Optimizing Value for Money in Contracting Health Services

11th Caribbean Conference on Health Financing Initiatives
Bonaire, 25 October 2016
FOR FURTHER INFORMATION

<table>
<thead>
<tr>
<th>ACSION</th>
<th>SZV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Engelenweg 21A</td>
<td>Sparrow Road 4</td>
</tr>
<tr>
<td>Willemstad</td>
<td>Philipsburg</td>
</tr>
<tr>
<td>Curacao,</td>
<td>St. Maarten</td>
</tr>
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<td>Phone</td>
</tr>
<tr>
<td>+(599-9) 737-3595</td>
<td>+(1-721) 546-6782</td>
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<td></td>
</tr>
</tbody>
</table>

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Agenda

- Our perspective on care procurement
- Intramural Care
- Pharmaceutical care
- Challenges
Procurement up till now
No link with changing care needs of the population and technological developments

Contribution system

Care budget

Financing needs of care providers

- Reimbursement system and Tariffs determined by Law
- Contract conditions allow some room for quality management
Care procurement now more demand driven
Processes described | interdependencies clear | templates for each step

- Specify
  - Product definitions
  - Expected care needs and consumption
  - Budget impact

- Select
  - RFP
  - Select providers

- Contract
  - Contract with provider
  - Parameters for monitoring and MIS

- Monitor/Evaluate
  - Approvals by medical department
  - Claims adjudication
  - Monitor budget

Templates

Management information

Dossiers

Parameters
  - ...
  - ...

Model contracts
The conflict model in procurement is not working
We should partner with care providers to achieve value for money

Partnerships with care providers to limit waste, prevent avoidable complications and improve outcomes.
From conflict model to multistakeholder roadmaps for the future

- Multistakeholder coalitions
- Build trust
- Shared vision and strategic goals
- Roadmap for the years to come
Healthcare expenditures SXM—Hospital care accounts for ~60%
Strategic focus on intramural care to achieve balance

Source: Annual account SZV 2013 certified and Trialbalance 2013
Agenda

• Our perspective on care procurement
  • Intramural Care
  • Pharmaceutical care
• Challenges
Our approach

From a shared vision to the strategy for hospital care
Hospital care is made available for the population of St. Maarten based on care needs of patients, preferably close to home and provided with involvement of their central care provider on St. Maarten in an affordable, sustainable manner and should meet requirements with respect to quality and safety. To safeguard that the shared vision and objectives prevail, representatives of the population and the healthcare system of St. Maarten determine the strategy for their own hospital care and are in charge when decisions have to be taken with respect to hospital care for the population.
Shared vision for intramural care
Build strategy counterclockwise in the 3 balance model

HOSPITAL CARE REMAINS AFFORDABLE

FIANCIAL BALANCE
Care should remain affordable for the population
Care providers need sufficient funding to ensure continuity of quality care

POPULATION COUNTS ON AVAILABILITY AND ACCESS TO HOSPITAL CARE THEY NEED (QUANTITY AND QUALITY)

CARE DEMAND = CARE SUPPLY
The care demand has to be fulfilled adequately by the care provided (quantity and quality)

THE NECESSARY HOSPITAL CARE CAN BE DELIVERED PREFERABLY LOCALLY AND IN A SUSTAINABLE MANNER

VALUE FOR MONEY
Balance between the reimbursement for care providers and the quantity and quality of care they deliver

THE NECESSARY AMOUNT AND QUALITY OF CARE IS AVAILABLE
Objectives for Hospital care for the population of St. Maarten

1. Development of hospital care on St. Maarten is demand driven and guided by the (changing) care needs both in volume and quality of care

2. Optimal Quality and Safety of care

3. Viable local healthcare infrastructure

4. An appropriate reimbursement system and tariffs for hospital care
The strategic framework
Translation of Vision and Objectives to a Strategy to be operationalized

- Demand driven
  - Care demand analysis
  - Care episode registration
  - Care product definition

- Optimal Quantity and Quality of care
  - Norms for quality and safety
  - Benchmark

- Viable healthcare infrastructure
  - Continuous development of the National Hospital
  - Medical coordination on St. Maarten

- Adequate financing
  - Financial balance
  - Value based reimbursement system
SCM will be described for the most important care products in Care Demand Analysis: high volume, high costs and/or referrals abroad necessary.

<table>
<thead>
<tr>
<th>Top 20 diagnoses</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>HNP (herniated nucleus pulposus, back/neck hernia)</td>
<td>194</td>
</tr>
<tr>
<td>Gonarthrosis (knee pain)</td>
<td>118</td>
</tr>
<tr>
<td>Prostate carcinoma (prostate cancer)</td>
<td>76</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>56</td>
</tr>
<tr>
<td>Varices (varicose veins)</td>
<td>51</td>
</tr>
<tr>
<td>Asthma</td>
<td>41</td>
</tr>
<tr>
<td>PSA (prostate-specific antigen)</td>
<td>33</td>
</tr>
<tr>
<td>Mamma carcinoma (breast cancer)</td>
<td>31</td>
</tr>
<tr>
<td>Scoliosis (curvature of the spine)</td>
<td>25</td>
</tr>
<tr>
<td>RA (rheumatoid arthritis)</td>
<td>24</td>
</tr>
<tr>
<td>Chronic headache</td>
<td>24</td>
</tr>
<tr>
<td>Meniscus tear</td>
<td>23</td>
</tr>
<tr>
<td>Retinal detachment (ablation retinae)</td>
<td>23</td>
</tr>
<tr>
<td>Mamma reduction (breast reduction)</td>
<td>22</td>
</tr>
<tr>
<td>BPH (Benign Prostatic Hyperplasia, prostate enlargement)</td>
<td>22</td>
</tr>
<tr>
<td>Diabetic Retinopathy (DRP, eye problems)</td>
<td>19</td>
</tr>
<tr>
<td>Cervical spine (C1 t/m C7)</td>
<td>18</td>
</tr>
<tr>
<td>Cardiomyopathy (heart muscle disease)</td>
<td>16</td>
</tr>
<tr>
<td>COPD (Chronic Obstructive Pulmonary Disease)</td>
<td>15</td>
</tr>
<tr>
<td>Prostatic hypertrophy (prostate enlargement)</td>
<td>14</td>
</tr>
</tbody>
</table>

- Predetermined care pathways
- Care described in Stepped Care Modules (SCMs)
- Every SCM starts, ends and is coordinated by GP and SMMC specialist
- Care delivered by foreign specialists is part of SCM procured at the SMMC
- Incentives for prevention, timely intervention and conservative treatments
- Checks and Balances!!
SCMs are based on international guidelines
Algorithm and SCMs for HNP

- SCM1a: conservative treatment for 12 weeks
- SCM 1b: conservative treatment for 12 weeks with assessment by neurologist after 6-8 weeks
- SCM 2: Intensive conservative treatment for another 8 weeks
- SCM 3: Operation
- SCM 4: Rehabilitation (after treatment) after successful therapy
- SCM 5: reassessment after first therapy was not successful
Care demand analysis based on episode registration
Input for procurement and development value based reimbursement

Care demand analysis: Insights in volume of SCMs to be delivered

New Hospital
- Volume per SCM
- Criteria per SCM
- Capacity, capabilities and facilities

Procurement
- Volume per SCM
- Criteria per SCM
- Benchmark
- Negotiations
- Contract

Follow-up Medical Tariff
- Costs per SCM
- Volume per SCM
- Budget for SCMs
- Deduct from budget related to production
Benchmark framework for care procurement

Care procurement process

- Specify
- Select
- Contracting
- Monitoring
- Evaluating

Different phases in the benchmark process

<table>
<thead>
<tr>
<th>Phase</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Selecting hospitals based on the care demand analysis (Based on the care demand analysis the Medical Committee determines which care can be provided by local healthcare providers and which care has to be procured abroad.)</td>
</tr>
<tr>
<td>Phase 2</td>
<td>Request information (The selected hospitals will be informed by the Medical Committee and asked to complete an online survey.)</td>
</tr>
<tr>
<td>Phase 3</td>
<td>Collection and reviewing requested information (The submitted information through the online survey will be reviewed by the medical committee.)</td>
</tr>
<tr>
<td>Phase 4</td>
<td>Preparation trip (Plan on-site visit dates, program and arrange travel)</td>
</tr>
<tr>
<td>Phase 5</td>
<td>On-site visit (The on-site visit entails an orientation to the hospital’s facilities and services and their quality System by means of interviews, document review and facility tour.)</td>
</tr>
<tr>
<td>Phase 6</td>
<td>Reviewing results (Based on all the information collected - including the patient/client satisfaction - hospitals will be selected per specific treatment)</td>
</tr>
<tr>
<td>Phase 7</td>
<td>Monitoring (The monitoring is an ongoing process that consists of periodic and ad hoc site visits, and collecting information about patient/client satisfaction.)</td>
</tr>
</tbody>
</table>
# Hospital Survey

## General
- General
- Capacity and production

## Quality and Safety
- Policy & Strategy
- Structure
- Safety
- Infection Prevention
- Documentation and information transfer
- Internal & External Assessment
- Services

### HOSPITAL SURVEY – General

<table>
<thead>
<tr>
<th>General</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name Hospital:</td>
<td></td>
</tr>
<tr>
<td>Hospital Type:</td>
<td></td>
</tr>
<tr>
<td>□ Acute</td>
<td>□ General</td>
</tr>
<tr>
<td>Number of employees:</td>
<td></td>
</tr>
</tbody>
</table>

### HOSPITAL SURVEY – Quality and Safety

<table>
<thead>
<tr>
<th>QI Policy &amp; Strategy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The hospital’s aims and mission explicitly include quality and safety of care?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>2. The hospital has a written description of the quality improvement policies and strategies?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>3. The hospital has a quality action plan at hospital level?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>4. The hospital has quality action plans (incl. plans for improvement) at department level?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>5. The hospital has a quality manual/handbook?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>6. The hospital has an annual quality report (or quality section in the annual general report)?</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capacity and production</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Capacity</td>
<td></td>
</tr>
<tr>
<td>No. nursing wards:</td>
<td></td>
</tr>
<tr>
<td>No. ICU beds:</td>
<td></td>
</tr>
<tr>
<td>No. employees (total):</td>
<td></td>
</tr>
<tr>
<td>No. doctors:</td>
<td></td>
</tr>
<tr>
<td>2. Production</td>
<td></td>
</tr>
<tr>
<td>No. of admissions:</td>
<td></td>
</tr>
<tr>
<td>No. of day care admissions:</td>
<td></td>
</tr>
<tr>
<td>No. of hospital days:</td>
<td></td>
</tr>
<tr>
<td>Av. length of stay:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QI Structure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The hospital has identified responsibilities for quality improvement?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>2. If yes, is the director or leader of quality improvement at a senior level in the organization?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>3. The hospital has one or more of the following provisions for quality improvement:</td>
<td></td>
</tr>
<tr>
<td>a) One or more quality steering groups or committees have been established?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>b) One or more quality coordinators/officers have been appointed?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>c) External quality management consultant has been hired?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>4. The hospital has a designated responsible person or group/committee for the following functions?</td>
<td></td>
</tr>
<tr>
<td>a) Control of hospital infections</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>b) Patient safety</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>c) Blood transfusion policy</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>d) Antibiotics policy</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>e) Prevention of decubitus</td>
<td>□ Yes □ No</td>
</tr>
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</table>
## Typical agenda for an on-site visit

### Activities during the on-site visit

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00-09:30</td>
<td>Pre meeting</td>
<td>Hospital CEO and SZV Visiting Team</td>
</tr>
<tr>
<td>09:30-11:30</td>
<td>Opening Meeting</td>
<td>Hospital CEO, members hospital leadership team, hospital visit coordinator and SZV Visiting Team</td>
</tr>
<tr>
<td>11:30-13:00</td>
<td>Document Review</td>
<td>SZV Visiting Team (and assistant from) hospital</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>14:00-16:00</td>
<td>Facility tour</td>
<td>SZV Visiting Team, chief engineer and circulating supervisory engineer(s), safety officer and/or facility manager, fire safety officer, in-charges of hospital departments, infection control practitioner and nursing leadership.</td>
</tr>
<tr>
<td>16:00-17:00</td>
<td>Departmental Interviews</td>
<td>Head of department/other leadership and SZV Visiting Team</td>
</tr>
<tr>
<td>17:00-18:00</td>
<td>End-of-day Briefing</td>
<td>Visiting team and CEO or other hospital leadership staff.</td>
</tr>
</tbody>
</table>
Facility Tour

- Safety and Security
- Fire Safety
- Medical Technology
- Utilities
- State building and rooms

HOSPITAL SURVEY – Facility Tour

Safety and security

1. The hospital has a program to provide a safe physical facility (inspection of safety risks such as sharp and broken furniture, linen chutes that do not close properly, broken windows, water leaks in the ceiling, and locations where there is no escape from fire)? □ Yes □ No

2. The hospital has a program to provide a secure environment:
   a) Staff identification through badges? □ Yes □ No
   b) Restricted areas (e.g., newborn nursery, operating theatre)? □ Yes □ No
   c) Remote or isolated areas with security cameras? □ Yes □ No

3. The hospital has a system to safeguard patients admitted or visiting the hospital? □ Yes □ No

4. The hospital has a system to safeguard possessions of patients (e.g., emergency patients)? □ Yes □ No

5. The hospital has a program to provide a secure environment? □ Yes □ No

Fire Safety

1. The hospital has a documented program to ensure that all occupants of the hospital's facilities are safe from fire, smoke, or other non-fire emergencies, including:
   a) Risk reduction through safe storage and handling of flammable materials? □ Yes □ No
   b) Safe and unobstructed means of exit in the event of a fire? □ Yes □ No
   c) Early warning, early detection systems, such as smoke detectors, fire alarms, and fire patrols? □ Yes □ No
   d) Suppression mechanisms, such as water hoses, chemical suppressants, or sprinkler systems? □ Yes □ No
   e) All staff participates in at least one fire and smoke safety program test per year? □ Yes □ No
   f) Inspection, testing, and maintenance of equipment and systems is done and documented? □ Yes □ No
Client satisfaction

Consist of 4 questionnaires

*Depending on the situation should be determined which questionnaire must be filled in.*

- Medical Travel Agency/International department hospital
- Inpatients
- Outpatients
- Hotel

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### CLIENT SATISFACTION – Medical Travel Agency/International department hospital

**Name of Medical Travel Agency**

#### CLIENT SATISFACTION - Inpatients

**Your admission to the hospital**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Which Department did you stay?</td>
<td>Surgery</td>
</tr>
<tr>
<td>2. Which option below best describes the reason for this hospital stay?</td>
<td>Unexpectd Illness</td>
</tr>
<tr>
<td></td>
<td>Accident</td>
</tr>
<tr>
<td></td>
<td>Other medical reason</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. How many nights was this hospital stay?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>4. Were you admitted to this hospital through the Emergency Room?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>5. During your admission at the Emergency Room, did the admission clerk/officer treat you with courtesy and respect?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>6. During your admission at the Emergency Room, did the admission clerk/officer explain things in a way you could understand?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

**Your care from nurses**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often did nurses treat you with courtesy and respect?</td>
<td>Never</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td>Usually</td>
</tr>
<tr>
<td></td>
<td>Always</td>
</tr>
<tr>
<td>2. How often did nurses listen carefully to you?</td>
<td>Never</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td>Usually</td>
</tr>
<tr>
<td></td>
<td>Always</td>
</tr>
<tr>
<td>3. How often did nurses explain things in a way you could understand?</td>
<td>Never</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
</tr>
</tbody>
</table>
Financing SMMC as proposed
Budget financing ensures financial tranquility while developing a value-based system.

- Out of Pocket payers, tourists (~10%)
- Quality incentive (~10%)
  - To be agreed upon annually
- Budget based on care production (~40%)
  - Based on production
  - Now: per activity
  - Future: value based
- Budget for designated services (~40%)
  - ER
  - 24 hrs services
  - Critical equipment
  - ICU
  - Underutilized specialties
  - Central ICT
  - Non-care related depts.

Financing needs SMMC
100%

Financing by health insurers
Services/Investments allocation to the first two compartments in the budget

Compartment 1: Designated services
- Building and accompanying areas – capital costs
  - Depreciation cost and interest
  - Insurance (building related)
- Designated services
  - Emergency room
  - IC
- Investments
  - Depreciation cost and interest expenses
- Hospital Information System
  - Depreciation cost and interest expenses
- Non-care related supportive services
  - Which are independent of the volume (not care related - management, strategy and policy department, etc.)
- Training costs

Compartment 2: Care production based
- Travel and accommodation costs of medical personnel
- Hospital Information System
  - License fees
- Care consumables
- Supportive services related to the care delivered
  - Which depend on the volume
- Patient logistics
- Insurance
  - Not building related insurance (liability, employee illness, deductibles etc.)

To ensure that the hospital continues to provide the intended value a number of conditions for financing are advised based on the Audit of the Inspection.
Calculation method for the different compartments of the budget financing
Principle for substantiating care production: avoid complexity with only 4 parameters

- Financing needs SMMC 100%
- Financing by self responsibles, tourists, BES 10%
- Financing through quality incentive 10%
- Financing designated services (at cost) ~ 40% (-/-)
- Financing based on care production ~ 40%
- Financing special functions (at cost) ~ 10% (-/-)
  - Dialysis, Medication, Transplants, Blood products
- Budget that is substantiated with 4 parameters ~ 30%

<table>
<thead>
<tr>
<th>Parameter</th>
<th>#</th>
<th>Weighing</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>n</td>
<td>10,00</td>
<td>n * 10,00</td>
</tr>
<tr>
<td>Hospital day</td>
<td>x</td>
<td>0,50</td>
<td>x * 0,50</td>
</tr>
<tr>
<td>Daycare</td>
<td>y</td>
<td>3,50</td>
<td>y * 3,50</td>
</tr>
<tr>
<td>Consultation</td>
<td>z</td>
<td>1,25</td>
<td>z * 1,25</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>Σ</td>
</tr>
</tbody>
</table>

\[
\frac{\text{Care related budget}}{\text{Total Points}} = \text{Value per point}
\]
Phased approach towards demand driven affordable care

### Budget for designated services

**Short term (1 – 2 year)**
- ~ 40% of total budget
- Periodic advance payments
- Post calculation based on actual costs

**Mid term (3 – 5 year)**
- ~ 30-40% of total budget
- Periodic advance payments
- Post calculation based on actual costs

**Long term (> 5 year)**
- ~ 20-40% of total budget
- Periodic advance payments
- Post calculation based on actual costs

### Budget related to Care production

**Short term (1 – 2 year)**
- ~ 40% of total budget
- Periodic advance payments
- Substantiation based on 4 parameters

**Mid term (3 – 5 year)**
- ~ 40-50% of total budget
- 70% substantiation payment based on 4 parameters
- 30% reimbursement care products

**Long term (> 5 year)**
- ~ 50-60% of total budget
- 50% substantiation payment based on 4 parameters
- 50% reimbursement care products

### Incentive (Quality)

**Short term (1 – 2 year)**
- ~ 10% of total budget
- Incentive for correct and consistent registration of data for care product definitions

**Mid term (3 – 5 year)**
- ~ 10% of total budget
- Incentive linked to yet to be determined quality indicators

**Long term (> 5 year)**
- ~ 10% of total budget
- Incentive linked to yet to be determined quality indicators

### Advantages

- Cost covering for SMMC
- Predictable expenditures for health insurers
- Conditions for further development of SMMC

- Relatively more care delivered by SMMC and less medical referrals abroad
- More incentives to deliver appropriate care in the SMMC

- More control to reduce medical referrals abroad and enabling more and better care in St. Maarten
Phased approach towards demand driven affordable care

**Demand driven**
- Start with episode registration
- Assess current care demand based on available data
- Product definitions (care pathways) and SCM’s
- Continuous evaluation

**Optimal quantity and quality**
- Quality system: minimal norms and indicators (overall and per care product)
- Procurement based on demand and quality criteria per care product
- Continuous evaluation

**Viable local healthcare infrastructure**
- New reimbursement structure and tariffs
- Investments for renovation, extensions and new hospital
- Increase competencies and capacity based on care demand
- Extend the service area (neighboring islands and medical tourism)

**Adequate financing**
- Change cooperation with primary and tertiary care (CVRM)
- Economies of scale
- Change financing model with external sources for funding

Timeline:
- 2015
- 2016
- 2017
Agenda

• Our perspective on care procurement

• Intramural Care

  • Pharmaceutical care

• Challenges
Let’s stop fighting battles from the past
Joint responsibility to abolish waste and guarantee continuity

- COGS account for 70% of the expenditures on pharmaceuticals
- Biggest saving potential
Cost of goods sold (COGS)

Volume can be rationalized by:
- Reducing the package of reimbursed medication
- Stimulating rational prescribing of medication

Price can be rationalized by:
- Reviewing the pharmaceutical value chain
- Analyze cost(driver)s and profit margins
Breakdown of the value chain

• Total expenses per medication are calculated based on parameters entered
• The parameters in the driver three can be adjusted easily to see how it effects the total pharmaceutical expenses
• The driver three gives insight in the gross margin
1. Bruto marge
Op dit moment wordt er geen maximum bruto marge gehanteerd. De marges die gehanteerd worden variëren van -50% t/m 344%.

Interventie 1: de bruto marge is maximaal 25% (maximaal bruto marge)
Interventie 2: de bruto marge is gelijk aan 25% (bruto marge)

Overzicht kosten/besparingen

<table>
<thead>
<tr>
<th>Interventie 1</th>
<th>Interventie 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ZV</strong> 37.023,33</td>
<td><strong>ZV</strong> (81.239,58)</td>
</tr>
<tr>
<td><strong>OZR</strong> 21.217,12</td>
<td><strong>OZR</strong> (28.604,96)</td>
</tr>
<tr>
<td><strong>ZV+OZR</strong> 3.612,32</td>
<td><strong>ZV+OZR</strong> (6.903,25)</td>
</tr>
<tr>
<td><strong>Totaal</strong> 61.852,76</td>
<td><strong>Totaal</strong> (116.747,80)</td>
</tr>
</tbody>
</table>

Interventie 1: de bruto marge is maximaal 25% (maximaal bruto marge)
Interventie 2: de bruto marge is gelijk aan 25% (bruto marge)

Overzicht kosten/besparingen

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<tr>
<th>Interventie 1</th>
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</tr>
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<tbody>
<tr>
<td><strong>ZV</strong> 58.674,09</td>
<td><strong>ZV</strong> 58.674,09</td>
</tr>
<tr>
<td><strong>OZR</strong> 22.440,99</td>
<td><strong>OZR</strong> 22.440,99</td>
</tr>
<tr>
<td><strong>ZV+OZR</strong> 5.543,02</td>
<td><strong>ZV+OZR</strong> 5.543,02</td>
</tr>
<tr>
<td><strong>Totaal</strong> 86.658,10</td>
<td><strong>Totaal</strong> 86.658,10</td>
</tr>
</tbody>
</table>

2. Doelmatiger voorschrijven
Besparingen op medicatie kunnen gerealiseerd worden door ondoelmatig voorschrijven tegen te gaan.

Situation 1: 10% (percentage fout voorgeschreven)
Situation 2: 20% (percentage fout voorgeschreven)
Situation 3: 30% (percentage fout voorgeschreven)

Overzicht besparingen

<table>
<thead>
<tr>
<th>Omschrijving</th>
<th>Uitgangssituatie</th>
<th>Situatie 1</th>
<th>Situatie 2</th>
<th>Situatie 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hardlopers (o.b.v. kosten)</td>
<td>ANG 625.991,03</td>
<td>ANG 62.599,10</td>
<td>ANG 125.198,21</td>
<td>ANG 187.797,31</td>
</tr>
<tr>
<td>Hardlopers (o.b.v. volume)</td>
<td>ANG 267.902,07</td>
<td>ANG 26.790,21</td>
<td>ANG 53.580,41</td>
<td>ANG 80.370,62</td>
</tr>
<tr>
<td>Totaal UR medicatie</td>
<td>ANG 766.138,82</td>
<td>ANG 76.613,88</td>
<td>ANG 153.227,76</td>
<td>ANG 229.841,64</td>
</tr>
</tbody>
</table>

Farmaceutische uitgaven

<table>
<thead>
<tr>
<th>Uitgangssituatie</th>
<th>ANG 625.991,03</th>
<th>ANG 267.902,07</th>
<th>ANG 766.138,82</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situatie 1</td>
<td>ANG 563.391,92</td>
<td>ANG 241.111,86</td>
<td>ANG 689.324,93</td>
</tr>
<tr>
<td>Situatie 2</td>
<td>ANG 500.792,82</td>
<td>ANG 214.321,66</td>
<td>ANG 612.931,05</td>
</tr>
<tr>
<td>Situatie 3</td>
<td>ANG 438.193,72</td>
<td>ANG 187.531,45</td>
<td>ANG 536.297,17</td>
</tr>
</tbody>
</table>
Agenda

• Our perspective on care procurement
• Intramural Care
• Pharmaceutical care
• Challenges
Progress and results hampered by challenges

• **Trust comes by foot and goes by horse ...**
  – There was reason for distrust and (signs of) those reasons don’t disappear overnight

• **Hidden agenda’s**
  – Barrier for trust in partnerships
  – Resistance against transparency

• **Focus on new hospital rather than strategy for hospital care**
  – A new building is politically more interesting than a strategy with promises for the future

• **Lack of useful data even though Health IT is on the agenda since 2010**
  – Care providers do not have systems nor the drive to register data in a standardized manner
  – Data registration strategy is challenges by continuous shifting of priorities and ‘fear’