. Although, there are no functional enablers applicable to the releasing role, normative enablers are applicable to the releasing role. Because if a health insurer chooses for a releasing role, this implies it has a vision regarding the subject it wants to release.

The facilitating, stimulating and directing role, suggested by the experts and found in literature, are for organizational and professional integration applicable. This implies six different possibilities, two of these will be further explained. A directing role of a health insurer in combination with professional integration might look like a not usual combination, but it is possible. For instance, GPs and medical specialists who want to keep joint or one-off consultations in hospital. But health insurer believes that this does not lead to expedient delivery of care because both patients and healthcare providers do not get detached from the 'hospital thinking' (see enabler 7). For that reason a health insurer can take a directing role and state that joint

or one-off consultations will not be kept in hospital. By means of this the health insurer recognizes that others also have a role, but believes it's important that it directs. Next to that, both functional as normative enablers apply for this combination, for instance the expediency of care and the collaborative work values of the healthcare professionals.

A facilitating role of a health insurer in combination with organizational integration is possible when for instance the board of a care group suggests a new care initiative and a health insurer sees possibilities in developing and supporting it. In this example a health insurer chooses to take a facilitating role, it waits for initiatives from elsewhere, or does not primarily focus on a subject, and when it sees possibilities in it can choose to facilitate that initiative with for instance support in setting up a business case. For this combination of role and integration type apply both functional and normative enablers, for instance the support in setting up a business case and shared values about an initiative.

The regulating role of a health insurer could be applicable for system integration. This because it refers to the alignment of rules and policies of the healthcare system, but also to the alignment of rules and policies of a health insurer. For instance sanctioning violation of health insurer rules, policy or made agreements. Next to that, a health insurer will keep a regulating role when it changes from role. This because regulating will always remain an instrument for a health insurer in healthcare (42), for instance controlling or monitoring activities. For that reason these integration types are indicated with "O".

Table 4.2: Suitable roles for a health insurer plotted in the RMPCP

Suitable roles health insurer in PCP	System integration	Organizational integration	Professional integration	Clinical integration
Functional enablers				
- None				
Functional and normative enablers				
- Regulating	X	O	O	O
- Directing		X	X	
- Stimulating		X	X	
- Facilitating		X	X	
Normative enablers				
- Releasing				

Possible incentives plotted in the RMPCP

In Table 4.3 one can see the incentives plotted in the RMPCP. All incentives are applied as functional and normative enablers, this because all incentives should be applied with a functional intention, namely substitution of secondary to primary care. These incentives result in or cause a normative way of thinking, for that reason are all incentives applicable to both types of enablers. For instance, a health insurer could give a hospital revenue guarantees for not going bankrupt. This incentive starts with a functional enabler (giving revenue guarantees), so hospital is more inclined to substitute care (shared work values). It is also possible that healthcare organizations or professionals are more inclined to cooperate if a health insurer (threats) to

Table 4.3: Possible incentives plotted in the RMPCP

Suitable roles health insurer in PCP	System integration	Org. integration	Prof. integration	Clinical integration
Functional enablers				
- None				
Functional and normative enablers				
1. Paying the hospital mortgage costs for being able to shrink.		X		
2. Threaten to approach third parties if one will not cooperate.	X	X	X	
3. Daring to experiment with initiatives and/or funding models.	X	X	X	
4. Two-side model contract, e.g. Blue Cross Shield.		X	X	
5. Public-ranking or benchmarking. (43, 45)		X	X	
6. Alignment of financial incentives for both GPs and medical specialists to motivate both for substitution. (26)			X	
7. Preservation of/profile strengthening innovations. (13, 29, 54)		X	X	
8. Determining a long term procurement policy for a region. (17)		X	X	
9. Multiyear financing/long term contracts. (29)		X		
10. Revenue guarantee for hospital not going bankrupt. (17, 50)		X		
11. Selective procurement. (17, 25)		X	X	
12. Laying down a basis for a facilitated setting. (29)		X	X	
Normative enablers				
- None				

apply an incentive, for instance threaten to approach third parties, public-ranking or benchmarking. By means of this an incentive becomes more a normative enabler, but it could still be used as a functional enabler.

All incentives are plotted in Table 4.3 with the organizational and/or professional integration types. There are some exceptions, for instance, 'daring to experiment with initiatives and/or funding models'. This incentive is also applicable for system integration because regarding the funding models, it refers to the alignment of rules and policies within a system. The incentive 'laying down a basis for a facilitated setting' is plotted for organizational and professional integration. Because it is for a health insurer possible to facilitate both healthcare organizations and professionals in setting up a PCP initiative for instance by means of staff support, education, information exchange etc. So a health insurer could facilitate in the coordination of services across different organizations and disciplines.

Possible incentives per health insurer role

The possible incentives are plotted against the possible roles for a health insurer in Table 4.4, in this table a distinction is made between incentives found in literature and from the interviews. As one can see in Table 4.4 are ten out of twelve incentives applicable for the stimulating role, four for the facilitating role, six for the directing role and two for the regulating role. There is no correlation between the incentives found in literature and from the interviews, it is just an indication of its source.

An important incentive found in literature is the alignment of financial incentives for both GPs and medical specialists to motivate both to substitute care form secondary to primary care. This incentive is applicable for a facilitating, stimulating and directing role of a health insurer. This because potentially negative financial consequences for either medical specialists or GPs could prevent substitution of secondary to primary care. It could also harm the relationship between both healthcare professionals if one of both would be financially be stimulated or disadvantaged (17, 26). For that reason this incentive is applicable and important for these three roles, because otherwise it might occur that a PCP or substitution initiative will not succeed.

Selective procurement is an incentive which is applicable for a stimulating or directing role of a health insurer. This incentive is in line with determining a long term procurement policy for a region because selective procurement assumes that multiple healthcare providers are present in a region so selective procurement is possible. A stimulating or directing role starts with a policy in order to achieve something, in this case substitution or PCP. The same applies to selective procurement and for that reason this incentive is applicable for these two roles.

Table 4.4: Possible incentives per role

Possible incentives per health insurer role	Releasing	Facilitating	Stimulating	Directing	Regulating
Incentives from interviews					
- Paying the hospital mortgage costs for being able to shrink.			X	X	
- Threaten to approach third parties if one will not cooperate.				X	X
- Daring to experiment with initiatives and/or funding models.		X	X		
- Two-side model contract, e.g. Blue Cross Shield.			X	X	
Incentives from literature					
- Public-ranking or benchmarking. (43, 45)					X
- Alignment of financial incentives for both GPs and medical specialists to motivate both for substitution. (26)		X	X	X	
Incentives from both literature and interviews					
- Preservation or profile strengthening innovations. (13, 29, 54)			X		
- Determining a long term procurement policy for a region. (17)		X	X	X	
- Multiyear financing/long term contracts. (29)			X	X	
- Revenue guarantee for hospital not going bankrupt. (17, 50)			X	X	
- Selective procurement. (17, 25)			X	X	
- Laying down a basis for a facilitated setting. (29)		X	X		

As mentioned in Paragraph 2.4, giving space to the vitality of a care field is more likely if a health insurer climbs the participation stairs as little as possible. But this depends on the vitality/wish of the care field and the pace in which the health insurer wants to develop PCP. The health insurer can apply appropriate incentives, matching with its chosen role. Next to that is the role of, and cooperation with a health insurer is in most substitution projects different, this is caused by the fact that the role of a health insurer depends on contextual factors (6, 17). Examples of contextual factors are described in Paragraph 2.4.

4.3. Conclusion one

This chapter was aimed to give answer on sub-question 1, “What role could a health insurer take in an ideally organized PCP setting?”. Based on the literature research and the interviewed experts, one can conclude that:

1. A health insurer can take different roles in (the development of) PCP, namely facilitating, stimulating and/or a directing role;
2. No ideally organized PCP setting exists (yet), but seven enablers for PCP are found.

The first conclusion is based on the fact that according to literature and the interviewed experts the most appropriate role for a health insurer in (the development) of PCP is a facilitating, stimulating and/or a directing role. The most suitable role for a health insurer in PCP depends on its context and subject. For instance, sustainable local cooperation (2, 25), willingness to cooperate (25), market share of a health insurer, present knowledge and competences in PCP (17, 33), coordination on location (17), type of medical intervention (34) and the possible incentives to be used.

The second conclusion is based on the fact that literature does not provide a blueprint for PCP and the interviewed experts neither had a solution for an ideally organized PCP. But from the interviewed experts emerged seven enablers for PCP, so these enables could be taken into account when one will start up or create a PCP initiative.

All results, as described in this chapter, are plotted in tables of the RMPCP. In this section are the enablers, roles and incentives plotted in the RMPCP figure, see Figure 4.1. Most enablers, roles and incentives are applicable for both functional and normative enablers and for organizational and professional integration. This implies that a health insurer could, if it takes a directing, stimulating or facilitating role, apply six out of seven enablers and it could apply all incentives. So, a health insurer can interfere in the extent in which services across different organizations and disciplines are organized. And it can interfere in the extent in which for instance support, back-office functions, values and mission are shared or coordinated.

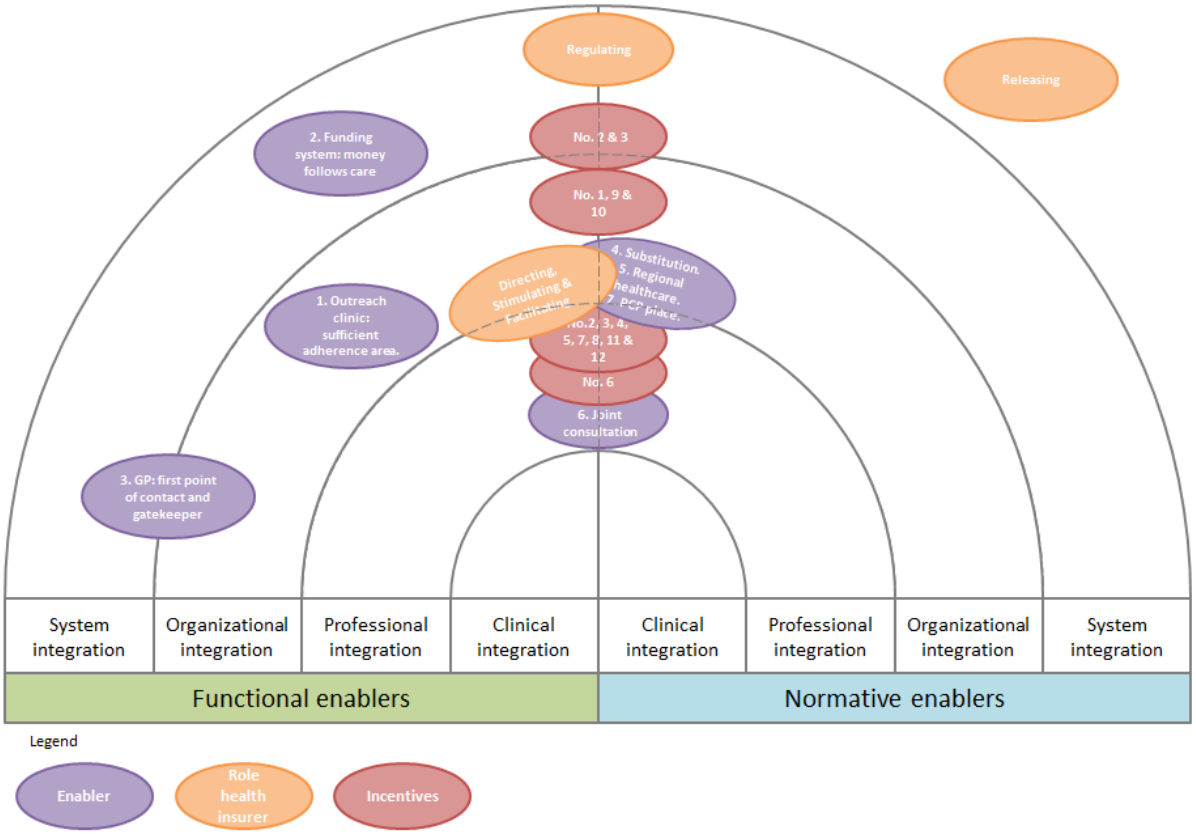

Figure 4.1: Enablers, health insurer roles and incentives plotted in the RMPCP

5. Opportunities for improvement for PCP in the Netherlands

This chapter describes the visited practices, Sûnenz, Antonius, ECT and Thermion. It further describes the practice experience with PCP and other experiences regarding PCP, for example their expectations of the health insurer. Thereafter we will present a ranking of the success and failure factors of the visited practices and at last we describe the provided PCP types. Results from this chapter will be plotted with the integration types and enablers of the RMPCP and will be visualized in the RMPCP figure. This chapter will give answer to sub-question 2, "What opportunities for improvement does the current PCP in the Netherlands have?".

5.1. Description of PCP centres

Primary Care Plus centre Sûnenz

Primary Care Plus centre Sûnenz is one of the longest and few running PCP centres in the Netherlands, Sûnenz is located in Drachten. Sûnenz benefited some years ago that a nursing home needed to be rebuild. At that time directors in the region believed that healthcare was changing and that the region needed to change to. A GP wanted for example 'GP beds' (now: primary care beds) and by means of other projects a PCP way of thinking has arisen. So, by a combination of chance, vision and courage Sûnenz has arisen.

Sûnenz expects from health insurer that it will think along with a common vision. But Sûnenz also would like to see that the health insurer should take more initiative for PCP projects, it should stimulate PCP and it should create a proactive attitude from the hospitals regarding PCP. Sûnenz suggests that if one would like to set up PCP, then all stakeholders should go for it, they should invest time in the development and they should dare to take risks.

Sûnenz believes that a behavioural change of healthcare professionals and patients can be realized by informing them well. But a financial incentive will also work states Sûnenz. When one looks at research results of patient satisfaction in Sûnenz then one can conclude that patients are satisfied. Patients prefer Sûnenz approximately 50% more than the hospital and one can also conclude that deductible plays a role for choosing Sûnenz, because 70% chose for Sûnenz because their deductible would not be harmed.

Health centre in hospital Antonius

Health centre in hospital Antonius, located in Oostburg, is the shortest running healthcare centre where one wants to provide PCP care. Environmental factors of Antonius are its location in a shrinkage region and at the border of Belgium, for this reason it has to deal with aging, rejuvenation and some inhabitants who consume care in Belgium. Antonius is created because the pharmacy in Oostburg needed a new location, the hospital had financial problems and unused space. For this reason a win-win situation could be created and other stakeholders joined. Health centre Antonius has two operations rooms for small, relative simple operations, but these were not in use during the interview. At the moment Antonius does not provide PCP care, but this is the intention for the near future. Antonius is positive about the municipality because it thought along in the development. According to Antonius the health insurer should procure health integrally, especially in a region where Antonius is located.

ECT Tiel

ECT Tiel is a primary care centre where one wanted to provide PCP, ECT drafted a so called 'Breakthrough Program for PCP' (80). ECT lies in a similar region as Twente, for these two reasons is chosen for ECT. ECT is located in Tiel and according to ECT located in a relatively defined area. Twelve years ago Tiel had a GP succession problem, for this reason stakeholders found each other and a primary care centre, ECT, was created to secure the continuum of future care in Tiel. In 2012 directors of the health insurer, hospital and ECT found each other and came up with the Breakthrough Program for PCP. This program was a new, visionary, way of thinking on how care in that region could be organized, independently from the care lines. But this initiative never got implemented because the health insurer did not want to give financial guarantees to the hospital. ECT's cooperation experience with directors and medical specialist in salaried employment is good (they were even initiators), but ECT's experience with independent medical specialists is less good, this because they are more of 'struggling along' (in Dutch: meestribbelen).

Nowadays, ECT thinks that care will be substituted, because health insurer will shorten hospital budget. This is different compared to 2012 and that's fine for ECT but ECT wants care to be substituted at a proper way. ECT finds it difficult to make good business cases because evidence is hard to find and assumptions need to be made. ECT indicates that new initiatives come in most causes from the healthcare professionals, this because they run into a problem and want to solve it.

ECT thinks that PCP can be more stimulated by (threat of) outsourcing, this because competition might work stimulating for current stakeholders to cooperate in PCP. Other suggestions of ECT are sharing best practices from elsewhere, shorten hospital budget and to make hospitals aware of their social responsibility in healthcare. ECT would like to see that health insurers become reliable, transparent and that care can be discussed on content. Health insurers should have trust in the professionality and competences of healthcare professionals, regarding costs and quality of provided care. ECT also mentions that it is important that all stakeholders interests become clear, so this can be taken into account or resolved.

Academic health centre Thermion

Thermion is an academic health centre, located in Lent, which has a partnership with Radboudumc (university medical centre), for this reason is chosen for Thermion because we hoped that this would lead to interesting results. In recent years Lent has grown because of construction of a new neighbourhood, population in Lent increased. The old health centre Thermion became too small and for that reason is searched, in cooperation with other disciplines, for a new location. Next to that wanted Radboudumc connect itself to Thermion.

The PCP types, provided in Thermion depends on the interest of the GP and what may be substituted by the hospital. For instance, Health Bridge, but this did not work because it was hard to consult a patient with a virtual medical specialist at the same time (12). Thermion believes that intrinsic motivation of GPs and medical specialists are most important in setting up PCP. Next to that believes Thermion that clear communication and a good motivation towards patients is important to convince them in receiving PCP.

According to Thermion, thinks the health insurer along with projects and innovative care. But the health insurer expects from healthcare professionals that they will provide business cases with corresponding numbers about health gains and/or potential cost savings. Thermion would like to see, for that matter, a more facilitating role of the health insurer, for example providing a format for business cases or best practices elsewhere. Next to that experiences Thermion the funding of care as complicated. Thermion thinks that it would be more easily if it would receive money from the health insurer, had more spending freedom and the ability to declare afterwards what it did with the received money. This implies that Thermion would like to receive more trust of the health insurer.

PCP centres plotted in the RMPCP

The PCP centres are plotted in Table 5.1 with the integration types of the RMPCP. In the most left column the PCP centres are indicated, divided among the two different enabler types, functional and normative. In the four right columns are the four different integration types indicated, system, organizational, professional and clinical integration. The PCP centres are plotted (indicated with 'X') with the different integration types.

All PCP centres are applicable to organizational and professional integration and to functional enablers. This because back-office work and supportive functions are coordinated on an organizational or professional level, for instance contracting of care and cooperation with secondary care organizations. Antonius is the only centre which did not provide (during the interview) PCP, but functional enablers were already present, for instance establishment of healthcare professionals in the same building. For that reason clinical integration is not applicable, but organizational and professional integration are. Sûnenz is a true PCP centre, it only provides PCP, ECT is a primary care centre and has the ambition to create a regional integrated healthcare and provides most PCP types. For these reasons both centres are applicable for organizational, professional and clinical integration. And because, both centres want to or have developed and implemented a PCP way of thinking, normative enablers are the foundation for this success.

Table 5.1: PCP centres plotted in the RMIC

PCP centre	System integration	Organizational integration	Professional integration	Clinical integration
Functional enablers				
Antonius		X	X	
Thermion		X	X	X
Functional and normative enablers				
Sûnenz		X	X	X
ECT		X	X	X
Normative enablers				
None				

5.2. Success and failure factors

During the interviews the respondents of the visited practices are asked to make a ranking of success and failure factors of PCP and substitution. From the interviews appeared also some additional success and failure factors, these were not included in the ranking of factors. The ranking which emerged from this is presented in Table 5.2. The individual rankings from each practice is given in Table 5.3, the initial average and ranking, the lowest and highest deviation of the average deviation, the corrected average and ranking. The used method for ranking the success and failure factors are described in Paragraph 3.3.

Ranking of PCP success and failure factors

Table 5.2: Ranking of success and failure factors

Ranking no.	Success and failure factor
1	A common vision and ambition.
2	Healthcare professionals have to give form and content to a PCP initiative.
3	Invest in building a solid trust relation between involved stakeholders.
4	Create a win-win situation and take all stakeholders interests into account.
5	Appoint a leader at an administrative and at a healthcare professional level.
6	Financial preconditions are essential for good cooperation.
7	Appoint an external, independent integrator/program/project leader.
8	Monitor or evaluate cooperation based on the progress of realization of ambition and objectives.
9	Some form of organization seems to be important, for example an administrative consultative body.
10	Facilitate cooperation with a 'flanking policy' at staff support, education, information exchange and develop common ICT.
11	Keep up the pace.
12	There needs to be (municipal) governmental support.

Explanations for deviations

This subsection describes the explanations for the deviations from the average deviation, see Table 5.3. The sequence is based on the ranking of factors in Table 5.2.

1. No deviations.
2. Antonius ranked this factor as eight. But from the transcribed interview appeared that this factor is not applicable for Antonius, for that reason this factor is excluded for Antonius.
3. Antonius ranked this factor as first, from the transcribed interview appeared that this factor was of great importance.
4. Thermion ranked this factor as eleventh, this because this factor was not applicable. For that reason this factor is excluded for Thermion. Sûnenz and Antonius ranked this factor as third, Thermion raised the average with their ranking, causing a higher deviation from average deviation.
5. ECT ranked this factor as second, from the transcribed interview appeared that this factor was of great importance.
6. Sûnenz ranked this factor as second and ECT ranked this factor as ninth, both causing a deviation from average deviation. But from the transcribed interview did not appear that this factor was of great importance for Sûnenz, one would rather expect that this factor was or more importance for ECT. Although it is ranked this way, this factor was applicable for both practices. For these reasons this factor stands out, but is not excluded for Sûnenz or ECT.
7. ECT ranked this factor as eleventh, this because this factor was not applicable. For that reason this factor is excluded for ECT. Antonius ranked this factor as second, from the transcribed interview appeared that this factor was of great importance.
8. Antonius ranked this factor as twelfth. But from the transcribed interview appeared that this factor is not applicable for Antonius, for that reason this factor is excluded for Antonius.
9. No deviations.
10. ECT ranked this factor as third, causing a deviation from AD. But from the transcribed interview did not appear that this factor was of great importance for ECT neither it was applicable for ECT. For that reason this factor stands out, but is not excluded for ECT.
11. No deviations.
12. No deviations.

Table 5.3: Scores and ranking success and failure factors

Factor no.	Success and failure factors	Sûnenz	ECT	Ther-mion	Anto-nius	Initial avg.	Initial ranking	Lowest deviation from AD	Highest deviation from AD	Corrected avg.	Correct ranking
1	A common vision and ambition.	1	1	1	4	1,75	1	0,75	2,25	1,75	1
2	Create a win-win situation and take all stakeholders interests into account.	3	7	11	3	6,00	6	3,00	5,00	4,33	4
3	Invest in building a solid trust relation between involved stakeholders.	4	6	6	1	4,25	2	3,25	1,75	4,25	3
4	Appoint a leader at an administrative and at a healthcare professional level.	7	2	4	7	5,00	5	3,00	2,00	5,00	5
5	Some form of organization seems to be important, e.g. an administrative consultative body.	6	8	10	5	7,25	8	2,25	2,75	7,25	9
6	Appoint an external, independent integrator/program/project leader.	8	11	7	2	7,00	7	5,00	4,00	5,67	7
7	Healthcare professionals have to give form and content to a PCP initiative.	5	4	2	8	4,75	3	2,75	3,25	3,67	2
8	Monitor or evaluate cooperation based on the progress of realization of ambition and objectives.	9	5	5	12	7,75	9	2,75	4,25	6,33	8
9	Facilitate cooperation with a 'flanking policy' at staff support, education, information exchange and develop common ICT.	10	3	8	10	7,75	10	4,75	2,25	7,75	10
10	Financial preconditions are essential for good cooperation.	2	9	3	6	5,00	4	3,00	4,00	5,00	5
11	There needs to be (municipal) governmental support.	12	12	12	9	11,25	12	2,25	0,75	11,25	12
12	Keep up the pace.	11	10	9	11	10,25	11	1,25	0,75	10,25	11
						Avg. deviation (AD)		2,83	2,75		
	Additional success and failure factors, not scored during the interviews.										
13	*Cooperation with another healthcare organisation/building. For instance a nursing home, because of 24/7 care is primary care beds possible.*										
14	*Clients could regularly and unconsciously be monitored. Because PCP was provided in combination with welfare and enjoyment, so clients came voluntary.*										
15	*Inclusion of elderly unions, because they can be good ambassadors for the target group.*										
16	*Having a common sense of urgency or "common enemy" works more binding than creating a common vision, because then one cannot take its own interest into account.*										

Legend for Table 5.3

Deviating values from average deviation.

Deviating factor can be explained.

Excluded deviating factor.

Deviating factor cannot be explained.

Success and failure factors plotted in the RMPCP

Organizational integration is applicable to all success and failure factors, with the exception of factor no. 7 "Healthcare professionals have to give form and content to a PCP initiative", see Table 5.4. This factor is specific for healthcare professionals and for that reason only applicable to professional integration. The same applies to factor no. 14, this factor is specific applicable to clients and for that reason to clinical integration.

Twelve out of sixteen factors are applicable to professional integration, so four are not applicable to this type of integration. For instance, no. 15 "Inclusion of elderly unions, because they can be good ambassadors for the target group". In the cooperation/inclusion of the elderly unions, no (healthcare)professionals got involved, for that reason professional integration is not applicable. Another example is no. 11 "There needs to be (municipal) governmental support". At an organizational or at a (regional) policy level are organizational or system integration applicable because this factor refers to the alignment of rules and policies within a system or it refers to the extent in which organizations coordinate services across different organizations. The no. 1 ranked success factor "A common vision and ambition" is divided among the normative enablers because it refers to the extent in which vision and work values are shared and drafted in a system. This factor is applicable to organizational and professional integration because it refers to the extent in which services across different organizations and disciplines are coordinated, for instance shared work values or clarity about responsibilities.

Table 5.4: Success and failure factors plotted in the RMIC

Success and failure factors	Syst. int.	Org. int.	Prof. int.	Clin. int.
Functional enablers				
6. Appoint an external, independent integrator/program/project leader.		X	X	
10. Financial preconditions are essential for good cooperation.		X	X	
11. There needs to be (municipal) governmental support.	X	X		
13. Cooperation with another healthcare organisation/building. For instance a nursing home, because of 24/7 care is primary care beds possible.		X		
Functional and normative enablers				
2. Create a win-win situation and take all stakeholders interests into account.		X	X	
4. Appoint a leader at an administrative and at a healthcare professional level.		X	X	
5. Some form of organization seems to be important, e.g. an administrative consultative body.		X		
7. Healthcare professionals have to give form and content to a PCP initiative.			X	
8. Monitor or evaluate cooperation based on the progress of realization of ambition and objectives.		X	X	
9. Facilitate cooperation with a 'flanking policy' at staff support, education, information exchange and develop common ICT.		X	X	
12. Keep up the pace.		X	X	
15. Inclusion of elderly unions, because they can be good ambassadors for the target group.		X		
Normative enablers				
1. A common vision and ambition.		X	X	
3. Invest in building a solid trust relation between involved stakeholders.		X	X	
14. Clients could regularly and unconsciously be monitored. Because PCP was provided in combination with welfare and enjoyment, so clients came voluntary.		X	X	X
16. Having a common sense of urgency or "common enemy" works more binding than creating a common vision, because then one cannot take its own interest into account.		X	X	

5.3. Provided PCP types

During the interviews the respondents were asked what types of PCP care are provided in their practices. This resulted in the outcomes given in Table 5.5. One can see that Sûnenz provides most types of PCP, see (81, 82). This might be caused by the fact that Sûnenz is a full-fledged PCP centre and is the longest running, visited, PCP centre. Antonius already had facilities for PCP, but was not yet in use during the interview. This is caused by the fact that Antonius just has been opened. ECT provides also most types of PCP, typically in cooperation with stakeholders in their region. For example primary care beds, ultrasound in the hospital, e-mental health programs, expertise centrum for speech therapy, psychology, physiotherapy, orthopaedics, dietetics etc., and it has a wound expertise network in cooperation with home nurse organizations. This might be caused by the fact that ECT is located in a relatively defined area, where stakeholders know each other well. Thermion provides some specific types of PCP, especially specialized GPs and practice nurses. This might be caused by the fact that Thermion is an academic health centre.

Some types of PCP do appeal patients deductible, see the remarks in Table 5.5. This is interesting because according to the definition of PCP is PCP, care that is funded from the primary care financial framework. In addition, it is noticeable that some types of PCP care are actually secondary care but provided in primary care (or even in the hospital), appealing patients deductible and funded from the secondary care financial framework. One logically can doubt about the actual purpose of this type of PCP care, because it appeals the patients deductible. One could according to the definition of this study better speak about integrated care, instead of PCP. This difference might be caused by the fact that each practice or region has its own definition or elaboration of PCP.

Substitutable care products

The most common substitution diseases are cardiovascular risk management (CVRM), insertion and removal of a coil (intrauterine device, IUD), substitution of emergency care to GP posts, ENT care, dermatology, cardiology, osteoporosis, eye care, diabetes mellitus type II, Chronic Obstructive Pulmonary Disease (COPD), mental healthcare practice support for GPs (POH-GGZ) and elderly care (83).

Additionally, Menzis composed, in cooperation with a hospital, a substitution list with care products which could be substituted (n=244). A part of this list (in Dutch) is given in Appendix I, an example of this list is [Consult at outpatient clinic for high blood pressure]. When one knows what role the health insurer could take in the development of PCP, then it could take these substitutable care products into account.

Table 5.5: Provided PCP care practices

Practice	Type of PCP care	Remark
Sûnenz	Region poli (joint consultation)	For specific treatments and diagnostics, see ICPC-referral indications Sûnenz and GP referral instructions (81, 82). Consults in region poli does not harms patients deductible, diagnostic tests do.
	22 Primary care beds	
	Geriatric Advice and Treatment Centre	
	Small chirurgic operations	
Antonius	Antonius has two operation rooms for small, relative simple operations.	Not yet in use.
ECT	Joint consultation psychiatrist	
	Joint consultation specialist geriatric medicine	
	In the past: Joint consultation paediatrician	Not anymore because no waiting lists and not enough problems.
	Primary care beds	A foundation arranges this in Tiel.
	Secondary care diagnostics (blood puncture)	Appeals patients deductible.
	Ultrasound in the hospital	Appeals patients deductible.
	Teleconsultation	Not centrally regulated, 1 or 2 GPs are doing this.
	E-mental health programs	GGZ in primary care.
	Expertise centrum for speech therapy, psychology, physiotherapy, orthopaedics, dietetics etc.	Integrated care for children with multiple problems.
	Wound expertise network	A home nurse provides wound care at home.
Thermion	(child) Psychiatry	
	Ophthalmology (fundus photos)	Two specialized practice nurses and a GP. With a doctor in training as specialist.
	Gynaecological consultation hour	Specialized GP.
	Vasectomy	
	Tele-dermatology	
	CRP pricking	Respondent did not know if these two types harmed the deductible.
	ECG's and 24care (Holter hart monitoring)	
	In the past: Health Bridge	Not anymore because of logistic problems (12).

Types of PCP care plotted in the RMPC

In Table 5.6 are the provided types of PCP of the visited practices divided among the seven PCP types found in literature. One can see that some types of PCP are more comprehensive than others, for instance substitution of low complex interventions or joint consultation compared to primary care beds. Because every type of PCP, presented in Table 5.6, is implemented, clinical integration is applicable. For instance primary care beds, this type of PCP refers to the extent in which care services are coordinated across various disciplines and organizations. Diagnostics nearby and GPwSI are not applicable to normative integration because this refers to the extent in which missions, work values etc. are shared within a system. Diagnostics nearby and GPwSI are two examples of care services which can be provided by a single healthcare provider or practice. For that reason work values about these two PCP types do not necessarily need to be shared with other healthcare professionals, so it is not applicable for normative integration. These two types do apply for functional integration because it refers to the extent in which back-office and support functions are coordinated.

One PCP type, joint consultation, is applicable for system integration, this because the NZa (Dutch Healthcare Authority) made it possible to declare joint consultations with a fixed, integral tariff. At last, the wound expertise network is in fact not PCP, but could be better defined as ½ line care. This because this care is provided by home care nursing, this prevents admissions in the hospital, so it totally skips an eventually PCP. But it does meet the denominator, substitution of low complex interventions.

Table 5.6: PCP types plotted in the RMIC

Type of provided PCP	System integration	Organizational integration	Professional integration	Clinical integration
Functional enablers				
Diagnostics nearby				
- CRP pricking, blood puncture				X
- ECG's and 24care (Holter hart monitoring)				X
GP with special interest (GPwSI)				
- Ophthalmology (fundus photos)				X
- Vasectomy				X
Functional and normative enablers				
Substitution of low complex interventions				
- Secondary, outpatient, consults		X	X	X
- Small chirurgic operations			X	X
- Wound expertise network		X	X	X
Specialist outreach clinic				
- Geriatric Advice and Treatment Centre			X	X
- Expertise centrum for multiple healthcare professionals		X	X	X
EHealth				
- E-mental health programs				X
- Teleconsultation, e.g. tele-dermatology			X	X
Joint consultation				
- Joint consultation of (child) Psychiatrist, geriatric medicine, internal medicine, gynaecologist or pulmonologist.	X		X	X
Primary care beds				
- Primary care beds		X	X	X
Normative enablers				
- *None*				

5.4. Conclusion two

This chapter was aimed to give answer on sub-question 2, "What opportunities for improvement does the current PCP in the Netherlands have?". Based on the interviewed representatives of the visited practices, one can conclude that:

- A common vision and ambition is experienced as most important in the development of PCP;
- Seven types of PCP exist and are applied in practice, but all types are not applied in every practice;
- Literature provides diseases which could be substituted, Menzis composed a substitution list with care products which could be substituted to primary care (plus).

The first conclusion is based on the fact that sixteen success and failure factors are identified, of which twelve factors are ranked. Based on this ranking one can conclude that a common vision and ambition is experienced as most important for the development of PCP. Stakeholders of PCP in the Netherlands should take these success factors into account in developing PCP projects. Interestingly, two out of the first five factors are plotted as normative enablers and three factors are plotted as functional and normative enablers. This implies that (only) 'hard' functional enablers are not necessarily the starting point for a PCP initiative, for a successful PCP initiative are normative enablers considered to be of more importance. This corresponds to findings of Valentijn as described in the literature review.

The second conclusion is based on the fact that seven types of PCP are identified in literature and are applied in the visited practices. But all types of PCP are not applied in every practice, for example GP with special interest was applied in only one visited practice. For that reason healthcare centres could take the seven PCP types as starting point and could by means of this expand their PCP services.

The third conclusion is based on the fact that literature provides diseases which are eligible to substitute. Literature or dome organizations for healthcare do not provide a list with substitutable care products. For that reason Menzis composed a substitution list with care products which could be substituted, this list is reviewed and adjusted by a hospital. Menzis could share this list with healthcare (dome) organizations in the Netherlands, so the Dutch healthcare can benefit from this.

All results, as described in this chapter, are plotted in tables of the RMPCP. In this section are the PCP centres, success and failure factors and types of PCP plotted in the RMPCP figure, see Figure 5.1. When one looks at Figure 5.1, one could state that it is important to take 'soft' normative enablers into account when starting up PCP. This because two (successful) PCP centres accomplish both enabler types, in contrast to the two other centres and because normative success factors are experienced of more importance. Next to that, when one wants to work towards an integrated healthcare (PCP) then one needs to work at all different types of integration (19). For that reason, most profit can be gained at a system integration level, for instance a steering role of the regulatory framework for substitution of care. This because only two results are plotted at a system integration level.

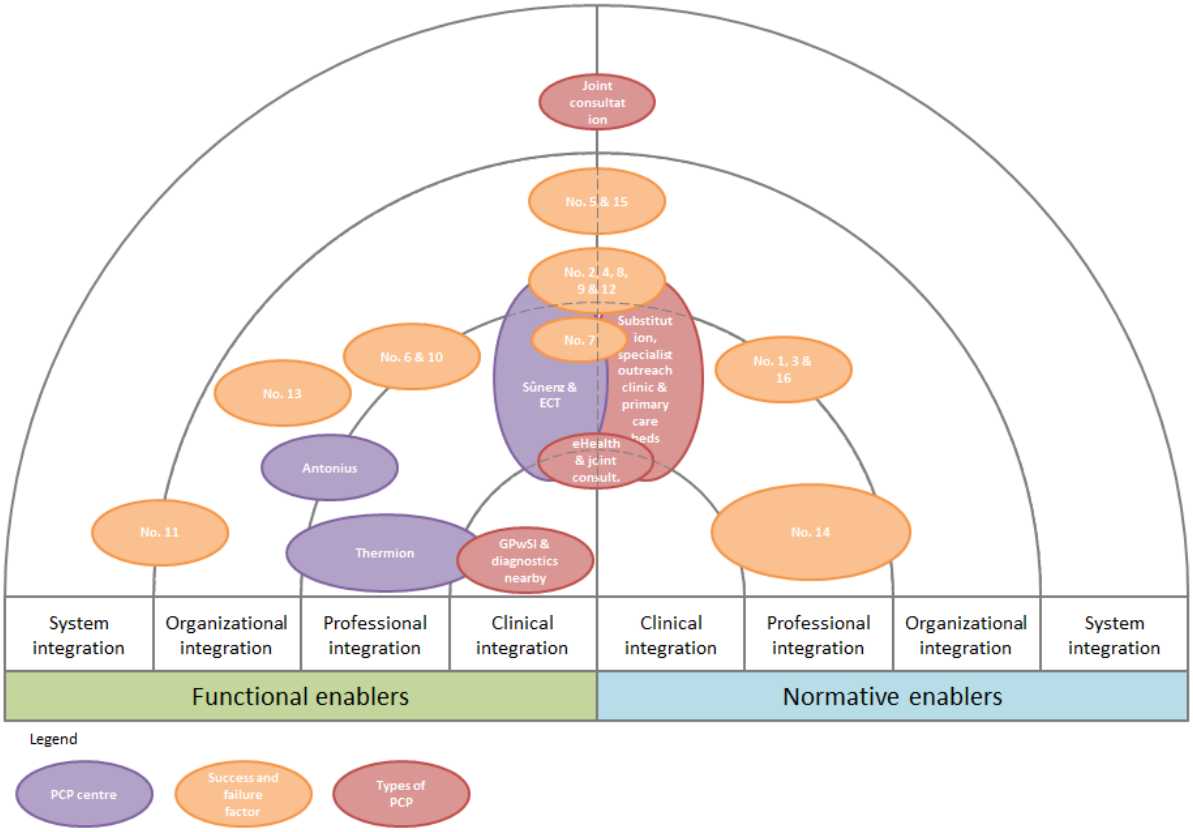

Figure 5.1: PCP centres, success and failure factors and types of PCP plotted in the RMPCP

6. PCP in Twente

This chapter describes the roles of the involved stakeholders and the current PCP projects in Twente. Next to that, we describe the opportunities, risks and needs which came forward from the interviews with the involved stakeholders. At last, results from this chapter are plotted with the integration types and enablers of the RMPCP and will be visualized in the RMPCP figure. This chapter will give answer to sub-question 3, "What is the current state of PCP in Twente?".

6.1. Roles of the involved stakeholders in Twente

ZGT sees for itself an important role in PCP, for instance a staff supplying role (nurses and medical specialists). Next to that wants ZGT to determine which care can be substituted to PCP. Which care this will be depends for ZGT on the hospital profile and how this care, in cooperation with the primary care, can be substituted. MST sees for itself an initiating role in substitution projects, in cooperation with involved stakeholders, to improve in and outflow of hospital patients. For MST lies the focus in PCP mainly on reducing hospital admissions. MST sees inefficiencies in the current patient in and outflow process and for this reason a steering group on substitution is founded to improve, integrally with primary care, this process.

Both care federations, THOON and FEA, see for itself a facilitating role in PCP. It wants to arrange financing, logistics, taking care of the start and implementation of PCP projects. Both care federations work on behalf of the general practitioners in the region of Twente. THOON represents mainly GPs in the city's Enschede, Hengelo, Oldenzaal and surrounding cities and villages. FEA represents GPs in the city Almelo and surrounding villages.

Health insurer Menzis is a cooperation which represents 2,2 million insured persons in the Netherlands. Menzis represents approximately 315.000 insured persons in the region Twente (50% market share) (84). The role of Menzis in PCP is to purchase qualitatively good care, for an affordable price. For this reason PCP, financed by Menzis, needs to have an efficiency gain of at least 33%.

Medical Staff of ZGT (Coöperatie Medisch Specialisten) and MST (Medisch Stafbestuur) see for itself a healthcare providing role in PCP in cooperation and interaction with GPs. It sees for itself the role to determine, in cooperation with GPs, the desired development of PCP. By means of that they can determine what specific role they could take.

At last, Zorgnetwerk Zenderen, facilitated by Roset, is created to bring all involved stakeholders in the region of Twente together. In order to discuss transitions in healthcare, this resulted in five administrative theme groups, among other for primary and secondary care. A coordination group in Zorgnetwerk Zenderen has been held responsible for the progress of these theme groups. Zorgnetwerk Zenderen is a network organization which facilitated discussions between all involved stakeholders in Twente. In Figure 6.1 one can see the connections of the involved stakeholders in Twente regarding PCP.

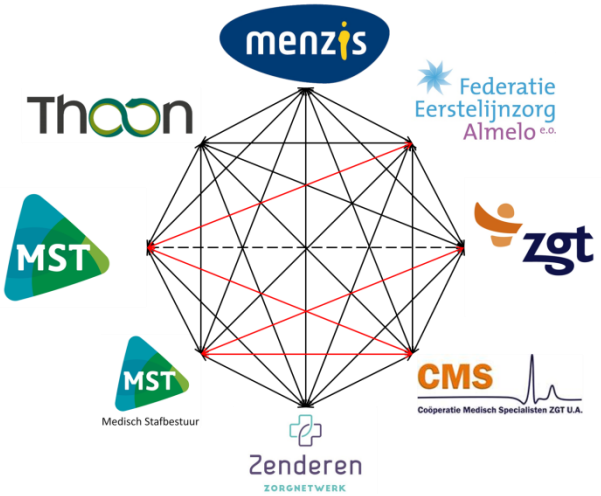

Figure 6.1: Connections of involved stakeholders in Twente in PCP

The black lines in Figure 6.1 imply a connection between both stakeholders regarding PCP, the red line implies no connection and the dashed line implies a connection but Menzis does not know if PCP will be discussed between them, this is the case for the connection between MST and ZGT. THOON, Zorgnetwerk Zenderen and Menzis have a connection with all stakeholders, MST and FEA, MST and CMS, MST medical staff and ZGT and MST medical staff and CMS have no connection with each other.

6.2. Current PCP projects in Twente

At the moment multiple PCP projects are present in Twente, these projects with its explanation and the involved stakeholders are described in Table 6.1. From the seven PCP types are (specialist) outreach clinic, eHealth and primary care beds at the moment not applied in the region of Twente.

Table 6.1: PCP projects in Twente

PCP project	Explanation	Involved stakeholders
Ophthalmology	Optometrists are deployed in primary care for diagnostics.	THOON, MST, ZGT (Hengelo), Menzis.
Dermatology	Joint consultation of GP and medical specialist once or twice a month, resulting in specialized GPs.	THOON, MST, ZGT (Hengelo) Menzis.
ECMS (one-off consultation medical specialist).	GPs are able to let patients consult a specialist once and get, when possible, their patient back with an advice for treatment (only applicable for three diseases).	THOON, MST, Menzis.
Shoulder one-off consultation hour.	GPs refer patients with shoulder complaints to physiotherapists for diagnostics only (ultrasound).	Individual GP groups, MST, physiotherapists, Menzis.
Osteoporosis	Case-finding, treatment and referring back of patients with osteoporosis.	THOON, MST, Menzis.
Eye opener	Deployment of optometrists in secondary care against primary care tariffs.	FEA, ZGT, Menzis.
In development	*This does not mean that these projects actually will be implemented.*	
Atrial Fibrillation (AF)	Case-finding of patients with AF in primary care.	FEA, THOON, ZGT, MST, Menzis.
Sleep apnea detection	Case-finding of patients with sleep apnea in primary care.	FEA, THOON, ZGT, MST, Menzis.
Osteoporosis	Scaling up of afore mentioned project in FEA area.	FEA, THOON (Hengelo), ZGT, Menzis.

6.3. Opportunities and risks for PCP in Twente

This section describes all different opportunities and risks resulting from the stakeholders interviews. Section 6.3.1 describes the opportunities for the development of PCP and these will be plotted in the RMPCP table. Followed by Section 6.3.2 the risks for the development of PCP, also plotted in the RMPCP table. In Figure 6.2 are both opportunities and risks and the resulting plotted in the RMPCP figure.

6.3.1. Opportunities for PCP in Twente

The eight opportunities for the development of PCP in Twente are plotted in Table 6.2 with the integration types of the RMPCP. In the most left column the opportunities are indicated, divided among the two different enabler types, functional and normative. In the four right columns are the four different integration types indicated, system, organizational, professional and clinical integration. The opportunities are plotted (indicated with 'X') with the different integration types. Further on will all opportunities pointwise be explained. Some opportunities will be substantiated how it is plotted.

Table 6.2: Opportunities plotted in the RMPCP

Opportunities for PCP	Syst. int.	Org. int.	Prof. int.	Clin. int.
Functional enablers				
1. Clarifying the preconditions of a PCP project and making a simplified (concept) business-case.		X	X	
Functional and normative enablers				
2. Making use of environmental factors, e.g. making use of GP posts or scaling up one-off consultation medical specialists.		X	X	
3. (Re)designing care pathways with e.g. the social domain, technology and eHealth.	X	X	X	X
4. The baffles of healthcare might fade away in combination with creating a new funding system.	X	X	X	
5. Another deployment of healthcare professionals.			X	
6. A pro-active, co-leading, open-minded and facilitating role is expected from Menzis.		X		
7. Zorgnetwerk Zenderen is easy to activate again.		X		
Normative enablers				
8. Determining a clear, common vision, in order to know where to work towards with PCP.		X	X	

1. Clarifying the preconditions of a PCP project and making a simplified (concept) business-case.

Possible initiatives need to be proposed by means of a business case, but the involved stakeholders experience a business-case as a bureaucratic, time and energy consuming mandatory task. If a PCP proposal meets the Triple Aim principles, care groups and hospitals experience it as unnecessary task for small PCP projects. But the health insurer wants it to be substantiated in a business-case. For this reason a solution might be that the (concept) business case will be simplified for a provisionally go or no-go or healthcare providers could be facilitated by an external project manager/facilitator to set up a business case. In this context the involved

stakeholders would like to see more clarity about the preconditions of a PCP project. Next to that would care groups like to see more clarity about who they can contact in hospital for PCP projects.

This opportunity is applicable for organizational and professional integration because it refers to the extent in which organizations and professionals want to coordinate services, in this case clarity about preconditions of a PCP project, across different organizations and disciplines. Because this opportunity is about back-office and supporting functions for a PCP project, it is plotted as a functional enabler.

2. *Making use of environmental factors, e.g. making use of GP posts or scaling up one-off consultation medical specialists.*

Making use of environmental factors might work as a successful strategy for the development of PCP. First of all a concrete opportunity, the one-off consultation of medical specialists had enough support in the pilot group, so one thinks that this can be scaled up. Another environmental example is a bad financial situation of a hospital, because hospital then might be more inclined to substitute care. The use of the GP post is also suggested as an opportunity, this because GP posts are used in daytime. If this opportunity will be taken then the next opportunity might arise that GPs and medical specialists will provide care at central places in the region (for specific patient groups).

3. *(Re)designing care pathways with e.g. the social domain, technology and eHealth.*

The involved stakeholders believe that care pathways, for specific target groups, needs to be integrally determined by GPs and medical specialists, so the whole care chain will be involved. A suggested opportunity is that social domain might be involved in PCP. PCP might lead to a redesign of healthcare and for this reason the opportunity will arise that technology or eHealth, for example home monitoring, can easily be implemented. The expected labour shortage might also be tackled with redesigning the regional healthcare.

This opportunity is applicable for all four types of integration in the RMPCP. Because this opportunity has influence on all types of integration, it wants to (re)design care pathways with for instance social domain and incorporate technology and eHealth. Because this opportunity has influence on both back-office and supporting functions and the extent in which missions, work values are shared in and might change a system it is plotted for functional and normative enablers.

4. *The baffles of healthcare might fade away in combination with creating a new funding system.*

One sees the opportunity that the baffles of healthcare might fade away by PCP. Because the involved stakeholders believe that PCP will create more cooperation and integration between primary and secondary care. For this reason a new funding system could be created for PCP, detached from the healthcare lines.

5. *Another deployment of healthcare professionals.*

Healthcare professionals might be deployed in different ways. For example, regarding independent medical specialists, one thinks that this might be an opportunity for PCP, because these medical specialists are independent of the hospital and can for that reason easily be deployed in PCP. Another opportunity for PCP is to create GPs with a specialist interest. In line with this are different solutions suggested for changing healthcare, namely; task differentiation, eHealth, substitution of tasks to social domain or self-management. Although it appears that healthcare professionals find it hard to change their healthcare providing role to a more directing role, because they don't have sufficient time to study potential solutions and this is not their priority.

6. *A pro-active, co-leading, open-minded and facilitating role is expected from Menzis.*

A pro-active, co-leading, open-minded and facilitating role is expected from Menzis regarding PCP. It has, for instance, been experienced as desirable when Menzis joins in an initial project phase, because then potential adjustments can be made. The involved stakeholders expect from Menzis that good agreements will be made, that Menzis takes a facilitating role by putting forward PCP best practices and takes risk. The involved stakeholders hope that multi-year contracts can be agreed, so a long term direction can be chosen for PCP. The involved stakeholders believe that healthcare professionals will typically be attracted by the content of a PCP idea, not directly its cost savings. Menzis believes it is powerful when healthcare professionals will suggest ideas by themselves. For this reason a setting could be created in which healthcare professionals will be stimulated to suggest PCP ideas and where healthcare professional(s) will stand up and be initiators for PCP. Although, one believes that Menzis is in the position to give their opinion or preferences about proposals, because Menzis has a co-leading role. For this reason a medical staff board suggested that Menzis should invest in 'care content' personnel, to be able to conduct a substantive discussion with healthcare providers.

7. *Zorgnetwerk Zenderen is easy to activate again.*

The stakeholders believe that good agreements need to be made for PCP and this can be realized by founding a steering group with all involved stakeholders. In this steering group can at first be determined which care

and how this care could be substituted, another advantage might be that more structure can be applied to PCP. In line with this, from the interviews appears that Zorgnetwerk Zenderen is easy to activate again.

8. *Determining a clear, common vision, in order to know where to work towards with PCP.*

From the interviews appears that the involved stakeholders need a clear, common vision, in order to determine where to work towards with PCP. This could be determined in a regional steering group, see opportunity 7. In this steering group one could also brainstorm about the future healthcare in Twente, in combination with social domain, elderly care etc. see opportunity 3. When one may reach consensus about the future healthcare in Twente, one can determine which steps need to be taken and what goals need to be reached in order to work towards an affordable and durable healthcare in Twente. This may possibly result in a new distribution of to be provided care, e.g. one hospital will provide all prostate cancer patients and primary care will provide aftercare. Because this risk is specific focussed on drafting a clear, common vision of both healthcare organizations and professionals is this risk plotted as a normative enabler.

6.3.2. Risks for PCP in Twente

Section 6.3.1 described the opportunities for PCP in Twente. This section describes the risks, which came forward from the interviews with the involved stakeholders of PCP in Twente. The eight risks for the development of PCP in Twente are plotted in Table 6.3 with the integration types of the RMPCP. Some risks will be substantiated how it is plotted.

Table 6.3: Risks plotted in the RMPCP

Risks for PCP	Syst. int.	Org. int.	Prof. int.	Clin. int.
Functional enablers				
1. The baffles of healthcare, because of double financing of PCP.	X	X	X	
2. In case of small, separate PCP projects healthcare might become (more) fragmented.		X	X	
3. Ambiguity how secondary care could be substituted to primary care, because of the expected labour shortage in primary care.		X	X	
4. Not sufficient organized primary care, due to labour shortage, the absence of support and expertise in primary care.		X	X	
Functional and normative enablers				
5. Poor motivation of GPs and medical specialists, e.g. due to the lack of a win-win situation.			X	
6. Ambiguity how a potential revenue decline for the hospital could be solved.		X		
7. Disagreement about the production incentive of medical specialist and not efficient use of medical specialist time.			X	
Normative enablers				
8. The involved stakeholders should take their social responsibility and missing of leadership.		X	X	

1. *The baffles of healthcare, because of double financing of PCP.*

The baffles of healthcare and the funding system of healthcare are considered as a risk for the development of PCP. This because at the moment, substituted care is sometimes still double financed. This is due to the fact that the costs of care are not transparent. For this reason one wants to seek for new ways of financing PCP.

This risk is applicable to system, organizational and professional integration because this risk refers to the alignment and coordination of rules and policies within a system, between different organizations and across various disciplines. This risk is plotted as a functional enabler because it refers to the extent in which back-office and supportive functions are coordinated.

2. *In case of small, separate PCP projects healthcare might become (more) fragmented.*

When all small, separate PCP projects will be implemented, then the risk is considered that healthcare will become (more) fragmented, for instance what happened in England with specialist outreach/outpatient clinics. One medical staff board believes that GPs in the region are already fragmentally organized. This makes it hard for the hospital and/or medical specialists to make agreements with them. Because all GP-patients will come, if necessary, to the hospital. It may be possible that external organizations will jump into the 'PCP market', but it then needs to be well arranged. This because it is most important that healthcare needs to be provided close to the patients home and this is a logistical problem. For these reasons one thinks that larger, structural projects are more desirable and this can be best controlled by an integral steering group.

3. *There is ambiguity about how secondary care could be substituted to primary care, because of the expected labour shortage in primary care.*

From the interviews appears that one does not know exactly how secondary care should be substituted to primary care, this because of the expected capacity/labour shortage in primary care. For this reason it is/will be hard for primary care to manage potential substituted care. From the interviews appears that this is the main problem for PCP. Hospitals namely expect from care groups that they need to manage substituted care. Although do hospitals see that primary care has insufficient support and expertise to manage potential substituted care. For this reason care groups need to be careful in starting up PCP projects. Therefore care groups do not mind if one will start with a small project, because then can support be created among other GPs. In order to manage more substituted care, primary care needs to be reorganized. And because this is an integral problem in the care chain, the stakeholders believe that this needs to be integrally solved in for instance a steering group.

4. *Not sufficient organized primary care, due to shortage of capacity, the absence of support and expertise in primary care.*

The shortage of capacity in primary care is considered as a risk for the development of PCP. This because substituted secondary care needs to be managed in primary care. For this reason one states that primary care needs to be organized better to manage PCP, a possible solution might be that solo or duo GP practices need to be merged. The absence of support and expertise in primary care is also considered as a risk for the development of PCP.

5. *Poor motivation of GPs and medical specialists, due to the lack of a win-win situation.*

Poor motivation of GPs and medical specialists is also considered as a risk for the development of PCP. This might be caused by the fact that all healthcare professionals are 'raised' in the current healthcare system. For GPs applies that when PCP will be imposed to them, they don't want to cooperate quickly. For medical specialists applies that they lose (emotionally) control over their patients, one states that medical specialist find it hard to take a more directing role instead of only a care providing role. For the care federations apply that FEA works more bottom-up and THOON more top-down, this might explain a difference in GPs motivation. For medical specialists applies that when they substitute care, they want to focus more on top clinical care. If this is not possible for medical specialists they might counteract PCP. This shows that a win-win situation is important for medical specialists (85).

This risk is only applicable to professional integration because it refers to the extent in which services, in this case preconditions which result in a good or poor motivation of healthcare professionals, are coordinated across various disciplines. Because these preconditions can be of all kinds, this risk is plotted for both functional as normative enablers.

6. *Ambiguity how a potential revenue decline for the hospital could be solved.*

When secondary care will be substituted, then money needs to follow care, otherwise it will not lead to a cost reduction. When hospitals will not supplement substituted care, what will be hard given the increasing demand of care, then substitution of care may result in a revenue decline of the hospital. From the interviews appeared that this is seen as a threat for hospitals to substitute care and for this reason hospitals see this as a common problem. In addition, the actual care will become cheaper in primary care, but fixed costs for the hospital will remain the same. So if hospitals will supplement care, for instance to meet mortgage payments, than healthcare costs will only increase.

7. *Disagreement about the production incentive of medical specialist and not efficient use of medical specialist time.*

One disagrees about the production or volume incentive of the medical specialists. This because one party believes that this will increase the costs of care and another party believes that because of the turnover limit this is not an issue. One sees no risk for revenue decline for medical specialists, because enough care will remain for hospital as well as in PCP. In case of potential revenue decline one believes that this will have 'emotionally' a greater impact on independent medical specialist, compared to salaried employed medical specialist. Although one does not experience a difference between both types of medical specialists regarding PCP. In case of the one-off consultation of the medical specialist, the specialist is not able to consult outpatients and this is not cost-efficient for the hospital. For this reason one considers that health insurer and hospital have the duty to study and tackle these problems. At last, from the interviews appears that GPs want a financial reward for substituted secondary care and one thinks that healthcare professionals will be motivated for PCP when them will be offered perspective, barriers taken away and creating of (financial) conditions.

8. *The involved stakeholders should take their social responsibility and missing of leadership.*

From the interviews appears that one believes that everybody must take their social responsibility, this in order to realize an affordable and durable healthcare. This implies that everybody needs to be aware of the affordability problem and therefore needs to be able to let go certainties, own interests and domains. In line

with this when no investments of money, time (pace) and courage to take risks will be made, then this is considered as a risk for the development of PCP. One also states that Twente misses leadership to determine the healthcare for the coming five years. Next to that would the involved stakeholders like to see that Menzis should take more risk in starting up a PCP project. Because when hardly any risk will be taken, then it will take a long time before one has experience with PCP. And because this risk is specific focussed on the social responsibility of both healthcare organizations and professionals, this risk plotted as a normative enabler.

6.3.3. Analysis of opportunities and risks

This section will give a short analysis of the stated opportunities and risks. When we look to the opportunities and risks as described in previous sections and when we look to the outcomes from the experts interviews in Chapter 4 and the success and failure factors in Chapter 5, we could state that, keeping Twente outside of thoughts, many opportunities and risks could also be applicable to other regions in the Netherlands. Because the opportunities and risks have many similarities with the outcomes from the experts interviews and/or the success and failure factors. By means of the following example comparisons, this can be explained.

Opportunity no. 3 '(Re)designing care pathways with e.g. the social domain, technology and eHealth' is in line with enabler no. 5 'Organize a regional integrally healthcare, with more cooperation'. Opportunity no. 8 'Determining a clear, common vision, in order to know where to work towards with PCP' is in line with success factor no. 1 'A common vision and ambition'. Opportunity no. 4 'The baffles of healthcare might fade away in combination with creating a new funding system' and risk no. 1 The baffles of healthcare, because of double financing of PCP' are in line with enabler no. 2 'A funding system where money follows care'. Risk no. 5 'Poor motivation of GPs and medical specialists, e.g. due to the lack of a win-win situation' is in line with success factor no. 4 'Create a win-win situation and take all stakeholders interests into account'.

For this reason one could state that the found opportunities and risks could also be applicable to other regions in the Netherlands. Although, specific regional/contextual factors cannot always be generalized and remain for that reason important for (the development) of PCP.

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6.3.4. Needed support for the development of PCP

Based on the opportunities and risks is determined where the involved stakeholders need support regarding the (further) development of PCP in Twente. These eight needs will not be explained, because this is already done in Section 6.3.1 and 6.3.2. The eight needs for support in the development of PCP in Twente are:

1. More clarity about the preconditions of a PCP project (opportunity 1);
2. New ways of financing PCP (opportunity 4);
3. A better organized primary care and a solution for the expected labour shortage in primary, so secondary care can be substituted (risk 3 and 4);
4. A win-win situation, resulting in better motivated healthcare professionals for PCP. For instance, offering perspective, taking away of all kinds of barriers and creating of (financial) conditions (risk 5);
5. Realization of and a solution for a common problem, the revenue decline for the hospital (risk 6);
6. A clear, common vision is needed in order to know where to work towards to in PCP (opportunity 8);
7. A leader at administrative and at healthcare professional level for the development of PCP (risk 8);
8. Awareness of the affordability and durability problem of healthcare. Therefore the involved stakeholder should take their social responsibility and let go certainties, own interests etc. (risk 8).

All these needs are already plotted in the RMPCP tables, for that reason this won't be done again. Although, the needs will be plotted in the RMPCP figure, see Figure 6.2, this is order to clarify its relation with each other.

6.4. Conclusion three

This chapter was aimed to give answer on sub-question 3, "What is the current state of PCP in Twente?". Based on the interviewed stakeholders in Twente one can conclude that:

- The roles of the eight involved stakeholders for PCP in Twente are identified;
- Eight opportunities and eight risks are mapped for (the development of) PCP in Twente, interestingly many opportunities and risks could also be applicable to other regions in the Netherlands;
- Eight needs for support for the involved stakeholders in the development of PCP are identified.

The first conclusion is based on the fact that ZGT and MST see for itself an initiating/determining role in which care will be substituted to PCP, ZGT sees next to that for itself a staff supplying role in PCP. Both care federations, THOON and FEA, see for itself a facilitating role in PCP. Health insurer Menzis sees for itself a

healthcare purchasing role in PCP. Medical Staff of ZGT and MST see for itself a healthcare providing role in PCP in cooperation and interaction with GPs. Zorgnetwerk Zenderen sees for itself, if this is needed, a facilitating role in discussions between involved stakeholders in Twente.

The second conclusion is based on the fact that eight opportunities and eight risks are identified for (the development of) PCP in Twente. Although, if one keeps Twente outside thoughts, than could many opportunities and risks also be applicable for other regions in the Netherlands. This is determined by comparing the opportunities and risks with outcomes of the experts interviews and the found success and failure factors. Although, specific regional/contextual factors cannot always be generalized and remain for that reason important for (the development) of PCP.

The third conclusion is based on the fact that from the opportunities and risks appear eight needs for support for the involved stakeholders in the development of PCP in Twente. We believe that when need no. 8, "Awareness of the affordability and durability problem of healthcare and letting go certainties, own interests etc." will be met, than all other needs can easily be satisfied. This because these problems are integral problems across the whole care chain, for that reason these problems need to be integrally approached. Stakeholders need to be aware of this and need to release own interest. We believe that when the involved stakeholders are willing to do this, then the main obstacle is tackled for the development of an integral healthcare (PCP).

All results, as described in this chapter, are plotted in tables of the RMPCP. In this section are the opportunities, risks and needs plotted in the RMPCP figure, see Figure 6.2. When one looks at Figure 6.2, one could state that almost all opportunities, risks and needs are well divided among functional and normative enablers. Although, one could also state that nearly all opportunities, risks and needs are only applicable for organizational and professional integration. This is (logically) caused by the fact that all respondents work in these domains. For that reason are system and clinical integration less applicable for the interviewed respondents in case of PCP. But the respondents were able to identify multiple opportunities, risks and needs for the development of PCP in Twente. For that reason one can conclude that the involved stakeholder for PCP in Twente are capable in doing a sufficient market exploration for PCP. Because the identified opportunities, risks and needs are well divided among the functional and normative enablers and correspond with found success and failure factors in Chapter 5.

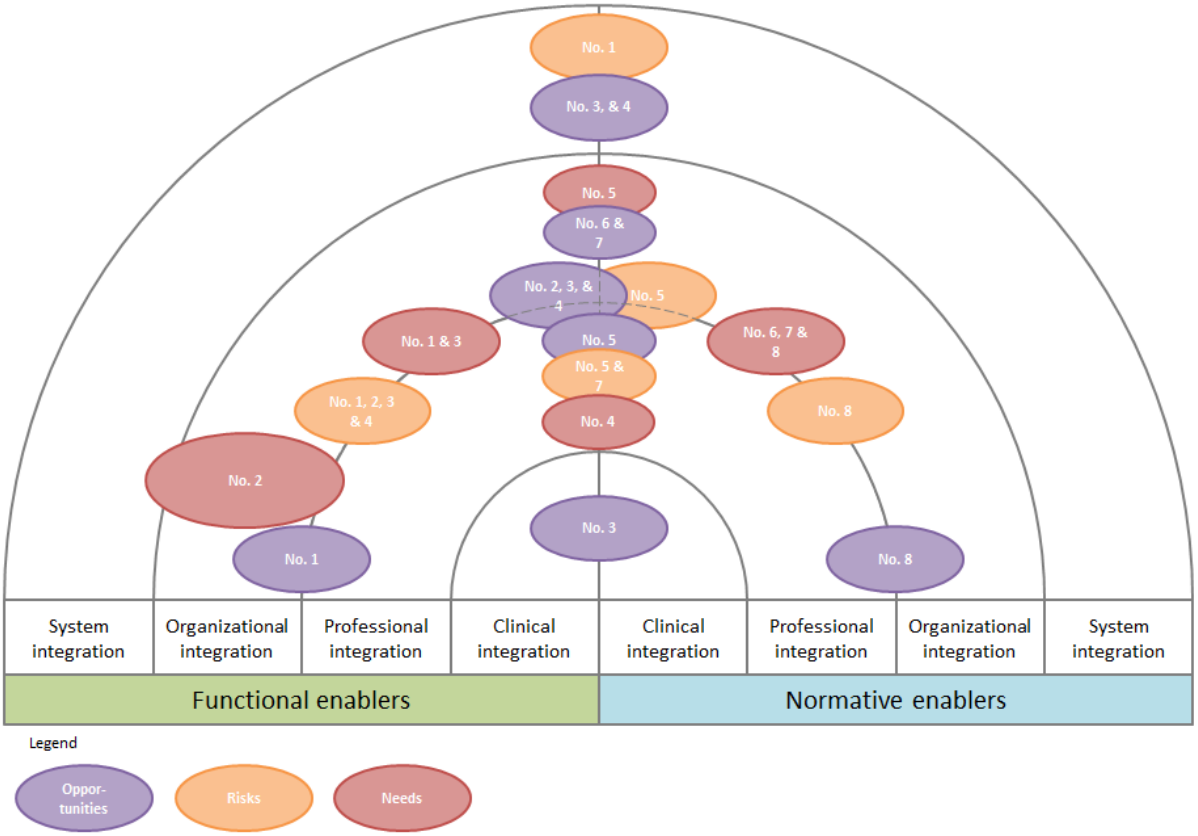

Figure 6.2: Opportunities, risks and needs plotted in the RMPCP

7. Possible role for Menzis in the development of PCP in Twente

This chapter describes the possible roles for health insurer Menzis with its associated possible/expected effects in the development of PCP in Twente. Based on the two most experienced problems in PCP by Menzis are two scenarios with two different roles for Menzis drafted. These scenarios also provide how Menzis can give PCP in Twente direction by means incentives. At last we will also be describe what these scenarios imply for the involved stakeholders, so one knows what it could take into account. The steps from the scenarios are plotted with the integration types and enablers of the RMPCP and will be visualized in the RMPCP figure. This chapter will give answer to sub-question 4 "What (possible) role could health insurer Menzis take in the development of PCP in Twente?".

7.1. Regional meeting of Menzis

The used method for this section is described in Paragraph 3.5. In a regional meeting for employees of Menzis, the employees indicated several problems in the development of PCP, namely: how to catch up the substituted care in primary care, how to unlock money in secondary care, a not matching opinion or statement of the hospital management and medical specialists to the health insurer, the willingness to change of healthcare professionals, the healthcare funding system and the patient willingness and the patients ability regarding self-management as a result of substitution of care. But the employees indicated that the two most important problems in the development of PCP were 'medical specialists who are not willing to move or cooperate in PCP' and 'the small number of initiatives coming out of the care field'. Care field is defined as healthcare professionals in PCP, such as GPs and medical specialists. The last two problems are used as starting point is drafting the scenarios.

7.2. Possible scenarios PCP in Twente

Chapter 4 provided three possible roles for a health insurer in the development of PCP, namely a facilitating, stimulating and a directing role. In Chapter 4 are also incentives per role described, see Table 4.4, which will be used in the scenarios. Although, a facilitating role is for both identified problems not applicable because if a health insurer believes that medical specialists need to move or cooperate in PCP and if it believes that too few PCP initiatives come from the care field, then a facilitating role does not apply because a facilitating role implies that medical specialists want to move or cooperate in PCP or that initiatives come from the care field and that Menzis will facilitate that. For that reason a stimulating or directing role are applicable for Menzis in the two identified problems. An overview of the stimulating and directing scenario is given in Table 7.1.

Table 7.1: Overview of stimulating and directing scenario

Stimulating scenario	Directing scenario
Menzis determines a policy for developing PCP, with a stimulating role for itself.	Menzis shares its long term policy for PCP with its involved stakeholders. Menzis will be director in this policy.
Appointing an external, independent facilitator.	Appoint an external, independent facilitator and attempt, in cooperation with the involved stakeholders, in order to adjust the drafted long term PCP policy (if stakeholders are not satisfied).
A meeting about the expected future trends in Twente should be organized for the involved stakeholders. This in order to achieve a common mind-set.	A framework with preconditions should be created for PCP ideas.
A framework with preconditions should be created for PCP ideas.	Healthcare professionals should be facilitated e.g. by setting up a business-case etc.
Healthcare professionals should be facilitated e.g. by setting up a business-case etc.	Both GP and MS need to be (financially) stimulated otherwise the risk might arise that one will not cooperate anymore.
Both GP and MS need to be (financially) stimulated otherwise the risk might arise that one will not cooperate anymore.	Selective procurement & multiyear financing and/or revenue guarantees for hospital
Revenue guarantees for hospital/paying hospital mortgage costs for being able to shrink.	(Semi-regulating role Menzis) threaten to approach third parties if one will not cooperate.

For both scenarios applies that the implementer needs to continuously evaluate which role is most suitable in each situation/step.

7.2.1. Explanation of the scenarios

This section will explain the stimulating and directing scenario, as given in Table 7.3 and 7.4. In the leftmost column are the steps indicated, these steps do not indicate a time path, these are just a sequence. In the

second column is the explanation of the step indicated. The third column gives an argumentation why is chosen for this step, based on results found in Chapter 4, 5 and 6 for instance enablers, incentives, success and failure factors, opportunities and risks. The columns four to nine indicate for which stakeholder(s) a step is applicable. Column ten indicates what Menzis could do if a stakeholder does not want to cooperate or if a step does not succeed. Menzis then needs to go to another step with the stakeholders who does not want to cooperate/succeed or Menzis needs to change to another role with this stakeholder. For instance step 4 of the stimulating scenario. If GPs, MS or PC does not want to cooperate in this step, or if this step does not succeed for one of these stakeholders, then Menzis needs to go to step 8 with this stakeholder. If the hospital does not want to cooperate or if this step does not succeed with the hospital then Menzis needs to go to step 11 with the hospital. And if Menzis does not want step 4 then Menzis needs to go back to step 1. At last, in the most right column is indicated how this step is applicable to the RMPCP, indicated with abbreviations as described below. By means of the argumentation why this step should be taken is determined how this step is applicable to the RMPCP.

The sequence of steps are determined by the ranking of success and failure factors, incentives, opportunities and risks as described in Chapters 4, 5 and 6. For instance, based on no. 1 ranked success factor "A common vision and ambition" is determined to start the stimulating scenario with this. Thereafter, based on the content of that step, is determined for which stakeholders this step is applicable and by means of logical thinking is determined what to do if a stakeholders does not want to cooperate or if a step does not succeed. The following step is again based on the possible incentives, success factors, opportunities and risks.

In the scenarios are abbreviations included, meanings of these abbreviations are:
GPs: General Practitioners, MS: Medical Specialists, PC: Primary Care (groups), Hsp: Hospital, Mzs: Menzis, EF: External Facilitator. F: Functional enablers, N: Normative enablers, O: Organizational integration, P: Professional integration, S: System integration.

Dependent and guiding trends

This section will describe the dependent and guiding trends, which underlie both scenarios. Table 7.2 shows that if one should substitute 0,1% of hospital care to GP care then a cost reduction of ≈ €3 million can be realized. But given the expected staff shortage of 7,4% to 9,1% in 2022, one need to work towards labour or timesaving solutions (30-32). These two facts imply a potential revenue decline for hospital and/or medical specialists and a capacity shortage in primary care. Primary care in Twente wanted to tackle this problem, among others for that reason Zorgnetwerk Zenderen was founded, with theme group primary and secondary care. Medical specialists are logically not enthusiastic about a potential revenue decline. But something needs to change in healthcare, because doing nothing is not possible seen the expected increasing healthcare demand. For that reason these dependent and guiding trends are taken into account in drafting the two scenarios.

Table 7.2: Calculations current and new healthcare costs

Inhabitants	627.210		
Healthcare costs on average in Twente for 2017 (84)			
	Per insured	Twente (in millions)	%
Hospital care	€1.230,00	€771,5	86,9
GP care	€185,00	€116,0	13,1
Total hospital and GP care	€1.415,00	€887,5	100,0
New healthcare costs in Twente based on 2017			
	Per insured	Twente (in millions)	%
1% of hospital care	€12,30	€7,7	n.a.
1% of hospital are with its cost saving of 33%	€8,20	€5,1	n.a.
Hospital care	€1.217,00	€763,8	86,1
GP care	€193,20	€121,2	13,7
New total hospital and GP care	€1.410,90	€884,9	99,7

7.2.2. Scenario with stimulating role Menzis

Table 7.3: Scenario with stimulating role Menzis

Stimulating role Menzis

How		Why	Applicable to						Effects/consequences	RMPCP
Step	**Explanation**	**Argumentation**	**GPs**	**MS**	**PC**	**Hsp**	**Mzs**	**EF**	**If one does not want to cooperate or if a step does not succeed.**	**Step applicable to**
1	Menzis determines a policy for developing PCP, with a stimulating role for itself.	Incentive no. 8.					X		Menzis: Facilitating or directing role Menzis	FN + O
2	Creating awareness among healthcare professionals.	Success factors no. 1 and 16.					X		Menzis: Step 5	N + OP
3	Appointing an external, independent facilitator.	Success factor no. 6.					X	X	Menzis: Directing role Menzis Facilitator: search for another facilitator which wants to work loyally together (needs to cooperate in all steps).	F + OP
4	A meeting about the expected future trends in Twente should be organized for the involved stakeholders. This in order to achieve a common mind-set.	Success factors no. 1, 3 & 16, opportunity no. 8 and risk no. 8.	X	X	X	X	X	X	GPs, MS and PC: Step 8 Hospital: Step 11 Menzis: Step 1	N + OP
5	Menzis should be willing to invest in cost and/or time saving ideas/solutions.	Success factor no. 10 and risks no. 7 & 8.					X		Menzis: Step 7 or directing role Menzis	FN + OP
6	MS should earn the same salary in PCP as it does with its current work.	Incentive no. 6, success factor no. 10 Risk no. 5 & 7.		X			X		MS: Continue, but extra attention in step 9 Menzis: Step 5	FN + P
7	A framework with preconditions should be created for PCP ideas. This could for instance give clarity about minimal cost savings, quality of care, care closer to patients home (Triple Aim) and time & labour saving solutions.	All enablers, risks no. 1 & 2, opportunity no. 1 and risk no. 1 & 2.					X	X	Menzis: Step 8	FN + OP
8	Healthcare professionals should be facilitated in step 9, e.g. by setting up a business-case, cost savings calculations and/or by sharing successful initiatives.	Incentive no. 12, success factor no. 9, opportunity no. 6 and risk no. 4.	X	X				X	GPs & MS: Step 9	FN + P
9	Healthcare professionals should be stimulated with incentives, appropriate to the stimulating role, to invest time in creating jointly substitution/PCP ideas.	Incentive no 6, success factor no. 2 & 7, opportunity 3 and risk no. 5.	X	X	x	x	X		GPs & MS: Involve primary care groups/hospital in step 9, otherwise directing role Menzis Menzis: Step 5	FN + OP
10	Both GP and MS need to be (financially) stimulated otherwise the risk might arise that one will not cooperate anymore.	Incentive no. 6, success factor no. 2 and risk no. 5.	X	X			X		GPs & MS: Directing role Menzis Menzis: Step 5	FN + P
11	Revenue guarantees for hospital / paying hospital mortgage costs for being able to shrink.	Incentives no. 1 & 10, risk no. 6.	NA	NA	NA	X	X		Hospital: Directing role Menzis Menzis: Step 5	FN + O

7.2.3. Scenario with directing role Menzis

Table 7.4: Scenario directing role Menzis

Directing role Menzis

How		Why	Applicable to						Effects/consequences	RMPCP
Step	**Explanation**	**Argumentation**	**GPs**	**MS**	**PC**	**Hsp**	**Mzs**	**EF**	**If one does not want to cooperate or if a step does not succeed.**	**Step applicable to:**
1	Menzis determines a long term (procurement) policy for PCP. Menzis will be director.	Incentive no. 8.					X		Menzis: Stimulating role Menzis	FN + O
2	Menzis shares its policy with its involved stakeholders.	Success factor no. 9.	X	X	X	X			If stakeholders are satisfied: 4 If stakeholders are not satisfied: 3 If stakeholders want a stimulated setting: Stimulating role Menzis.	FN + OP
3	If stakeholders are not satisfied: Appoint an external, independent facilitator and attempt, in cooperation with the involved stakeholders, in order to adjust the drafted long term PCP policy.	Success factors no. 1, 3, 4, 8, 9 & 16, opportunity no. 8 and risk no. 8.	X	X	X	X	X	X	GPs, MS, PC and/or hospital: Step 10 Menzis: Step 1 Facilitator: search for another facilitator which wants to work loyally together (needs to cooperate in all steps).	FN + OP
4	If stakeholders are satisfied: Appoint an external, independent facilitator (see step 3). & Menzis should be willing to invest in cost and/or time saving ideas/solutions.	Success factors no. 6 & 10 and risks no. 7 & 8.					X		Menzis: Step 6 or step 1	FN + OP
5	MS should earn the same salary in PCP as it does with its current work.	Incentive no. 6, success factor no. 10 Risks no. 5 & 7.		X			X		MS: Continue, but extra attention in step 8 Menzis: Step 4	FN +P
6	A framework with preconditions should be created for PCP ideas. Where for instance clarity about minimal cost savings, quality of care, care closer to patients home (Triple Aim) and time & labour saving solutions will be given.	All enablers, risks no. 1 & 2, opportunity no. 1 and risk no. 1 & 2.					X	X	Menzis: Step 7	FN + OP
7	Healthcare professionals should be facilitated in step 8, e.g. by setting up a business-case, cost savings calculations and/or by sharing successful initiatives.	Incentive no. 12, success factor no. 9, opportunity no. 6 and risk no. 4.	X	X				X	GPs & MS: Step 8	FN + P
8	Healthcare professionals should be stimulated with incentives, appropriate to the directing role, to invest time in creating jointly substitution/PCP ideas.	Incentive no 6, success factor no. 2 & 7, opportunity 3 and risk no. 5.	X	X	x	x	X		GPs & MS: Directing of primary care groups/hospital by Menzis in step 8, otherwise step 10 Menzis: Step 4	FN + OP
9	Both GP and MS need to be (financially) stimulated otherwise the risk might arise that one will not cooperate anymore.	Incentive no. 6, success factor no. 2 and risk no. 5.	X	X			X		GPs & MS: Step 10 Menzis: Step 4	FN + P
10	Selective procurement & multiyear financing / long term contracts / two-sided model.	Incentives no. 4, 9 & 11.	X	X	X	X	X		GPs, MS & PC: Step 12 Hospital: step 11 Menzis: Step 4 or 11	FN + OP
11	Revenue guarantees for hospital / paying hospital mortgage costs for being able to shrink.	Incentives no. 1 & 10, risk no. 6.	NA	NA	NA	X	X		Hospital: Step 12 Menzis: Step 4 or 12	FN + O
12	(Semi-regulating role Menzis) threaten to approach third parties if one will not cooperate.	Incentive no. 2.					X		Menzis: Step 1	FN + SOP

7.3. Explanation scenarios

In Tables 7.3 and 7.4 one can see the two generated scenarios based on the stimulating and directing role of Menzis in the development of PCP. This section will explain both tables, next to that will underlying argumentation and effects be explained.

Stimulating role Menzis

Step 1

Step 1 will be the starting point for the stimulating role. Based on incentive no. 8 "Determining a long term procurement policy for a region" Menzis needs to determine a policy for developing PCP. If Menzis does not want this then it should take a facilitating or a directing role.

Step 2

Based on success factors no. 1 "A common vision and ambition" and no. 16 "Having a common sense of urgency or "common enemy" works more binding than creating a common vision, because then one cannot take its own interest into account", one believes that this will be a good starting point, namely: Creating awareness among healthcare professionals. If Menzis does not want this then it should go to step 5.

Step 3

Based on success factor no. 6 "Appoint an external, independent facilitator/program/project leader", the author believes that this is a good starting point in order to bring stakeholders together. If Menzis does not want this then it should take a directing role because an external, independent facilitator is needed in a stimulating role of Menzis. The facilitator is needed in order to make sure that the cooperation will run smoothly. If no facilitator can be found, then Menzis should search for another facilitator which wants to work loyally together (this because the facilitator needs to cooperate in all steps of the scenario when it is needed).

Step 4

According to the success factors no. 1 "A common vision and ambition", no. 3 "Invest in building a solid trust relation between involved stakeholders", no. 16 "Having a common sense of urgency or "common enemy" works more binding than creating a common vision, because then one cannot take its own interest into account", opportunity no. 8 "Determining a clear, common vision, in order to know where to work towards with PCP" and risk no. 8 "The involved stakeholders should take their social responsibility and missing of leadership", a facilitator should among others organize a meeting for the involved stakeholders about the expected future trends of healthcare in Twente. This in order to achieve a common mind-set. If GPs, MS and PC don't want to cooperate then Menzis should go to step 8 with these stakeholders. If the hospital doesn't want to cooperate (depending on its reason) then Menzis should go to step 11 with the hospital. And if Menzis does not want this then it should go back to step 1 and change its policy.

Step 5

Based on success factor no. 10 "Financial preconditions are essential for good cooperation" and risks no. 7 "Disagreement about the production incentive of medical specialist and not efficient use of medical specialist time" and no. 8 "The involved stakeholders should take their social responsibility and missing of leadership", Menzis should be willing to invest in cost and/or time saving ideas or solutions. If Menzis does not want this then it should continue to step 7 or it should take a directing role.

Step 6

Because of the dependency relation and problem of medical specialist it will be important that MS will earn the same salary in PCP as it does with its current work. This is based on incentive no. 6 "Alignment of financial incentives for both GPs and medical specialists to motivate both for substitution", success factor no. 10 "Financial preconditions are essential for good cooperation", Risks no. 5 "Poor motivation of GPs and medical specialists, e.g. due to the lack of a win-win situation" and no. 7 "Disagreement about the production incentive of medical specialist and not efficient use of medical specialist time". If MS does not want this then Menzis should continue with MS and pay extra attention in step 9 for MS. If Menzis does not want this then it should go back to step 5.

Step 7

Based on all enablers, risks no. 1 "The baffles of healthcare, because of double financing of PCP", no. 2 "In case of small, separate PCP projects healthcare might become (more) fragmented", opportunity no. 1 "Clarifying the preconditions of a PCP project and making a simplified (concept) business-case", risk no. 1 "The baffles of healthcare, because of double financing of PCP" and no. 2 "In case of small, separate PCP projects healthcare might become (more) fragmented", a framework with preconditions should be created for PCP ideas. In this framework should clarity be given about minimal cost savings, quality of care, care closer to patients home (Triple Aim) and time & labour saving solutions. If Menzis does not want this, then it should go to step 8.

Step 8

According to incentive no. 12 “Laying down a basis for a facilitated setting”, success factor no. 9 “Facilitate cooperation with a 'flanking policy' at staff support, education, information exchange and develop common ICT”, opportunity no. 6 “A pro-active, co-leading, open-minded and facilitating role is expected from Menzis” and risk no. 4 “Not sufficient organized primary care, due to labour shortage, the absence of support and expertise in primary care”, should healthcare professionals be facilitated (in step 9), for instance by setting up a business-case, cost saving calculations or by sharing successful initiatives. This should be done by the external facilitator. If GPs and MS do not want this then Menzis should go to step 9 with these stakeholders.

Step 9

In step 9 should healthcare professionals be stimulated with incentives, appropriate to the stimulating role, to invest time in creating jointly substitution/PCP ideas. This is based on incentive no. 6 “Alignment of financial incentives for both GPs and medical specialists to motivate both for substitution”, success factors no. 2 “Create a win-win situation and take all stakeholders interests into account”, no. 7 “Healthcare professionals have to give form and content to a PCP initiative”, opportunity no. 3 “(Re)designing care pathways with e.g. the social domain, technology and eHealth” and risk no. 5 “Poor motivation of GPs and medical specialists, e.g. due to the lack of a win-win situation”. If GPs and/or MS do not want this then primary care groups and/or hospital should be involved in step 9, otherwise Menzis should take a directing role. If Menzis does not want this then it should go back to step 5.

Step 10

This step is based on incentive no. 6 “Alignment of financial incentives for both GPs and medical specialists to motivate both for substitution”, success factor no. 2 “Create a win-win situation and take all stakeholders interests into account”, for that reason both GP and MS need to be (financially) stimulated, otherwise the risk might arise that one will not cooperate anymore. If GPs and/or MS do not want this then Menzis should take a directing role. If Menzis does not want this then it should go back to step 5.

Step 11

Based on incentives no. 1 “Paying the hospital mortgage costs for being able to shrink”, no. 10 “Revenue guarantee for hospital not going bankrupt” and risk no. 6 “Poor motivation of GPs and medical specialists, e.g. due to the lack of a win-win situation”, revenue guarantees for the hospital could be given in order to let a hospital shrink, Menzis could pay the hospital mortgage costs when a department is unnecessary due to substitution. If a hospital does not want this then Menzis should take a directing role. If Menzis does not want this then it should go back to step 5.

Directing role Menzis

Step 1

Step 1 will be the starting point for the directing role. Based on incentive no. 8 “Determining a long term procurement policy for a region” Menzis needs to determine a policy for developing PCP. Where Menzis will be director. If Menzis does not want this then it should go back to a stimulating role of Menzis.

Step 2

Based on success factor no. 9 “Facilitate cooperation with a 'flanking policy' at staff support, education, information exchange and develop common ICT”, Menzis should share its policy with its involved stakeholders. If stakeholders are satisfied with Menzis long term PCP policy then one should go to step 4. If the stakeholders are not satisfied then one should go to step 3. If stakeholders want a stimulated setting of Menzis then one should go back to stimulating role of Menzis.

Step 3

According to the success factors no. 1 “A common vision and ambition”, 3 “Invest in building a solid trust relation between involved stakeholders”, no. 4 “Appoint a leader at an administrative and at a healthcare professional level”, no. 8 “Monitor or evaluate cooperation based on the progress of realization of ambition and objectives”, no. 9 “Facilitate cooperation with a 'flanking policy' at staff support, education, information exchange and develop common ICT” and, no. 16 “Having a common sense of urgency or “common enemy” works more binding than creating a common vision, because then one cannot take its own interest into account”, opportunity no. 8 “Determining a clear, common vision, in order to know where to work towards with PCP” and risk no. 8 “The involved stakeholders should take their social responsibility and missing of leadership”. An external, independent facilitator should be appointed if the stakeholders are not satisfied with Menzis long term PCP policy, then one should, in cooperation with the involved stakeholders, attempt to draft a new long term PCP policy. If GPs, MS, PC and/or hospital do not want to cooperate then one should go to step 10. If Menzis does not want this then it should go back to step 1. If a facilitator cannot be found, then it

should search for another facilitator which want to work loyally together (this because the facilitator needs to cooperate in all steps of the scenario when it is needed).

Step 4

This step is the same as the steps 3 and 5 of the stimulating role.

Step 5

This step is the same as step 6 of the stimulating role.

Step 6

This step is the same as step 7 of the stimulating role.

Step 7

This step is the same as step 8 of the stimulating role.

Step 8

In step 8 should healthcare professionals be stimulated with incentives, appropriate to the directing role, to invest time in creating jointly substitution/PCP ideas. This is based on incentive no. 6 “Alignment of financial incentives for both GPs and medical specialists to motivate both for substitution”, success factor no. 2 “Create a win-win situation and take all stakeholders interests into account”, opportunity no. 3 “(Re)designing care pathways with e.g. the social domain, technology and eHealth” and risk no. 5 “Poor motivation of GPs and medical specialists, e.g. due to the lack of a win-win situation”. If GPs and/or MS do not want this then primary care groups and/or hospital should be directed by Menzis in step 8, otherwise one should go to step 10. If Menzis does not want this then it should go back to step 4.

Step 9

This step is the same as step 10 of the stimulating role.

Step 10

Based on incentives no. 4 “Two-side model contract, e.g. Blue Cross Shield”, no. 9 “Multiyear financing/long term contracts” and no. 11 “Selective procurement”, Menzis could apply these incentives. If GPs, MS and PC do not want this then they should go to step 12. If a hospital does not want this then it should go to step 11 and if Menzis does not want this then it should go back to step 4 or step 11.

Step 11

This step is the same as step 11 of the stimulating role.

Step 12

At last, a semi-regulating incentive (and role) for Menzis is based on incentive no. 2 “Threaten to approach third parties if one will not cooperate”. If stakeholders do not want to cooperate then Menzis can threat to approach third parties. A regulating incentive and role are the last instruments which one can use. If Menzis does not want this then it should go back to step 1.

7.3.1. Stimulating scenario related to results Chapters 4, 5 and 6

This section explains why some enablers, success and failure factors, opportunities and risks are not (directly) applied in the stimulating scenario. For instance, some factors which are not applied, can still be applied in the stimulating scenario, but this depends on the context. It also describes why some factors are not applied.

The enablers found in Chapter 4 are applied in the stimulating scenario, although enabler no. 3 “Professional integration by means of joint or one-off consultation” might be restrictive for creating PCP ideas. Because according to success factor no. 7 “Healthcare professionals need to give form and content to an initiative”, enabler no. 3 could maybe be better omitted.

All possible incentives are included in the stimulating scenario and eight out of sixteen success and failure factors are directly applied in the stimulating scenario. Factor no. 8 “Monitor or evaluate cooperation based on the progress of realization of ambition and objectives” could simply be fulfilled, by keeping the external, independent facilitator responsible for monitoring activities. Factor no. 5 “Some form of organization seems to be important, for example an administrative consultative body” could also simply be fulfilled, by appointing the theme group for primary and secondary care which was founded by Zorgnetwerk Zenderen. The factors no. 4 “Appoint a leader at an administrative and at a healthcare professional level”, no. 11 “There needs to be (municipal) governmental support”, no. 12 “Keep up the pace”, no. 13 “Cooperation with another healthcare organisation/building, for instance a nursing home, because of 24/7 care is primary care beds possible”, no. 14 “Clients could regularly and unconsciously be monitored. Because PCP was provided in combination with welfare and enjoyment, so clients came voluntary” and no. 15 “Inclusion of elderly unions, because they can be good ambassadors for the target group”, are not applicable for this scenario. This because leaders at an administrative and healthcare professional level need to stand up by themselves, this cannot be imposed to someone. Success factors 11 and 12 are not determinative for the stimulating roles its success, for that reason these are not included. And the success factors 13, 14 and 15 can be applied in creating PCP

initiatives. This because these factors are too specific and might be restrictive for healthcare professionals in creating PCP initiatives.

Four out of eight opportunities are applied in the stimulating scenario. The opportunities no. 1 "Making use of environmental factors." and no. 4 "Another deployment of healthcare professionals" could be applied in step 9 of this scenario, but this depends on the created PCP ideas/solutions by the healthcare professionals. For that reason are these two opportunities are not directly applied in the stimulating scenario. Opportunity no. 7 "Zorgnetwerk Zenderen is easy to activate again", is in the previous section already described. And opportunity no. 4 "The baffles of healthcare might fade away in combination with creating a new funding system", is not applied in the stimulating scenario. This because it depends on the comprehensiveness of the PCP initiatives, a new funding system may be a result of this.

Seven out of eight risks are applied in the stimulating scenario. Risk no. 3 "Ambiguity how secondary care could be substituted to primary care, because of the expected labour shortage in primary care" is not included because this risk goes beyond the development of PCP. PCP might be a partial solution for this, but this still depends on the created substitution/PCP ideas. For that reason this risk might partially be tackled by the stimulating scenario.

7.3.2. Directing scenario related to results Chapters 4, 5 and 6

The enablers found in Chapter 4 are applied in the directing scenario. The deviating enabler in the stimulating scenario is applicable for the directing scenario. Next to that are all possible incentives for a directing role of a health insurer applied in this scenario. Ten out of sixteen success and failure factors are directly applied in the directing scenario, next to that are the same opportunities and risks applied in the directing scenario as in the stimulating scenario, explanation for these factors are given in Section 7.3.1.

7.4. Discussion most suitable role Menzis

Based on the explanations of the different scenarios, related to the results of Chapters 4, 5 and 6, one could state that both scenarios will result in almost the same outcomes of the problems which need to be solved. Which role Menzis should take depends on the context of the care field and the preference of Menzis. For instance, sustainable local cooperation (2, 25), willingness to cooperate (25), market share of a health insurer, present knowledge and competences in PCP (17, 33), coordination on location (17), type of medical intervention (34).

The main difference in the scenarios is its starting point. The stimulating role starts with awareness among healthcare professionals, the directing role starts with sharing its own policy and attempting to achieve a common, long term PCP policy. The advantage of stimulating is that a common sense of urgency could be created, namely the dependent and guiding healthcare trends, and this might work even more binding than a common vision. A disadvantage of the stimulating role, which appeared from the interviews, is that there is a risk that the stakeholders will take Menzis less serious when it changes to a directing role. Because a respondent believed that if Menzis would start with a 'soft' stimulating role and then changes to a 'hard' directing role, Menzis might lose its credibility and the care field might take Menzis less serious. An advantage of the directing role is that Menzis has more space to change of/within its role and can easily change to a stimulating role. The disadvantage of directing is that one could take its own interests into account in drafting a common policy. Because this is a failure factor for the development of PCP, Menzis could take a hard directing role in order to prevent this. The advantage of the stimulating role could, in drafting a long term policy, also be included but this depends on the preferences of the stakeholders.

The most important success factor for PCP is a common vision or ambition, for that reason both scenarios start (indirect) with this. Inclusion of all stakeholders will also be essential, given the two most important problems, 'medical specialist who are not willing to move or cooperate in PCP' and 'the small number of initiatives coming out of the care field', suggested by Menzis. The first problem is about medical specialist and the second about the whole care field, in particular primary care because it needs to catch up substituted care. If one of both stakeholders does not want to cooperate, one needs to seek for new ways/other incentives in order to let them cooperate, otherwise the risk arises PCP will not succeed. This could be done by means of 'seductive' or 'steering/regulating' incentives, as described in Chapter 4.

The first incentive to let medical specialists cooperate in PCP, "medical specialist should earn the same salary in PCP as it does with its current work", can be seen as a logical incentive, which also emerged from literature and the interviews with medical staff board of both hospitals. Next to that emerged from these interviews that medical specialists want to enter the conversation with its stakeholders about PCP. The

incentive that a hospital can get revenue guarantees should only be applied if PCP might harm hospital its revenues and if it is willing to cooperate in PCP. The trend of labour shortage and the increasing demand for healthcare are two main problems for primary care to seek time to create ideas/solutions for PCP. In line with these problems one really needs to work towards time or labour saving solutions in PCP to be able to cope with these problems.

If Menzis starts with taking the stimulating role then it would give space to the vitality of the care field because it climbs the participation stairs little as possible (42), see Section 2.4.1. Although, the author's advice would be to start with a directing role of Menzis in the development of PCP, because this would give Menzis more space to change of/within its role. Menzis could include the advantage of the stimulating role, creating a common sense of urgency, in step 2 or 3 of the directing role by means of adjusting the drafted policy. Menzis then takes the advantage of the stimulating role and might tackle the disadvantage, taking own interests into account, of the directing role.

Given the two problems which Menzis wants to solve in the development of PCP the author's advice would be to start with a directing role of Menzis in the development of PCP. Because if the care field does not want a directing role of Menzis or if it is not satisfied with Menzis' policy, then one could step back to a stimulating role of Menzis or one could try to achieve a common long term PCP policy. By means of this Menzis creates for itself more space to change of/within its role.

During a regional meeting for employees of Menzis the author presented the results of the research, the stimulating and directing scenarios and gave an initial advice for Menzis role in PCP. The employees of Menzis agreed with this advice, because they also believed that this role might be most effective for the development of PCP in Twente. The employees indicated that it is important to constantly monitor which role might be most suitable, given the (changing) contextual factors.

7.5. Conclusion four

This chapter was aimed to give answer on sub-question 4, "What (possible) role could health insurer Menzis take in the development of PCP in Twente?". Based on the generated scenarios one can conclude that:

- The author's advice is that Menzis should start with taking a directing role in the development of PCP in Twente.
- Menzis can give PCP direction by means of multiple incentives, most importantly: Salary guarantee for medical specialists, appointing an external, independent facilitator in order to facilitate the care field and (financial) incentives for health care professionals to create PCP ideas/solutions;
- The involved stakeholders should, regarding the development of PCP, take into account that: The care field will be facilitated by an external, independent facilitator, healthcare professionals will be stimulated to create PCP ideas/solutions and the hospital can get revenue guarantees if PCP harms its revenues and if it cooperates in PCP.

The first conclusion is based on the fact that the starting point of the directing role gives Menzis the best opportunity to respond on the context of the care field. If the care field reconsiders its opinion about the role of Menzis in PCP, then Menzis can easily respond to this by taking a next step or changing its role to a stimulating role in the development of PCP. The directing role gives Menzis more space to change of role.

The second conclusion is based on the fact that multiple incentives are applicable in the development of PCP, depending on the context of the care field. But most important incentives/enablers for the development of PCP are, first, salary guarantees for medical specialists, because by means of this a potential salary barrier will be taken away for medical specialists to cooperate in PCP. Second, appointing an external, independent facilitator in order to facilitate the care field, because the care field should be facilitated in setting-up business cases, cost savings calculations and sharing of successful PCP initiatives. Third, (financial) incentives for healthcare professionals to create PCP ideas/solutions. Because of the (expected) labour shortage in healthcare, healthcare professionals need and want to provide most of their time care. For that reason they should be stimulated to make time for creating PCP/time or labour saving solutions and next to that, previous results show that healthcare professionals should give form and content to a PCP initiative.

The third conclusion is based on the outcomes of the generated scenarios and on previous found results. For that reason the involved stakeholders should, regarding the development of PCP, take into account that the care field will be facilitated by an external, independent facilitator, healthcare professionals will be stimulated to create PCP ideas/solutions and the hospital can get revenue guarantees if PCP harms its revenues and if it cooperates in PCP.

All steps of both scenarios are plotted for the enabler and integration types of the RMPCP. In this section are these steps of both scenarios plotted in the RMPCP figure, see Figure 7.1. The stimulating role has clear distinctive features because three steps are plotted among functional and normative enablers, this does not apply for the directing role. All steps of the directing role are applicable for both functional and normative enablers. As stated before, the main difference of both scenarios is the starting point and this is reflected in plotted steps in the RMPCP. One can also see that six out of twelve steps of the directing scenario are applicable to functional & normative enablers and professional & organizational integration. Three steps more in comparison with the stimulating scenario. This is caused by the fact that the directing scenario has some overlap of steps. The directing scenario has one step that is also applicable for system integration, this is "(semi-regulating role Menzis) threaten to approach third parties if one will not cooperate". This incentive is according to Table 4.4 not applicable for a stimulating role, because it is a steering or directing incentive, for that reason it is not applied in the stimulating scenario. Based on Figure 7.1 one can conclude that the stimulating and directing scenario mainly take place at an organizational and professional integration level, wherefore both functional and normative enablers are applicable. Next to that one can conclude that the main difference of both scenarios is its starting point and an additional semi-regulating incentive for the directing scenario.

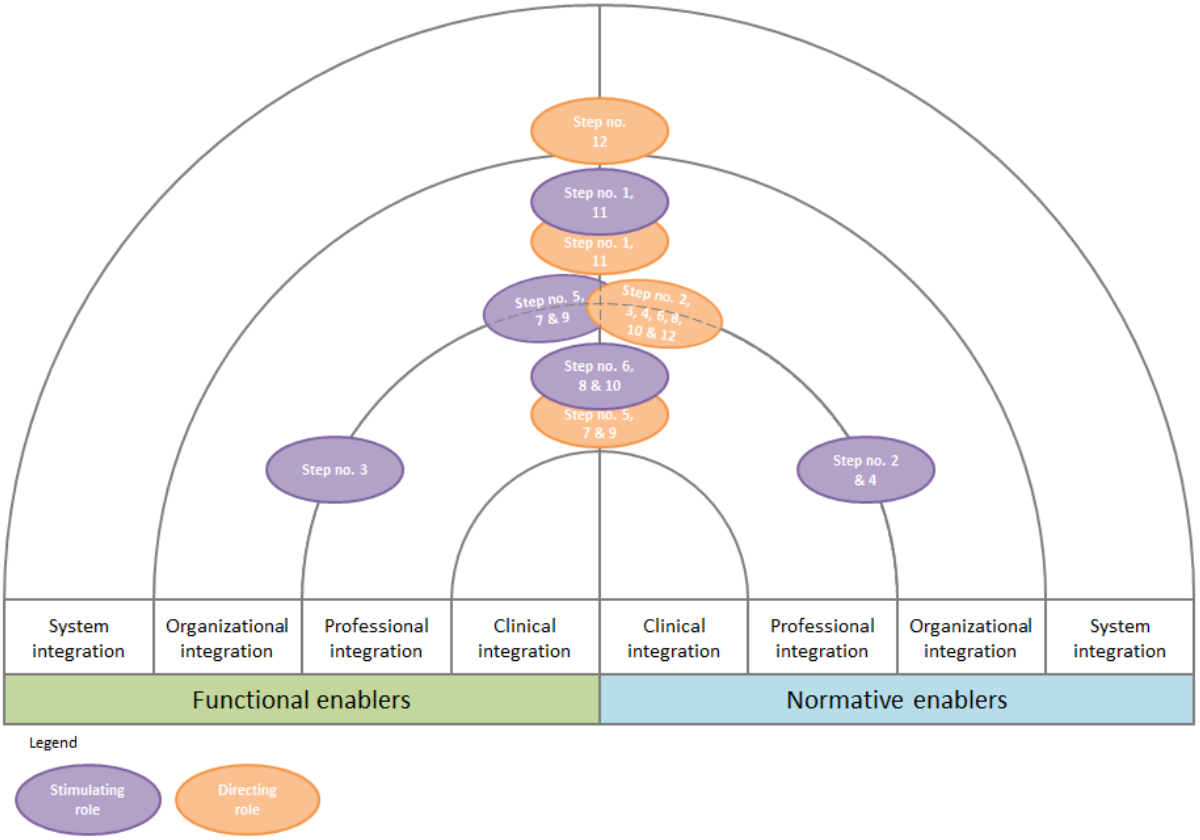

Figure 7.1: Stimulating and directing scenario steps plotted in the RMPCP

8. Discussion

This study investigated what role health insurer Menzis could take in the development of PCP in order to realize equal or improved quality of care at lower costs. In this study a literature research has been conducted, five experts, four representatives of visited practices and all eight stakeholders regarding PCP in Twente have been interviewed. Based on these results, two scenarios regarding Menzis' role in the development of PCP are generated. This chapter will answer the research question and the conclusion will be discussed in relation with the literature review. Furthermore will the RMPCP be discussed and will an adjusted rainbow model be presented. At last, will the strengths and limitations of this study be described and will recommendations be given.

8.1. Main findings

The stated research question of this study was: *"What role could health insurer Menzis take in the development of Primary Care Plus in order to realize equal or improved quality of care at lower costs?".* Four sub-questions were stated in order to answer this research question.

Chapter 4 shows that a health insurer can take different roles in PCP, namely a facilitating, stimulating or a directing role. The most suitable role for a health insurer in PCP depends on its context and subject (42). For instance, sustainable local cooperation (2, 25), willingness to cooperate (25), market share of a health insurer, present knowledge and competences in PCP (17, 33), coordination on location (17), type of medical intervention (34) and the possible incentives to be used. Chapter 4 also provides different incentives, plotted against the possible roles of a health insurer. Next to that shows this chapter that no ideally PCP setting exists, but seven enablers are found which could be used in the development of PCP.

Chapter 5 provides sixteen success and failure factors, of which twelve are ranked. A common vision and ambition is experienced as most important in the development of PCP. Additionally, normative enablers are considered to be of more importance than functional enablers for the development of PCP, because normative success factors were generally ranked higher than functional success factors. This corresponds to findings of Valentijn (19). Next to that provides Chapter 5 seven different types of PCP which are applied in practice, but all types are not applied in every visited practice. This chapter also provides diseases which could according to literature be substituted and it provides a substitution list with care products, composed by Menzis and a hospital, which could be substituted to primary care (plus). Based on applicable success and failure factors, provided types of PCP in a region, and the substitution list of substitutable care products, could a health insurer determine what role it could take in the development of PCP in a region.

In Chapter 6 a market exploration is conducted, all roles of the involved stakeholders in PCP in Twente are identified. Next to that are eight opportunities, eight risks and eight needs identified. Interestingly, if one keeps Twente outside thoughts, then could many opportunities, risks and needs be applied to other regions in the Netherlands. Because, if one compares opportunities, risks and needs with the outcomes of the experts interviews and the success and failure factors, one can see many similarities. Based on the contextual outcomes in Twente, health insurer Menzis could determine what role it could take in the development of PCP in Twente.

Chapter 7 continues where Chapter 6 stops. Menzis experiences medical specialists who won't cooperate in PCP and the small number of PCP initiatives coming out of the care field, as two most important contextual problems of PCP in Twente. Based on these problems are two scenarios with two different roles for Menzis drafted. Next to that are the found results of Chapters 4, 5 and 6 included in drafting these scenarios. Based on the contextual factors in Twente, the author's advice is that Menzis should start with taking a directing role in the development of PCP in Twente. This because this starting point will give Menzis the best opportunity to respond to potential reconsideration of stakeholders opinions and to the context of the care field. Menzis could give PCP in Twente direction by means of multiple incentives, most importantly: Salary guarantee for medical specialists, appointing an external, independent facilitator in order to facilitate the care field and (financial) incentives for healthcare professionals to create PCP ideas/solutions. This in order to take away potential barriers regarding salary, missing of support and missing of the incentive to make time for creating PCP ideas.

Concluding, the role which Menzis could take in the development of PCP depends mainly on the context of the care field. Three different roles are suitable for Menzis in the development of PCP, namely a facilitating, stimulating or directing role. Next to that are different incentives, appropriate to these roles, identified which could be used in the development of PCP. The context of the care field, in which Menzis wishes to interfere, is important (almost leading) for determining its role. In order to ascertain the quality of

care and its corresponding costs, a health insurer should make this explicit in a framework with preconditions and share this with its stakeholders. For instance, equal quality of care and a minimal cost saving percentage.

8.2. Relation with literature

Literature provides five roles which a health insurer could take (2, 13, 24, 25, 42), this study shows that a health insurer could take a facilitating, stimulating or directing role in the development of PCP. The choice for the most suitable role depends on the contextual factors of a region, for instance sustainable local cooperation (2, 25), willingness to cooperate (25), market share of a health insurer, present knowledge and competences in PCP, (17, 33), coordination on location (17), type of medical intervention (34). And based on these contextual factors of a region, a health insurer could determine which incentives could be best used, for instance if healthcare providers are not willing to cooperate a health insurer could use selective procurement as an incentive in order to substitute secondary care to primary care. But as stated before this depends on the context whether this is possible, selective procurement depends for instance also on the market share of a health insurer and the availability of other healthcare providers to do this. For that reason it is not possible to determine a general advice which incentives to use if certain contextual factors are present in a region. Normative factors of a region are then even left out of consideration.

Literature states that regional conditions are decisive for the success of substitution projects (2). Sustainable local cooperation between GPs and medical specialists is for instance experienced as the starting point for successful substitution projects. This study confirms literature, because from this study appears that the organization of PCP depends on contextual factors in a region. For that reason does literature not provide an ideal model or blueprint for PCP (6, 17). The author believes that it is also questionable if an ideal model or blueprint would be desirable or even possible. Because every healthcare region has other functional and normative factors.

The contextual problems which Menzis experiences as most important, medical specialists who won't cooperate in PCP and the small number of PCP initiatives coming out of the care field, are not unfamiliar in literature. Because of the unwillingness to cooperate, honorarium of medical specialist and labour shortage in healthcare (17, 25, 30-32).

The main incentives which Menzis could use, can be substantiated with literature. Literature states that salary guarantees for medical specialists are an important enabler in order to make substitution of care possible (2, 6, 25, 50). Appointing an external, independent facilitator is assumed as an important enabler in order to facilitate the progress and to support the healthcare professionals (26, 29, 50). And (financial) incentives could be used in order to influence healthcare professionals its behaviour (47-49). But a balance of financial and non-financial incentives is likely to be most effective (43-46). Next to that, literature states that health policy makers should address preconditions for substitution of care (26), for that reason Menzis should make this explicit in a framework with preconditions and share this with its stakeholders. Because of this, Menzis can ascertain the quality of care and its corresponding cost savings and work towards the Triple Aim in its framework of preconditions.

The suggested starting point for Menzis in PCP is in a matter of fact contradictory because literature states that, if one would give space to the vitality of the care field, one should climb the participation stairs as little as possible (42). But our suggestion is based on contextual factors and a consideration of (dis)advantages. The main benefit of starting with a directing role is that Menzis could easily change of/within its role.

Valentijn states with the RMIC that the development of integrated care should start with an analysis of the needs and system requirements, this in order to explore the best suitable integration strategy (19). The exploration of needs and system requirements has been conducted in this study. But this study had the assumption that PCP would be the solution for these needs and system requirements and for that reason Menzis wanted to know what role it should take in the (further) development of PCP in Twente. Although, this does not mean that PCP will be the best suitable integration strategy for Twente. According to the author one really needs to work towards time and labour saving solutions, because of the expected labour shortage in healthcare. This trend should, according to the author, be leading for the best suitable integration strategy.

This study shows that time and labour saving solutions are possible within PCP, for instance eHealth, so PCP could be a suitable integration strategy for Twente. But this is only possible when all stakeholders will release their own interests and will collectively search for the best suitable integration strategy to tackle the negative healthcare trends. The affordability and durability problem of healthcare should be approached as an integral, collectively problem of a region. This because no single stakeholder has the ultimate authority, resources or ability to control or manage the complexity of a system (21).

8.2.1. Adjusted RMPCP

This section describes the adjusted RMPCP. The RMPCP is adapted from the RMIC from Valentijn, the RMIC provides a synthesis of the current knowledge and theories on integrated and primary care into an overarching theoretical perspective (19). The RMIC seems to be a well-integrated theoretical model for integrated primary care, but practical application as done with the RMPCP appears to work less well. This because the RMIC was not designed for practical application.

One can see in all RMPCP figures (Figures 4.1, 5.1, 6.2 and 7.1), in which results of that chapter are plotted, that many results are applicable for both functional and normative enablers. This resulted in full and sometimes unclear RMPCP figures, because different plotted results were overlapping each other in the figure. Next to that gave the RMPCP figure no insight in the extent in which results were applicable for the functional and normative enablers. In Chapter 5 is for instance a ranking of success and failure factors given, but in the RMPCP figure this ranking became not clear.

For above described reasons is the RMPCP adjusted to an extended, more practical model, see Figure 8.1. As one can see in Figure 8.1 is the model divided into three parts instead of two parts in the 'old' model. This in order to make more space for both functional & normative enablers. In the adjusted model are at the left the functional enablers, in the middle functional & normative enablers and at the right normative enablers. By means of this it will be easier to plot practical integration efforts, for instance PCP, in the RMPCP. Beside, one can see in Figure 8.1 that the adjusted RMPCP has light dashed lines in it, by means of these lines different boxes originated. In addition, above the most outer line of the adjusted RMPCP are the numbers 1 to 5 indicated for each enabler type. This in order to make it possible to score results relative to each other in the RMPCP. Number 1 implies a good/most important result, and number 5 a least good/important result.

Although, this study was not focused on scoring or the extent of importance of results for PCP, by means of the adjusted RMPCP it is now possible. The theoretical RMIC of Valentijn is adjusted to a more simplified, practical model in which (different) integration efforts can be scored and plotted relative to each other. The added value of the adjusted RMPCP is that integration efforts, for instance PCP results, can be quantified in the rainbow model. The facets which have been omitted in the RMIC could, if one wishes, be added to the adjusted RMPCP, but this should only be done if it has practical added value. Otherwise, this can lead to unnecessary ambiguity.

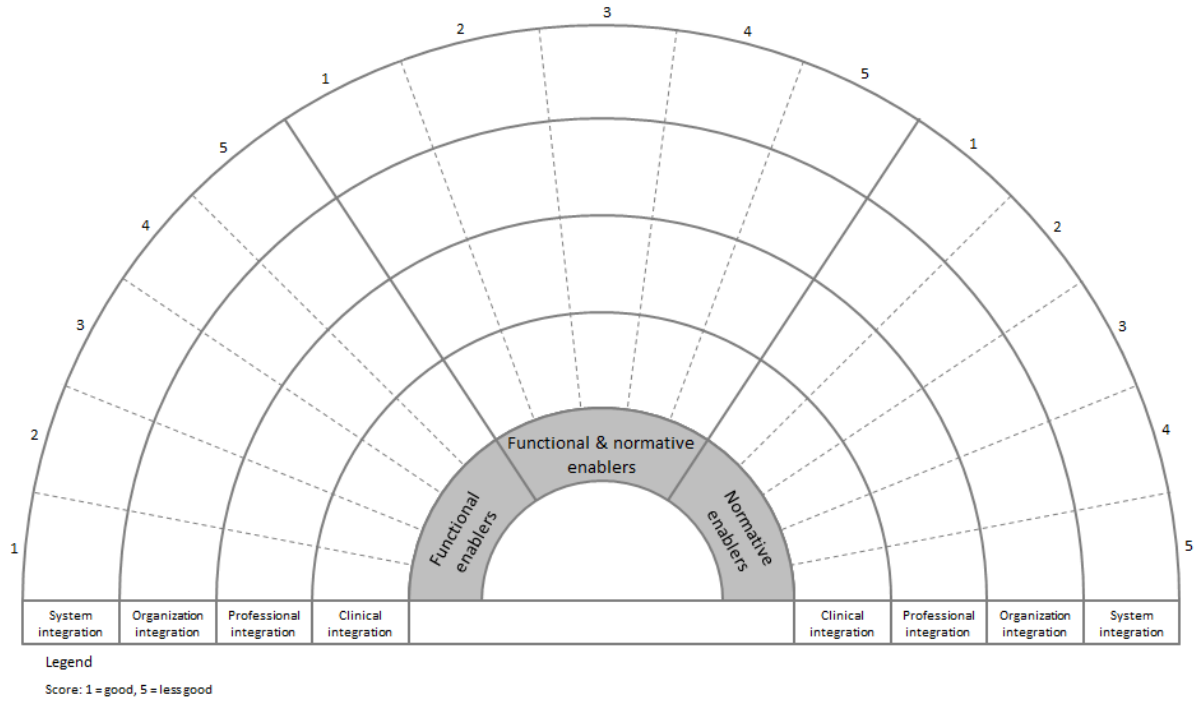

Figure 8.1: Adjusted RMPCP

Example of results plotted in the RMPCP

In Figure 8.2 one can see the twelve ranked success and failure factors plotted in the adjusted RMPCP. Success factor no. 1 "A common vision and ambition" is plotted as a normative enabler and for professional and organizational integration. Because this factor is ranked as first and is the most important normative enabler it

is scored below number 1. Success factor no. 7 “Appoint an external, independent facilitator/program/project leader” is plotted as a functional enabler and for professional and organizational integration. Because success factor no. 6 is ranked higher than factor no. 7, is factor no. 7 scored below number 2. The same applies to the factors scored in the ‘functional & normative enablers’ part, based on Figure 8.2 one can for instance see that success factor no. 4 is of more importance than success factor no. 11, because factor no. 4 is scored below 1 and factor no. 11 is scored below 5.

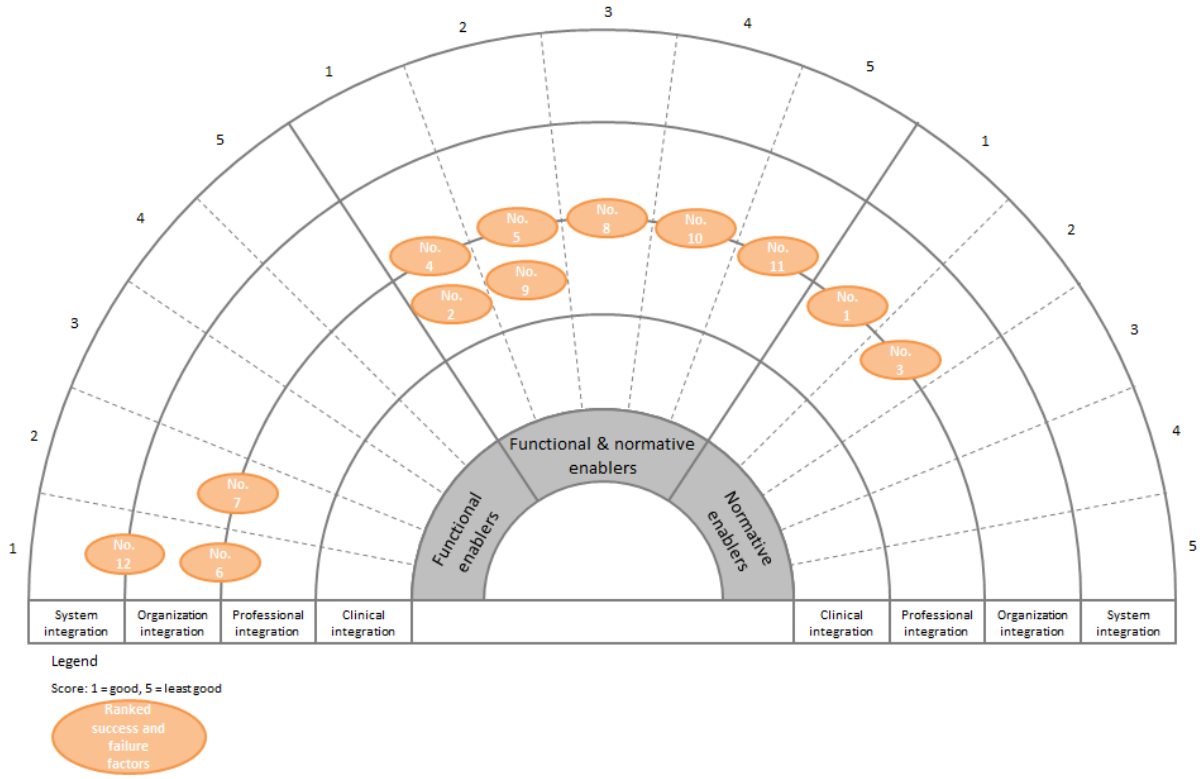

Figure 8.2: Example: success and failure factors plotted in the adjusted RMPCP

8.3. Strengths and limitations

This study has several strengths and limitations, which will be discussed in this section, starting with the limitations. The limitations of this study should be considered when one interprets the results of it. The first limitation of this study is that the results are only interpreted by the researcher, the same applies to the results plotted in the RMPCP. Second, eleven of the seventeen interviews were face-to-face, the other interviews were conducted by phone. This approach might have caused information bias because the respondents might have given socially acceptable answers, or they might have been influenced by the researchers’ intonation. At last, the researcher of this study is offered a job during the study by an indirect stakeholder of PCP in Twente.

Next to the limitations does this study have strengths. First, the five interviewed experts formed a representative group of experts, because of their experience, knowledge and their work field. Second, during the stakeholders interviews in Twente the researcher found out that three stakeholders were missing. For that reason these missing stakeholders were also interviewed. Third, all interviewed respondents gave feedback on their transcribed interviews and four out of five experts gave feedback on a draft model of an ideally organized PCP in Twente, resulting in enhanced internal validity. At last, the two drafted scenarios were presented to employees of Menzis in a region meeting, these employees provided the scenarios of feedback, resulting in two supported scenarios within Menzis.

8.4. Recommendations

This section describes two types of recommendations. First practical recommendations for Menzis' role in the development in PCP. Second, recommendations for further research.

Based on the drafted scenarios and assuming that Menzis still wants to develop PCP in Twente, Menzis should start with appointing an external, independent facilitator. Thereafter, it should draft a formal framework with preconditions for a PCP initiative. Subsequently, Menzis should determine its preferred, initial role for the development of PCP in Twente; stimulating or directing. In case of stimulating it should let the external facilitator organize a meeting to discuss the future trends of healthcare and what this means for Twente for all involved stakeholders. In case of a directing role, Menzis should draft a long term PCP policy and share this with all involved stakeholders.

Recommendations for further research are to do research for other healthcare changing solutions, because four out of five experts did not mention PCP as the solution for the future healthcare trends. In particular, to do research to the healthcare trends specific for the region of Twente. For instance, what will the healthcare trends imply for the region of Twente? And what would the best suitable integration strategy be for the region of Twente, to tackle these trends? This in order to create awareness among the involved stakeholders and to realize an affordable and durable healthcare in the region of Twente. Possible suggested solutions by the experts are for instance, substitution of care from primary or GP care to social domain and/or self-management or population oriented working/funding. Another recommendation would be to do research for a funding system independent of the healthcare lines, so this can be applied for PCP but also for other future healthcare systems. Because the funding system of healthcare is experienced as an obstacle in the implementation of PCP.

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Appendices

Appendix I - More information literature review

Substitution

Cost perspective of substitution

The HIA (Health Insurance Act) aims at more substitution, this because substitution is desirable from a financial perspective, assuming that primary care is less expensive than secondary care (1). With the advent of the HIA in 2006 the Dutch government included several incentives to stimulate substitution (2). The HIA introduced additional payments for specific services in primary care, substituted from secondary care. This because previous research showed that additional payments for specific services in primary care stimulates substitution (3, 4). Nivel states that substitution of healthcare will be cost-effective and therefore can help in reducing healthcare expenditures (5). This because the less expensive costs in the primary care will rise, but the total healthcare expenditures will decrease (6). Regarding the cost-effectiveness are two ways of substitution desirable: the quality of care remains the same against lower costs, or the quality of care improves at the same costs (7, 8). Although one of the goals of substitution is to control the healthcare expenditures, this is according to the Ministry of VWS not the main goal. Substitution is also important to guarantee the accessibility and continuity of care on the long term (2).

Potential for substitution

According to literature it seems that there is enough space for substitution of secondary to primary care in the Netherlands (5). Technological developments and innovations make it, for example, possible that more care can be substituted (2). Although these positive predictions, the extent and the speed of substitution are unknown and hard to predict (9). Next to that it is unknown to what extent and what kind of care will be eligible to substitute secondary to the primary care (5). In order to prove substitution it is essential to follow specific patient groups, this because possible effects of substitution will not be visible when patient groups will be merged (10). Literature also advices to substitute care which has clear care standards and guidelines and which has sufficient size in GP practices (5).

Preconditions for substitution

Literature prescribes preconditions for substitution of care, in this paragraph these preconditions are summarized. At first, substitution policy should focus on as well as the primary as the secondary line, this in order to create a consistent policy (5). Development of cooperation structures that stimulate referring back to primary care should be promoted, for example a guideline should be drafted to promote this (5). Substitution of care asks for a firm primary care, this because GPs and physician assistants need to have sufficient knowledge to guarantee the quality of care (1, 5), GPs should also have more support and insight in their own actions with regard to referrals (5).

Substitution will only succeed if appropriate agreements between healthcare professionals are made and if they have trust in each other (5). Next to that requires substitution a behavioural change, involving knowing (having the necessary knowledge of each other and each other's (im)possibilities), being able (being able to show relevant skills and competences for the delivery of care), willing (providing care given any additional (pre)conditions) and doing (implementation of the factual care delivery)(8, 11).

Insight in potential care which can be substituted and transparency are essential in comparing the quality and the purchase of care (8, 12). Financial space should also be provided to improve the consultation between the medical specialists and GPs (5) and alignment of incentives should also take place (for example integrated tariffs) (12). At last should patients preferences and trust be taken into account, because their preferences seem to be influenced by the type of medical intervention (5, 13).

RMIC

Scope, type and enablers categories

The comprehensive RMIC is organized into three main categories, namely scope, type and enablers, see Table I for its description (14).

Table I: Description of categories in the RMIC

Category	Description
Scope	The scope is divided into person-oriented and population-oriented. In specifying the scope of an integrated care initiative, this might help to understand and describe the guiding principles and objectives of that initiative.
Types of integration	The types of integration processes (integration at system, organizational, professional or clinical) can be used to explore the (dis)similarities of integration mind-sets between involved stakeholders.
Enablers	The enablers can be used to clarify and interpret the technical (functional) and cultural (normative) enablers, which are needed to achieve common aims and optimal results of an integration effort.

Types of integration

The different types of integration, as included in the RMIC, have the following definitions (14):

Table II: Integrated care dimension of the RMIC

Level	Types of integration	Description
Macro	System integration	The alignment of policies and rules within a system.
Meso	Organizational integration	The extent in which services across different organizations are organized by organizations.
Meso	Professional integration	The extent in which services across various disciplines are organized by professionals.
Micro	Clinical integration	The extent in which care services are coordinated.
Micro, meso & macro	Functional integration	The extent in which support and back-office functions are coordinated.
Micro, meso & macro	Normative integration	The extent in which work values, mission etc. are shared within a system.

Subgroups of (dis)similarity integration mind-sets between stakeholders

Valentijn identified three subgroups of (dis)similarity integration mind-sets between stakeholders, namely a 'united integration perspectives (UIP)' subgroup, a 'disunited integration perspectives (DIP)' subgroup and a 'professional oriented integration perspectives (PIP)' subgroup. The different subgroups had various effects on the interpersonal conditions in a project, see Table III for a description of these results (14).

Table III: Results per subgroup on interpersonal conditions in projects

Subgroup	Results
United integration perspectives (UIP)	These projects had the strongest increase in control-based (organizational dynamics and process management) and trust-based (mutual gains and relationship dynamics) collaboration conditions. Next to that had these projects the highest overall effectiveness among stakeholders.
Disunited integration perspectives (DIP)	In contrast to the UIP projects, projects with DIP had to lowest overall effectiveness among all stakeholders and decreased on collaboration conditions.
Professional oriented integration perspectives (PIP)	PIP projects had the highest effectiveness rates among professionals and showed an increase in control-based collaboration conditions (organizational dynamics and process management).

Valentijn states that in order to obtain an effective integrated care project, one need to have multiple stakeholders with a similar integration mind-set. One needs both trust-based and control-based collaboration conditions to align disunited integration viewpoints. Concluding, in order to achieve a collaborative advantage of an integrated care initiative, involved interpersonal collaboration conditions are essential in its development (14).

Participation stairs

In this section the roles which a health insurer can take on the participation stairs, will be described (15).

Table IV: Explanation possible roles health insurer

Role	Explanation
Releasing	When a health insurer releases a task completely. It has no involvement either in terms of content or in the process.
Facilitating	A health insurer chooses for a facilitating role if an initiative comes from elsewhere and it sees interest in making it possible.
Stimulating	A health insurer does have the wish that a certain policy or interventions get off the ground, but it leaves the realization of it to others. It is only looking for opportunities to get others to move.
Directing	When a health insurer chooses for directing, then this means that other stakeholders have a role, but the health insurer prefers to have the control in the cooperation with the stakeholders.
Regulating	The heaviest instrument which a health insurer can use is regulation through legislation and regulations. As a consequence of this means, the health insurer can also enforce and sanction violation.

(Dis)advantages of PCP

In this section will the disadvantages and advantages of PCP further described. First will the advantages be described, followed by the disadvantages.

Table V: (Dis)advantages PCP

Advantage	**Explanation**
1. PCP improves the (experienced) quality of care.	PCP improves the (experienced) quality of care because patients can receive care closer their homes (16), shorter waiting time (17), improved patient-centeredness (17), fewer referrals to hospital care and lower costs for patients (18-27). For substitution of care applies that it will improve the accessibility, approachability and care will be provided closer to patients home (1, 13, 28).
2. PCP is supposed that health outcomes of the population (non-acute, low complexity complaints) will be the same. & 3. PCP has no influence on the level of safety and equity of care	It is supposed that health outcomes of the population (patient with non-acute and low complexity complaints) will be the same. This because patient receive the same diagnostics and care as provided by healthcare professionals with the same level of expertise. Similarly, PCP has no influence on the level of safety of care and equity of care. (17)
4. PCP is supposed to reduce or at least not to increase healthcare costs.	It is supposed that PCP will lead to reduced healthcare costs or at least no increase in the total costs of care (19-22, 24, 26, 27, 29-33), this because fewer referrals will be made to the expensive hospital care, lower costs in PCP in comparison with hospital care due to lower overhead costs and more treatments in PCP at lower tariffs (16, 20, 21, 33). For this reason can be stated that, related to healthcare costs, PCP improves the efficiency of care (17). For substitution of care applies that it offers cost benefits, while health outcomes and quality of care seem to be remained at the same level (34-36).
5. PCP is supposed to improve the effectiveness of care.	PCP supposes to improve the effectiveness of care because PCP results in fewer unnecessary referrals to the hospital, so care will be less overused (17). PCP does also result in better patient selection, due to better referrals to and back from the primary to the secondary line and vice versa (1, 17, 37). Due to the provided service of secondary care in the primary and/or PCP line, results this in a quality improvement of care (38).
6. Healthcare professionals have more knowledge about each other's qualities.	Healthcare professionals between the primary and secondary care have easier and more contact (1). Healthcare professionals have also more knowledge about each other's qualities, because of the improved cooperation and communication (1, 17). In long term may this result in even fewer referrals to the hospital because the GP will treat patients themselves. (17)
Disadvantage	
1. PCP could lead to immoderate medical consumption and over-diagnosis.	PCP could lead to immoderate medical consumption and over-diagnosis (27, 32). And experience some GPs problems with referring patients to the correct place for care, for example PCP canter or the hospital.
2. Due to the current funding system, PCP is difficult to finance.	Until now there are no clear or simple financing options from the NZa. The same applies to substitution of care, due to the funding system of the healthcare the risk arises of double payments. The health insurer will pay the full DBC-tariff and the additional costs for the substituted care in the primary care. When patients are already in treatment in secondary care, substitution will then not be attractive for health insurers. This because in secondary care a DBC is then already opened, and for that reason will substitution not result in a cost-reduction.(1)
3. Joint consultation will not be cost-effective without an efficient planning/use of time	In case of joint consultation should the consultation hours and time of MS's be used efficient as possible. Joint consultation will not be cost-effective without an efficient planning and efficient use of consultation hours(18, 20, 21, 33, 39-41)
4. In case of a new PCP centre, could PCP lead to increased healthcare costs.	PCP could, in a new centre, possible lead to increased healthcare costs. This may be caused by overhead costs, medical and nurses staffing costs, travel time and costs and inefficient use of MS time (21, 27, 31).
5. No national blueprint is available for PCP.	Every PCP initiative must be started up separately because there is no national blueprint for PCP available (5). Next to that does PCP depends to a large extent on the content and follow-up of the involved healthcare providers(27) and does it seem logical that the demand for PCP differs per specialty because each specialty has a different patient population(27, 42). For these reason it is questionable if PCP is applicable to all kinds of specialties, in its current form (27).

Success and failure factors

In this section will the success and failure factors, as described in the literature review, be further explained. This section is divided in the same subsections as in the literature review.

A common vision and ambition

A common vision and ambition forms the basis for PCP cooperation. By working out goals that meet the population needs, the health of the population, the social impact and the objectives of Triple Aim, a solid foundation will be created. (18, 43)

Monitor or evaluate cooperation based on progress of the realization of ambition and objectives. Make this part of the regular process. Organize a process of learning and improvement. Focus not only on cost savings, but also on patient perception and better health. Use cost-data that is analysed and inserted by the insurer. Give substance to population management and also measure the social impact. Only then it is possible to assess the success of the cooperation (43).

For successful cooperation it is advisable to take the interests of all interested stakeholders into account (25), so a win-win situation arises for the individual stakeholders and added value for the whole. Take also into account the interests and possible risks for the individual healthcare professionals, such as overloading of GPs and loss of income for the MS (18, 43). The necessary cooperation of hospitals and MS to substitute care to the primary care is a conditional factor for substitution it's success (16). For this reason the right incentives for both GPs and MS need to be applied (8, 12).

The extent to which HI participates in the cooperation is decisive for success (43). According to NZa, substitution initiatives by care providers run into nothing during or after consultation with the HI (16). Why this happens is unclear. Next to that should resistance be taken into account, surprisingly often happens this with hospital directors, who have the feeling of losing autonomy (16).

For successful substitution should be invested in trust between individual healthcare professionals. A long cooperation tradition helps. When this tradition is not present one need to invest more in building up a solid trust relation (18, 43, 44). In a successful cooperation healthcare professionals can address each other on made agreements and complement each other (5, 18). This direct communication between GP and MS seems to have a positive influence on perceived quality of care and health outcomes, in comparison with GPs and MS without direct communication (18, 24, 31, 45). At last another important success factor is the trust from patients in GPs who perform MS services (8, 12).

Organization of PCP

Capturing the collaborative agreements in a formal agreement doesn't seem to be necessary for a successful cooperation. However, some form of organization seems to be important for process control. At least one representative from primary and secondary care and one from the HI need to participate in an administrative consultative body of the substitution project. Next to that should (non-) cooperating organizations, such as laboratory or academic hospitals, be defined (11, 16, 18).

Two key positions in a substitution project are crucial for its success. First a 'leader' who can connect the different organizations at an administrative level. And second a 'leader' who has the ability to connect all different healthcare professionals (18, 43, 44). Appointing a program-, project manager or facilitator is worth of return. This person is an external, independent and has the competencies to connect parties. He or she is preferably not included in the cooperation organization (18, 43).

At last there needs to be (municipal) governmental support. This because no one will start a project when halfway politics will choose the side of, for example, a troubled local population or counteractive directors or healthcare professionals. Next to that needs the process be designed that implementers can keep up the pace. At a low pace, will disintegrate support and will arise resistance (16, 18, 27).

Facilitate cooperation with 'flanking policy' on personnel support, training, information exchange and develop common ICT (5, 18). Ensure good accessibility and accessibility for the patient ('1-counter') (43).

In case of joint consultation does the consultation hours and time of MS's be used efficient as possible. Joint consultation will not be cost-effective without an efficient planning and efficient use of consultation hours. For this reason it's essential to have an adherence area that provides sufficient patients for an efficient use and planning of consultation hours (18, 20, 39-41).

Healthcare professionals

The healthcare professionals themselves in particular have to give form and content to the cooperation. This works better when they know each other's interests and experience the benefits of the cooperation. If insufficient attention is paid to this, this will form a great risk to success in the implementation phase (43).

Next to that should a diagnostic protocol, in which responsibilities for GPs and MS are defined, be created. The MS should also have access to previous diagnostic results, also from organizations other than the hospital, this in order to avoid double diagnostics (18). At last should GPs be able to deliberate with MS about referral uncertainties and should various possibilities be arranged for GPs to deliberate with MS (18).

Difference in job interpretation is an important impeding factor because in practice this could lead to suspicion, competence battle, competition and poor information provision (46). GPs and MS need to communicate about quality, because the essence of substitution is providing better care (16). For this reason Nivel and NZa suggest that an agreement between GPs and MS about eligible MS services which are manageable by GPs should be agreed, GPs should also be able to perform the agreed services (8, 12). Next to that should MS who will be working with PCP be eligible according an appropriate and qualified profile (18).

Financing of PCP

Next to that is the current way of financing both lines still strictly separate, which means that cooperation initiatives are still difficult to achieve (16). The lack of clear funding for substitution can be an impeding factor for the implementation (5, 18).

Another impeding factor is when an increase in the volume of GP care at the expense of hospital care as a result of substitution, the GPs risk that this will lead to exceeding the budgetary framework for GP care, resulting in a discount measure. The recent exceeds of the macro framework for GP care and the associated reductions may discourage GPs to provide extra (substituted) care (8, 12). The agreements on the honorarium of independent medical specialists concern a maximum, but this agreement can be considered as an impediment for HI's on substitution and the resulting cost savings. Next to that can making substitution agreements be complicated because these concern both hospital cost part and honorarium part of independent MS (8, 12).

The financial preconditions are essential for good cooperation. Make regional long-term agreements with profit-sharing and shared savings (43). The availability of a compensation funds can help to compensate 'losers' or take barriers for cooperation away (16). An obstacle in setting up new initiatives is the NZa-regulations and tariff-structure (6, 38). The Netherlands knows the DBC-system, this system has an incentive for substitution from primary care to secondary care, the opposite of the desired direction.

In order to support the process of substitution from secondary to primary care, financial incentives between GPs and MS should be aligned. This because potentially negative financial consequences for either GPs or MS, could prevent that substitution of care will take place. This could also harm the relationship between both types of healthcare professionals (8, 12).

Substitutable care products

In Paragraph 2.8 an example of the list for potential substitutable care products is described. In this section an example of a part of this list will be given, see Figure I.

dei	Zorgproduct	Omschrijving	Specialisme
15B412	990089010	Pijnbestrijding bij Lage rugklachten	Anesthesiologie
15C406	090301007	Consult op de polikliniek bij Hoge bloeddruk	Cardiologie
15B343	210301002	Sterilisatie van de man bij Anticonceptie / Voorbehoedsmiddelen	Chirurgie
15C190	029899007	Een ingreep aan de huid (enkelvoudig) bij Goedaardige tumor van de huid	Dermatologie
15B344	210301004	Plaatsen van een spiraal bij Anticonceptie / Voorbehoedsmiddelen	Gynaecologie
15C606	119999015	Consult op de polikliniek bij Een ziekte van slokdarm / maag / twaalfvingerige darm	Gastro-enterologie
15C502	109699016	Beeldvorming (rontgen/echo/CT/MRI) bij Een aandoening van het ademhalingsstelsel	Longgeneeskunde
15C726	131999150	Consult op de polikliniek (Vervolg contact) bij Ziekten van botspierstelsel	Neurologie
15A562	089999044	Consult op de polikliniek bij Middenoorontsteking	KNO
14E013	990416050	Consult op de polikliniek bij Diarree	Kindergeneeskunde
15B653	079999013	Consult op de polikliniek bij Een aandoening van ooglid / traanapparaat / oogkas	Oogheelkunde
15B114	131999197	Onderzoek of behandeling op de polikliniek of dagbehandeling bij Artrose (gewrichtsslijtage) in de knie	Orthopedie
15C714	131999117	3 tot 4 polikliniekbezoeken (met echo) bij Een reumatische aandoening	Reumatologie
15C937	149999069	Consult op de polikliniek bij Een aandoening van urinewegen of prostaat	Urologie
15B738	099799028	Consult op de polikliniek bij Een aandoening aan aders / lymfevaten / lymfeklieren	Inwendige Geneeskunde

Figure I: An example of the substitution list

References Appendix I

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Appendix II - Cooperated respondents

In this appendix the respondents and their backgrounds are described, this in order to give more insight in cooperated respondents of this research.

Experts

- Dr. P.P. Valentijn

Valentijn is a research consultant for value-based care solutions and active as vice president at Essenburgh, senior researcher at Maastricht University and at azM / Maastricht UMC+.

- Dr. M.A. Bruijnzeels

Bruijnzeels is associate professor at Leiden University Medical Centre and director of Jan van Es Instituut. Jan van Es Instituut is a Netherlands expert centre for integrated primary health care.

- Dr. G.J.C. Schulpen

Schulpen is medical director of foundation ZIO, chairman of foundation Gezondheidscentra Maastricht and member of program board of Vilans.

- Drs. J.E. de Wildt

De Wildt is director of care federation DOH, owner of De Eerstelijns platform for strategy and innovation and program coordinator for masterclasses eHealth strategy and primary care directors. Next to that is de Wildt active in multiple boards, such as member of Supervisory Board of care federation Syntein, member of advisory board of KNOV and member of the Board of Members of Slimmer Leven 2020

- Drs. P. Offringa

Offringa is manager care purchase at De Friesland Zorgverzekeraar. Therefor Offringa was manager commercial business at Bernhoven.

Practical visits

- M.R. Leeflang

M. Leeflang is director of ECT Tiel.

- Drs. M. van Rossum

M. van Rossum is manager of GP practice in Academic health centre Thermion Lent

- A. Ruesen

A. Ruesen is accountmanager of Sûnenz / ZuidOostZorg

- Anonymous

This respondent wished to be anonymous, the respondent is the chairman of the foundation that set up health centre Antonius in Oostburg.

Stakeholders Twente

- ZGT - Drs. R. van den Berg

Van den Berg is business administration manager at hospital ZGT, he is project manager 'zinnige en doelmatige zorg'.

- ZGT Coöperatie Medisch Specialisten – Dr. H.H.D. Idzerda

Idzerda is cardiologist at hospital ZGT. Next to that is Idzerda secretary and CFO of Cooperation Medical Specialists in ZGT.

- MST – Drs. R. van der Bijl, Drs. A. Ligthart-Molenkamp and Drs. E. Stijnen

Van der Bijl is staff manager marketing, communication and sales at hospital MST. Ligthart-Molenkamp is account manager marketing and sales at MST and Stijnen is project manager healthcare innovation at MST

- MST Medisch Stafbestuur – Dr. R.J. Trof

Trof is an intensivist at hospital MST. Next to that is Trof chairman of medical staff management in MST.

- THOON – C. van Dijk and M. Troost

Van Dijk is director of care federation THOON. Troost is advisor program development and care innovation.

- FEA – J. Snel and W. Veerman

Snel is director of care federation FEA and director of GP post Almelo. Veerman is GP, GP trainer, chairman of care federation FEA and GP post Almelo. At last Veerman is active as commissioner and vice-chairman of VvAA.

- Zorgnetwerk Zenderen – Drs. W. de Vries

De Vries is director of Roset, the facilitator of Zorgnetwerk Zenderen.

Appendix III-a – Interview schedule experts

Interview over ideaal georganiseerde anderhalvelijnszorg

Dit interview zal in het kader van de master scriptie van GertJan Engberts worden afgenomen om inzicht te krijgen in welke rol de zorgverzekeraar in een ideaal mogelijke anderhalvelijnszorg setting zou moeten innemen. Om onduidelijkheid over de definitie van anderhalvelijnszorg te voorkomen is de definitie die in dit onderzoek wordt gehanteerd hieronder opgenomen:

"Anderhalvelijnszorg is zorg dat wordt geleverd door een medisch specialist en/of een huisarts, geleverd in de eerste lijn en gefinancierd vanuit het eerstelijns bekostigingssysteem. Anderhalvelijnszorg is gebaseerd op twee basis principes: veranderingen in de organisatie van zorg en een gedragsverandering in zowel zorgverleners als patiënten. Anderhalvelijnszorg is zorg op het raakvlak van complexe- of chronische eerstelijnszorg en niet acute- laag complexe tweedelijnszorg. Anderhalvelijnszorg combineert de toegankelijkheid van de eerste lijn met specifieke kennis en diagnostiek uit de tweede lijn. De huisarts blijft in regie en is eindverantwoordelijk voor de patiënt in anderhalvelijnszorg."

Anderhalvelijnszorg heeft verschillende vormen, namelijk: substitutie van tweedelijns zorg en diagnostiek naar de eerste lijn, eerstelijnsverblijf bedden, gezamenlijke consultatie van medisch specialist en huisarts al dan niet ondersteunt met eHealth. Deze zorg kan geleverd worden in een speciaal anderhalvelijnszorg centrum of in een eerstelijnszorg/huisarts praktijk/centrum.

Op de volgende vragen hoop ik in ieder geval antwoord te krijgen in het interview.

1. Stel u hebt een greenfield van de Nederlandse gezondheidszorg, hoe zou volgens u anderhalvelijnszorg zo ideaal mogelijk georganiseerd kunnen/moeten worden?
    a. In welke mate is volgens u een rol weggelegd voor eHealth in anderhalvelijnszorg?
    b. Welke veranderingen zijn benodigd om uw ideaal geschetste 'model' van anderhalvelijnszorg te kunnen bewerkstelligen?
2. Welke passende rol (rollen) is voor de zorgverzekeraar weggelegd in uw ideaal geschetste 'model' van anderhalvelijnszorg?
    a. Op welke manier zou de zorgverzekeraar volgens u kunnen sturen in het opzetten / stimuleren van meer anderhalvelijnszorg?
    b. Welke prikkels zijn volgens u, vanuit de zorgverzekeraar, nodig om anderhalvelijnszorg meer te kunnen stimuleren?
    c. Is selectieve inkoop van zorg een manier om meer substitutie van zorg/anderhalvelijnszorg te kunnen bewerkstelligen?
3. Welke rol is voor het ziekenhuis en de medisch specialisten weggelegd in uw ideaal geschetste 'model' van anderhalvelijnszorg?
    a. Denkt u dat wanneer medisch specialisten in loondienst zijn van het ziekenhuis, substitutie afspraken sneller gemaakt zullen worden? Ja/nee, waarom?
4. Welke rol is voor de huisarts en de eerste lijn weggelegd in uw ideaal geschetste 'model' van anderhalvelijnszorg?
    a. Bij eventuele toenemende zorgvraag in de eerste lijn (door substitutie van zorg), hoe zal de eerste lijn de extra zorgvraag door substitutie op moeten gaan vangen?
5. Na aanleiding van uw interview en dat van vier andere experts ga ik een concept model van een zo ideaal mogelijk georganiseerde anderhalvelijnszorg maken. Zou u dit concept model t.z.t. van feedback willen voorzien om zo de interne validiteit van mijn onderzoek te bevorderen?

**** Einde interview ****

Appendix III-b – Interview schedule practical visits

Interview - Anderhalvelijnszorg

Dit interview zal in het kader van de master scriptie van G.J. Engberts worden afgenomen om inzicht te krijgen in verschillende soorten van anderhalvelijnszorg centra in Nederland. De uitkomst van dit interview zal niet door Menzis worden gebruikt in bijvoorbeeld de zorginkoop-gesprekken. Om deze reden is het mogelijk dat dit interview en de uitkomsten van dit interview geanonimiseerd worden. Om onduidelijkheid over de definitie van anderhalvelijnszorg te voorkomen is de definitie die in dit onderzoek wordt gehanteerd hieronder opgenomen:

"Anderhalvelijnszorg is zorg dat wordt geleverd door een medisch specialist en/of een huisarts, geleverd in de eerste lijn en gefinancierd vanuit het eerstelijns bekostigingssysteem. Anderhalvelijnszorg is gebaseerd op twee basis principes: veranderingen in de organisatie van zorg en een gedragsverandering in zowel zorgverleners als patiënten. Anderhalvelijnszorg is zorg op het raakvlak van complexe- of chronische eerstelijnszorg en niet acute- laag complexe tweedelijnszorg. Anderhalvelijnszorg combineert de toegankelijkheid van de eerste lijn met specifieke kennis en diagnostiek uit de tweede lijn. De huisarts blijft in regie en is eindverantwoordelijk voor de patiënt in anderhalvelijnszorg."

Anderhalvelijnszorg heeft verschillende vormen, namelijk: substitutie van tweedelijns zorg en diagnostiek naar de eerste lijn, eerstelijnsverblijf bedden, gezamenlijke consultatie van medisch specialist en huisarts al dan niet ondersteunt met eHealth. Deze zorg kan geleverd worden in een speciaal anderhalvelijnszorg centrum of in een eerstelijnszorg/huisarts praktijk/centrum.

Waar anderhalvelijnszorg centrum staat kan ook anderhalvelijnszorg behandeling, diagnostiek of samenwerking gelezen worden. Het interviewschema is opgebouwd in verschillende paragrafen, te beginnen bij "opzetten van dit anderhalvelijnszorg centrum".

Opzetten van dit anderhalvelijnszorg centrum

Omgevingsfactoren:

- **Centrum**:
- **Ziekenhuis**:
- **Huisartsen**:
- **Preferente zorgverzekeraar**:
- **Adherentie gebied**:

1. Welke omgevingsfactoren zijn nog meer relevant voor dit anderhalvelijnszorg centrum?
2. Hoe is dit anderhalvelijnszorg centrum opgezet?
    a. Hoe is de aanloopfase tot de ontwikkeling van dit anderhalvelijnszorg centrum gegaan?
    b. Hoe is een samenwerkingsverband met de betrokken actoren tot stand gekomen?
3. Waarom is er destijds voor gekozen om dit anderhalvelijnszorg centrum op te zetten? En waar lag het initiatief tot het opzetten van een anderhalvelijnszorg centrum?

Vormen van anderhalvelijnszorg en welke zorg

4. Welke verschillende vormen van anderhalvelijnszorg / substitutie van zorg worden hier toegepast? *Consultatie medisch specialist, eerstelijnsverblijfbedden (ELV), teleconsultatie/eHealth, laagcomplexe ingrepen & diagnostiek van 2e naar 1e lijn, acute zorg.*
    a. Waarom is er gekozen voor deze vormen van anderhalvelijnszorg / substitutie van zorg?
    b. Denken jullie dat in de nabije toekomst meer/andere vormen van anderhalvelijnszorg in dit centrum toegepast gaan worden? Zo ja: welke en waarom?
    c. Bij geen teleconsultatie/eHealth: Waarom vindt er vanuit dit anderhalvelijnszorg centrum (nog) geen teleconsultatie/eHealth plaats tussen een huisarts en een medisch specialist en wat is jullie visie hierop?

Aangeboden zorg(producten):

-

5. Welke zorg(producten) wordt in dit anderhalvelijnszorg centrum aangeboden?
    a. Welke zorgverlener is eindverantwoordelijk bij anderhalvelijnszorg / substitutie van zorg?

Succes- en faal/beperkende factoren & voor- en nadelen

Uit literatuur komen de volgende succes- en faal/beperkende factoren naar voren:

1. *Gemeenschappelijke visie en ambitie.*
2. *Creëer een van win-win situatie, houd rekening met de belangen van alle stakeholders.*
3. *Investeer in een vertrouwensrelatie tussen de betrokken stakeholders.*
4. *Zorg voor een leider op organisatie niveau en een leider op zorgprofessional niveau.*
5. *Enige vorm van organisatie in de processturing; een bestuurlijk overlegorgaan waar een vertegenwoordiger van alle betrokken stakeholders bij betrokken is.*
6. *Aanstelling van een externe, onafhankelijke programma/project leider.*
7. *De zorgprofessionals moeten zelf de samenwerking vorm en inhoud geven.*
8. *Monitor of evalueer de samenwerking aan de hand van de voortgang of de realisatie van de ambitie en doelstellingen.*
9. *Faciliteer de samenwerking met 'flankerend beleid' op personele ondersteuning, opleiding, informatie-uitwisseling en ontwikkel gemeenschappelijke ICT.*
10. *Financiële randvoorwaarden zijn essentieel voor een goede samenwerking.*
11. *Er moet (gemeentelijk) politieke steun zijn.*
12. *Houd het tempo hoog.*

6. Herkent u zich in deze succes- en faal/beperkende factoren?
7. Wat zijn de succes- en faalfactoren van dit anderhalvelijnszorg centrum?
    a. Waar moet, volgens uw ervaring, bij het opzetten en het managen van een anderhalvelijnszorg centrum voornamelijk rekening mee gehouden worden?
8. Zou u een ranking willen maken van de succes- en faalfactoren (uit literatuur) en jullie factoren?

Uit literatuur komen de volgende voor- en nadelen naar voren:

Voordelen:

- *Verbetering van de effectiviteit van zorg, door minder onnodige verwijzingen naar de tweede lijn, dus minder overmatig gebruik van zorg.*
- *Beter patiënten-selectie door betere door- en terug verwijzing van de eerste- naar de tweede lijn en andersom.*
- *Kwaliteitsverbetering in eerste/anderhalvelijnszorg door aanbod van tweedelijnsexpertise.*
- *Zelfde gezondheidsuitkomsten als zorg in de tweede lijn.*
- *Lagere kosten voor patiënten, door geen aanspraak op eigen risico.*
- *Verbetering in de ervaren kwaliteit zorg door zorg dichter bij huis, minder lange wachttijd, verbeterde patiëntgerichtheid.*
- *Eenvoudiger en meer contact tussen zorgverleners van de eerste- en tweede lijn en meer kennis over elkaars kwaliteiten.*
- *Verbetering van de efficiëntie van zorg, gerelateerd aan zorgkosten.*
- *Vermindering van zorgkosten, door; minder doorverwijzing naar het ziekenhuis waardoor minder gebruik van ziekenhuis services wordt gemaakt, lagere kosten in anderhalvelijnszorg door lagere overhead kosten en dezelfde verrichtingen in anderhalvelijnszorg tegen lagere tarieven.*

Nadelen:

- *Mogelijk hogere zorgkosten door overhead kosten, extra zorgpersoneelskosten, reistijd, inefficiënt gebruik maken van de medische specialist zijn tijd en overmatige medische consumptie en over diagnose.*
- *Minder efficiënt gebruik van tijd van medisch specialist.*
- *Elk initiatief dient weer afzonderlijk opgestart te worden omdat er geen landelijke blauwdruk voor anderhalvelijnszorg mogelijk is.*
- *Tot dusver nog geen eenduidige financieringsmogelijkheden.*

9. Welke voor- en nadelen zien jullie/hebben jullie nog meer gezien in dit anderhalvelijnszorg centrum?

Rol zorgverzekeraar

10. Wat is de rol van de zorgverzekeraar geweest in het opzetten van dit anderhalvelijnszorg centrum?

a. Wat is de rol van de zorgverzekeraar op dit moment in dit anderhalvelijnszorg centrum? Denkt/werkt de zorgverzekeraar mee met nieuwe ontwikkelingen?

11. Hoe worden de verschillende vormen van anderhalvelijnszorg in dit centrum gefinancierd?
    b. Wat is uw ervaring m.b.t. de bekostiging van anderhalvelijnszorg (door de twee verschillende bekostigingsstructuren van de eerste en tweede lijn)? Wat zou volgens u wenselijk zijn?
12. Hoe zou de zorgverzekeraar volgens u meer kunnen sturen/stimuleren op de ontwikkeling van anderhalvelijnszorg?

Rol anderhalvelijnszorg centrum in relatie met betrokken actoren

13. Wat is de rol van dit anderhalvelijnszorg centrum ten opzichte van/in relatie met andere stakeholders? Ziekenhuis/huisartsen praktijken/thuiszorg?
    c. Heeft de gemeente een rol gehad in het opzetten van dit anderhalvelijnszorg centrum/heeft de gemeente nu nog een rol in dit anderhalvelijnszorg centrum?
14. Anderhalvelijnszorg/substitutie van zorg vergt een gedragsverandering van de zorgverleners, hoe kan dit, op basis van uw ervaring, het beste bewerkstelligd worden? / Hoe stuur/stimuleer je zorgverleners om anderhalvelijnszorg te gaan verlenen?
15. Wat vindt de patiënt van het anderhalvelijnszorg centrum? Overbodig/goed/prettig i.v.m. eigen risico?

Uitkomsten van dit anderhalvelijnszorg centrum?

16. Bent u van mening dat door de komst van dit anderhalvelijnszorg centrum er (meer) sprake is van concentratie van zorg in het ziekenhuis (hoger gespecialiseerde zorg) en spreiding in bv. dit centrum (laagcomplexe zorg)?
17. Wordt de voortgang of realisatie van doelen/ambities van dit anderhalvelijnszorg centrum regelmatig gemonitord met de betrokken actoren?
18. Bent u van mening dat door het inzetten van anderhalvelijnszorg, middels dit centrum, sprake is van meer doelmatigheid en waarde gerichte zorg?
    a. Is de (ervaren) kwaliteit van zorg verbeterd door de komst van dit anderhalvelijnszorg centrum?
    b. Is de gezondheid van de populatie in deze regio verbeterd door de komst van dit anderhalvelijnszorg centrum?
    c. Zijn de kosten per hoofd van de bevolking verlaagt door de komst van dit anderhalvelijnszorg centrum?

**** Einde interview ****

Appendix III-c – Interview schedule stakeholders Twente

Interviewschema stakeholders anderhalvelijnszorg Twente

Dit interview zal in het kader van de master scriptie van G.J. Engberts worden afgenomen om inzicht te krijgen in de rollen van de betrokken actoren bij anderhalvelijnszorg in Twente. Om onduidelijkheid over de definitie van anderhalvelijnszorg te voorkomen is de definitie die in dit onderzoek wordt gehanteerd hieronder opgenomen:

"Anderhalvelijnszorg is zorg dat wordt geleverd door een medisch specialist en/of een huisarts, geleverd in de eerste lijn en gefinancierd vanuit het eerstelijns bekostigingssysteem. Anderhalvelijnszorg is gebaseerd op twee basis principes: veranderingen in de organisatie van zorg en een gedragsverandering in zowel zorgverleners als patiënten. Anderhalvelijnszorg is zorg op het raakvlak van complexe- of chronische eerstelijnszorg en niet acute- laag complexe tweedelijnszorg. Anderhalvelijnszorg combineert de toegankelijkheid van de eerste lijn met specifieke kennis en diagnostiek uit de tweede lijn. De huisarts blijft in regie en is eindverantwoordelijk voor de patiënt in anderhalvelijnszorg."

Anderhalvelijnszorg kan in verschillende vormen voorkomen, namelijk: substitutie van tweedelijns- zorg en diagnostiek naar de eerste lijn, eerstelijnsverblijf bedden, consultatie van medisch specialist al dan niet ondersteund met eHealth. Deze zorg kan geleverd worden in een speciaal anderhalvelijnszorg centrum of in een eerstelijnszorg/huisarts praktijk/centrum.

Heden

1. Welke rol ziet uw organisatie bij "kostenbesparing tegen gelijkblijvende kwaliteit, of hogere kwaliteit tegen dezelfde kosten"?

Een mogelijke manier om een kostenbesparing tegen gelijkblijvende kwaliteit, of hogere kwaliteit tegen dezelfde kosten te kunnen bewerkstelligen is anderhalvelijnszorg.

2. Wat is de rol van uw organisatie geweest in de huidige 'anderhalvelijnszorg diensten'?
3. Wat is de rol van uw organisatie in anderhalvelijnszorg in Twente?

Vanuit jullie perspectief

4. Wat is het beleid (of de visie) van uw organisatie met betrekking tot anderhalvelijnszorg?
5. In welke mate is anderhalvelijnszorg van belang voor uw organisatie?
6. Welke kansen en beperkingen ziet uw organisatie met betrekking tot anderhalvelijnszorg in Twente?
7. Ziet uw organisatie bedreigingen voor anderhalvelijnszorg in Twente? Zo ja; welke?

Verwachtingen

8. Wat verwacht uw organisatie van Menzis met betrekking tot anderhalvelijnszorg?
    a. Op welke manier zou Menzis anderhalvelijnszorg in Twente kunnen stimuleren volgens uw organisatie? / Welke prikkels zijn volgens uw organisatie gewenst?
9. Wat verwacht uw organisatie van de ziekenhuizen/zorggroepen in Twente met betrekking tot anderhalvelijnszorg?
10. Wat verwacht uw organisatie van de zorgprofessionals (huisartsen en medisch specialisten)?

Toekomst

11. Hoe ziet uw organisatie de gezondheidzorg in Twente in de nabije en verre toekomst voor zich?
12. Hoe ziet uw organisatie de samenwerking in de toekomst met de stakeholders voor de gezondheidszorg in Twente voor zich?

**** Einde interview ****

Appendix IV – Outcomes interviews experts on PCP

Health insurer Menzis believes that PCP is a way to work towards improved or unchanged quality of care at lower costs or improved quality of care at equal costs. However, Menzis wants to do research first. For this reason five experts have been interviewed, how, according to them, at a greenfield of the Dutch healthcare, PCP ideally should be organized. In this appendix a summary of the outcomes of the interviews is described.

Enablers ideally organized PCP

In this section four enablers for an ideally organized PCP, which resulted from the interviews, will be described. The experts believe that an ideally organized healthcare, should be organized and reasoned from the patients perspective. According to the experts is it most desirable for the patient if the GP remains the first point of contact and gatekeeper, reasoned from a generalist paradigm. One expert stated "*one should never touch the gatekeeper function of the GP, scientific research shows that this prevents a lot of referrals*".

At the moment that expertise in generalist paradigm is no longer sufficient, the experts believe that expertise from specialist paradigm should be provided in the GP practice, known as joint or one-off consultation of a medical specialist. This is an example of professional integration in the RMIC, where specialist expertise is moved in order to prevent (unnecessary) referrals. At the moment that specialist advice is not sufficient for GP, then the GP needs to refer the patient to specialist paradigm or an intermediate form of generalist and specialist paradigm, so called PCP.

Subsequently, the experts believe that when it is possible to substitute (expensive) low complex, simple care, where specialist facilities are not needed, to a cheaper, generalist infrastructure, then this should be done. The experts also believe that when a patient does not belong in the specialist paradigm, it should be referred back to generalist paradigm. In other words, substitution of care.

The experts believe that through the difference of generalist and specialist paradigm, echeloning in healthcare originated. PCP implicates that a new echelon between primary and secondary care will be created and this is according to the experts not desirable. They state that there is already a gap between generalist and specialist paradigms due to the legal framework and the funding system. The experts believe that one should look more across the healthcare lines. For this reason all the experts believe that healthcare should be integral, per region be organized. According to the experts is more cooperation and integration between organizations desirable (organization integration).

PCP in Maastricht

Interestingly, four out of the five experts would not organize PCP, their visions of an ideally organized healthcare are described in Section 'Visions about the future healthcare'. But according to Schulpen should PCP ideally be organized as it is in Maastricht (ZIO/Blauwe Zorg), here they work with two different models of PCP. First, joint consultation of a medical specialist in a GP practice. GPs are bundled in groups of three and a medical specialist visits them once every four or six weeks, together they consult the patient that would otherwise have been referred. GP remains main practitioner and medical specialist is consultant, GP is responsible for performing the medical specialist advice. After a year the bundled GPs change of specialty to work towards a new learning curve. This is qualitatively and cooperatively good working model. A disadvantage of this model is that no large patients groups can be served, for that reason a second model is developed, Stadspoli.

In Stadspoli are the principles of joint consultation translated to a volume model, here GP and medical specialist do not consult the patient jointly but as it were parallel to each other. The volume model is more a one-off consultation of a medical specialist in an independent city outpatient clinic. The medical specialist is allowed to consult a patient once and then needs to formulate an advice to the GP.

With joint consultation, 85% of jointly consulted patients can be treated in primary care. For Stadspoli applies that 80% of one-off consulted patient can be treated in primary care. So, this implies that knowledge and experience can be transferred from a medical specialist to GP. Schulpen indicates that this is possible by providing a specialist advice with a low threshold, therefore GP will not lose its responsibility for his patient.

Schulpen indicates that the PCP place is leading for its success. Because if a one-off consultation will be done in hospital then both patient and medical specialist are hard to detach from hospital thinking/routine, this because hospital facilities are within reach. Although, one-off consultations in a GP practice does neither work, because this reduces the referral threshold for the GP in the same practice and colleague GPs have difficulty referring their patient to a competitor GP practice, causing inefficient PCP. For that reason one has chosen in Maastricht for an independent city outpatient clinic where medical specialists can do one-off

consultations. This requires a sufficient adherence area, this can be determined by the frequencies of referrals to a specialism. At last indicates Schulpen that it can only succeed if healthcare has a funding system where money follows care, and here lies a task for the health insurer.

Visions about the future healthcare

The vision of an ideal organized PCP of Guy Schulpen is in previous section described. The experts visions are not aligned about how healthcare should be organized. The visions of the other four experts will be explained in more detail below.

Marc Bruijnzeels believes that healthcare professionals should be put in the lead. Healthcare professionals of generalist and specialist paradigm should jointly determine how an ideally organized healthcare should look like. Where the organization form (e.g. hospital or GP practice) needs to follow the provided care, the continuum of care needs to be leading, not its current organization form. This implies that the current organization forms needs to be transferred to a facilitating organization which can support the continuum of care. According to Bruijnzeels will this lead to integral organizations of care, where population-oriented working is the future. However, this will only work when this will be done structural, across the full width of the (regional) healthcare, and not just for three diseases.

Pim Valentijn believes that over the whole region care chain one need to work on data-unlocking/expansion by a neutral trusted party, starting with the GP information system. By gathering all these date one can determine precisely what the expected supply and demand will be for certain diseases, capacity estimation can then be made for a region. By means of this can also a risk assessment be made for the expected care in the future, in which one can work towards prevention at a certain population who meets certain determinants. Valentijn calls this data-driven performance management. By means of capacity estimation and the risk assessment model one can make an organization model for the regional healthcare.

Paul Offringa believes that one needs to go back to a kind of regional healthcare fund, where regional population-oriented working and funding will be the future. People want to live at home, but this is according to Offringa difficult because of the WLZ, WMO and ZVW legislation. Offringa believes that one 'availability organization' for GP care, emergency care, home care, social domain etc. needs to arise to bundle and integrate all types of care. There will remain distinction between elective, chronic and emergency care but where the hospital will become the regional centre for care. The hospital building has the highest fixed costs, for that reason it should be retained. Offringa believes that all kinds of care needs to be integrated in the hospital building, causing cooperation between the different domains and where care pathways will arise per disease.

Jan Erik de Wildt believes that the primary care budget needs to arranged by one executive health insurer per region, where other health insurers have an automatic follow-up policy. By means of this one health insurer, with the largest market share, can make integral agreements with all stakeholders. De Wildt believes that in line with this primary care needs to merged with social domain and needs to be financed by means of population-oriented funding. During the interview with de Wildt is less focused on population-oriented working or another future healthcare organization, this because de Wildt had some specific ideas for PCP. De Wildt states for example that in the development of a new care form, PCP, eHealth needs to be optimally utilized and that one needs to work towards such time and labor saving solutions.

Primary care

The experts believe regarding primary care that GP practices need to gain more knowledge about chronic care and that GPs need to take a broader view of their tasks. This because then more or even all chronic care can caught in primary care. One also believes that more welfare issues shall be provided by the GP, where a closer cooperation between municipality and primary care will be important. The experts believe that GPs need to be better supported/facilitated in the expected staff shortage in healthcare, increasing care demand/aging, substituted care and prevented referrals. According to the experts will this be a task for the (multidisciplinary) primary care organizations, care groups or GP practices, whereby the GP can focus on its primary care task. This could be done through multiple ways: the experts believe that care needs to be caught up across the full width of primary care. Other ways are organizing primary/GP care more efficiently, by means of task differentiation/delegation, eHealth (digitalizing), risk-selection by means of case-finding of people who are at risk and thereby prevention, or to work towards larger-scale partnerships in GP care. One expert expects that little initiatives will come from primary care to set up PCP, because primary care its priority is the extra expected care. Another expert believes that more GPs need to take place in the boards of care groups, causing more mandate from its colleagues so decisions in care groups could be made faster. Two experts suggest innovation and extra expected care to steer by means of a higher compensation per capita. Where a structural

compensation for innovation is in 'encrypted' so innovation and financing can originate based on healthcare outcomes.

Secondary care

Regarding secondary care the experts believe that the hospital has the central role in the region because of its high fixed costs of the building and the available facilities. However, this expensive building is most of the day unused empty. For this reason the experts believe that the usage of this building needs to be organized more efficiently and that the hospital needs to become a more facilitating organization because of its central role and diagnostic and treatment facilities.

The experts believe that selective procurement, fixing hospital budget or consciously controlled shrinkage of the hospital are ways to effectuate substitution. However, the experts do not agree if consciously controlled shrinkage of the hospital is necessary, because the demand of care will increase. Other experts mention that there is too much hospital capacity in the Netherlands, so consciously shrinkage is necessary. The experts expect that through abovementioned options, hospitals will consider what care they want and do not want to provide. By means of this the experts believe that hospitals will substitute low complex care to primary care. And according to the experts needs this care to be integrally caught up in primary care, otherwise the risk arises that this care will be caught up in other regional hospital. Causing a displacement of the problem. In order to effectuate substitution, the experts believe that the hospitals need 'a long landing strip'. They imply with this that hospitals need time to substitute care, because hospitals need business economic certainties. And this might be the most important incentive according to the experts. Next to that believe the experts that hospitals need to take their social responsibility, seen the affordability and durability of the healthcare.

Regarding medical specialist, the experts believe that they also need to be good facilitated, so they can focus on their primary care task. Next to that believe the experts that medical specialists, together with primary care professionals, need to have a leading role in (re)organizing (integrated)healthcare, this because they need to determine the continuum of care. The hospital environment is expensive, for that reason needs the medical specialist, when possible, provide care in a less expensive, less technical environment (primary care). At last, the experts indicate that the production incentive of the medical specialist needs to be removed. The experts indicate that the medical specialist needs to earn a good salary, but through the production incentive have the medical specialists and the hospital a contradictory financial interests.

Health insurer

Regarding the role of the health insurer, the experts indicate that with the potential future of population-oriented working/funding, the role of the health insurer will also become uncertain. Because this implies that a 'region-like premium' will arise for a population, possibly causing less competition. For that reason the experts indicate that a health insurer needs to step out of their own role and adopt another role.

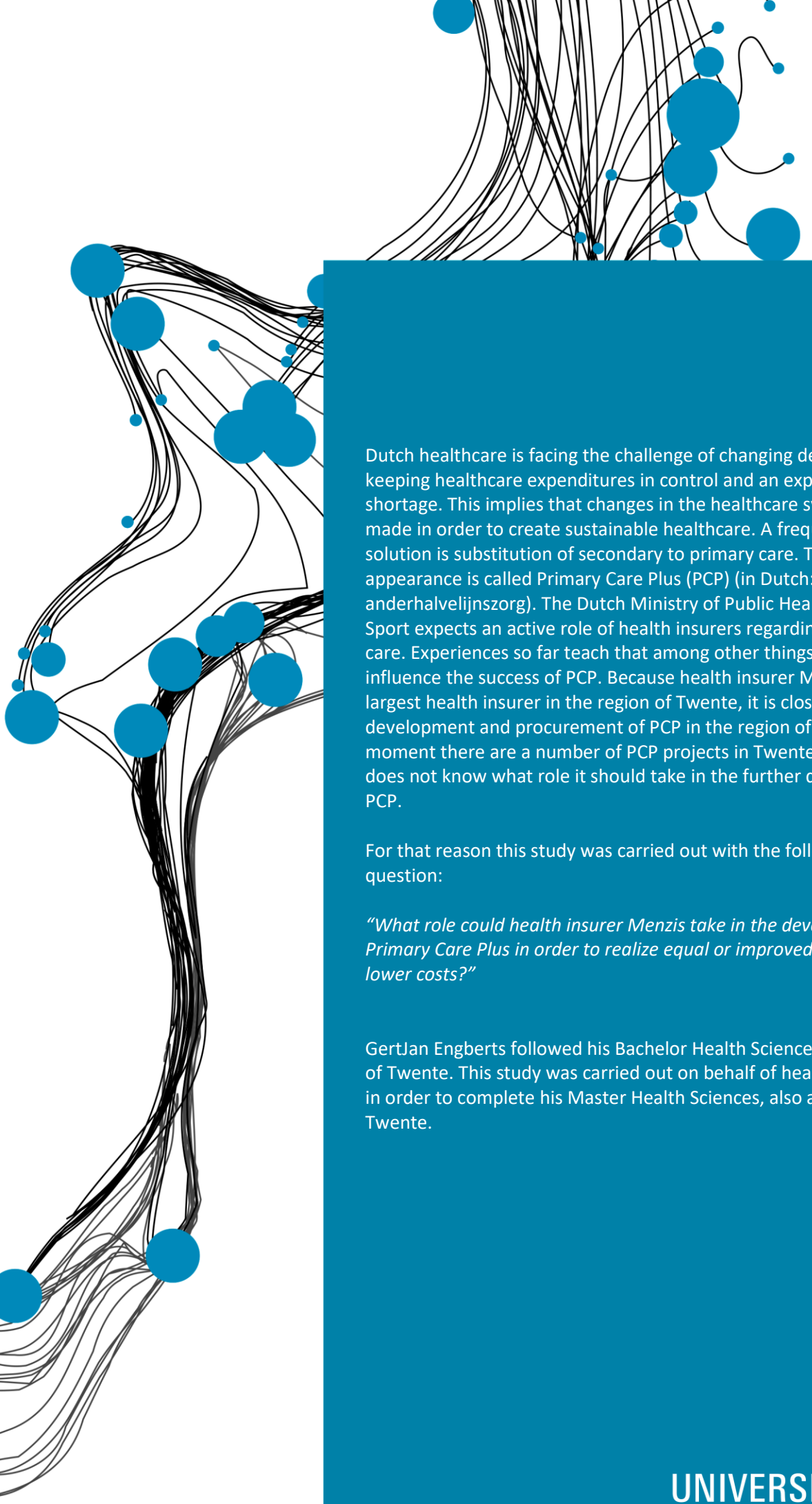
The experts are more clear about the role of a dominant health insurer, it should, eventually together with one or two other health insurers, determine a policy for a region so for one region, one policy will arise. The experts believe that the role of the health insurer is keeping healthcare affordable and accessible. Next to that believe all experts that the health insurer should take a facilitating role, appropriate within the experts vision. For example, by giving healthcare professionals a framework with enablers, stimulate them to determine the best for healthcare and stimulate them to take the lead. Or by facilitating on data-unlocking/expansion and in a 'regional capacity body'. Or by deepening in PCP models/best practices and providing these to a region, so they do not have to invest time in searching for this information. The experts indicate that the health insurer should lay down a basis, so healthcare providers get motivated/stimulated to cooperate in this facilitated setting. By means of this takes the health insurer a pro-active, facilitating and stimulating role. Next to that indicate the experts that the health insurer needs to dare to experiment with care projects and funding models.

The experts believe that a region with all involved stakeholders should devise a common vision how the regional healthcare should be arranged. The experts believe that by means of this a shift will be made from steering at production to steering at quality. Value Based Health Care is a frequently heard term, by means of this can healthcare providers be held accountable for their outcomes and based on the outcomes they can be rewarded. Precondition here is that outcomes will be made transparent, so benchmarking can be applied, causing more insight in practice variation and a substantive discussion can be held. In line with this indicate the experts that the health insurer should become more task-oriented, by no longer purchasing certain healthcare from certain healthcare providers.

The experts suggest different incentives to achieve abovementioned. At first, they indicate that transparency in costs and quality data could be an incentive for both health insurer and healthcare provider. As mentioned before, is selective procurement an incentive/a way to substitute care, but the experts indicate that this incentive must ensure that primary and secondary care will move towards each other.

Other incentives are focused on contract types, such as long term contracts of minimal five years, by means of this can hospitals get 'a long landing strip' to substitute care or to shrink the hospital(budget). In line with this can the health insurer give the hospital its guarantee that it will not go bankrupt. Shared savings contracts are also indicated by the experts, where the shared savings can be used for hospital profile innovations, by means of this it continues to specialize. Another suggested incentive comes from Blue Cross Shield, here is an innovative project/change a three-year experiment. A potential cost reduction will benefit the healthcare provider, when it is not cost beneficial this will be the risk for the health insurer. After the experiment needs the healthcare provider make a decision if it wants to continue with the project, but being responsible for financial gains or losses (two-sided model).

One expert suggested another way for consciously controlled shrinkage of the hospital, namely paying of the mortgage costs for not using a department. By means of this will disappear the production incentive to meet the financing obligations of the bank. This might cost the health insurer for example 10% of costs for not using a hospital department, but saves 90% of healthcare costs. At last, when all of the foregoing does not work, a health insurer might then threat to approach to third parties outside the region, such as diagnostic or independent treatment centers, causing competition in the region.



Dutch healthcare is facing the challenge of changing demand for care, keeping healthcare expenditures in control and an expected staff shortage. This implies that changes in the healthcare system need to be made in order to create sustainable healthcare. A frequently mentioned solution is substitution of secondary to primary care. The practical appearance is called Primary Care Plus (PCP) (in Dutch: anderhalvelijnszorg). The Dutch Ministry of Public Health, Welfare and Sport expects an active role of health insurers regarding substitution of care. Experiences so far teach that among other things local conditions influence the success of PCP. Because health insurer Menzis is the largest health insurer in the region of Twente, it is closely involved in the development and procurement of PCP in the region of Twente. At the moment there are a number of PCP projects in Twente. However Menzis does not know what role it should take in the further development of PCP.

For that reason this study was carried out with the following research question:

"What role could health insurer Menzis take in the development of Primary Care Plus in order to realize equal or improved quality of care at lower costs?"

GertJan Engberts followed his Bachelor Health Sciences at the University of Twente. This study was carried out on behalf of health insurer Menzis, in order to complete his Master Health Sciences, also at the University of Twente.

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