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International Comparison of Specialist Care Organization: Innovations in Five Countries

England • Germany • Italy • The Netherlands • The United States

Integrated Funding for Maternity Care

Lucie Michel, Zeynep Or (IRDES)

1-26

Études de cas

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Case studies

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About this study

Under pressure of increasing demand for healthcare from an ageing population with multiple chronic conditions, France, as other countries, seeks to advance care coordination and integration across primary, hospital and long-term care sectors. Specialists play an essential role in treating patients with chronic conditions, but little attention is given to their organization out of hospital, and their role in enhancing care coordination and patient-centered care provision. France Stratégie (French High Council for the Future of Health Insurance, *Haut Conseil pour l'avenir de l'Assurance maladie*, HCAAM) asked the Institute for Research and Information in Health Economics (IRDES) to provide an international perspective on the subject.

In collaboration with researchers and experts in five countries (England, Germany, Italy, the Netherlands, and the United States), we identified examples of specialist care delivery models. In order to understand the actual organization of care around specific health conditions, we carried out case studies in these countries between June 2018 and March 2019. These case studies do not aim to provide an overall description of ambulatory care provision in each country. Rather they look at the organization around specific patient care pathways by describing the coordination of roles and tasks between specialists and other professionals involved, its innovative features and the underlying financial models.

This case study describes the organization of maternity care in the Netherlands, and the experimentations with bundled payment which aims to support integrated maternity care models. It is based on site visits in December 2018 where we interviewed the experts and major actors who put in place the experimentations as well as those involved in bundled payment including healthcare professionals in one hospital.

THE DUTCH HEALTH CARE SYSTEM *in a nutshell*

The health care system in the Netherlands can be described as hybrid. It was first created according to a Bismarckian tradition of social health insurance, but the introduction in 2006 of regulated competition has brought new shared governance. All residents are mandated to purchase statutory basic health insurance for essential care from private insurers. This can be complemented by voluntary insurance for which the coverage and premiums, determined by insurers, vary. Statutory health insurance is financed through a nationally defined, income-related contribution, a government grant for the insured below age 18, and community-rated premiums set by each insurer (everyone with the same insurer pays the same premium, regardless of age or health status). Insurers are required to accept all applicants, and enrollees have the right to change their insurer each year. Insurers are expected to engage in strategic purchasing, and contracted providers are expected to compete on both quality and cost. Quasi-governmental, independent bodies monitor whether rules are observed by the market players (Schäfer et al., 2016). Since 2006, the stakeholders in health care market, consumers, care providers and health insurers were given a much more prominent role while the government, although still pulling the final strings, assumed a less controlling role.

The general practitioner (GP) is the central figure in Dutch primary care. Although registration with a GP is not formally required, referrals from a GP are required for hospital and specialist care. Many GPs employ nurses and primary care psychologists on salary (Wammes et al., 2017). To incentivize care coordination, bundled payments are provided for certain chronic diseases, such as diabetes and chronic obstructive pulmonary disease (COPD). Care groups are legal entities (mostly GP networks) that assume clinical and financial responsibility (the bundle) for the chronic patients who are enrolled; the groups can purchase services from multiple providers. At the moment bundled payments do not cover specialist services.

Nearly all specialists are hospital-based and either in group practice paid under fee-for-service (about 54% specialist,) or on salary (46%) mostly in university clinics. As of 2015, specialist fees are freely negotiable as a part of hospital payment. Almost all hospitals are private non-profit organisations, paid on the basis of activity through a type of diagnosis-related group system (Diagnosis Treatment Combinations). There are also small clinics, called independent treatment centers, specialized uniquely on day surgery. There is a recent trend toward working outside of hospitals in multidisciplinary ambulatory centers, but this shift is marginal, and most ambulatory centers remain tied to hospitals. Specialists in ambulatory centers are paid by fee-for-service, and the fee schedule is negotiated with insurers. Patients are free to choose their provider (after a GP referral), but insurers may set different conditions (cost-sharing) for different choices within their policies.

1. Background

- In the Netherlands, traditionally a strong emphasis is placed on natural birth and the role of midwives is very important in assisting future mothers with uncomplicated pregnancy and in minimizing unnecessary medical interventions.

- Women can choose freely how and where they want to give birth including at home.

- The maternity care is organized according to risk with the basic idea that healthy woman and uncomplicated pregnancy (low-risk) is best taken care of by a midwife encouraging "natural" (without epidural) birth.

- The first European perinatal survey in 2004 showed that the Netherlands had one of the highest rates of early perinatal mortality (within a week of delivery) in Western Europe (3 per 1000 newborn, against 1.8 in France).

- These results alarmed the healthcare care providers involved in maternity care and policymakers, and improving maternity care (including prenatal, natal and post-natal phases) became a policy priority.

- Various measures have been taken to improve the quality of care during pregnancy and childbirth, including the introduction of preconception visits, creation of the Steering Committee bringing together different maternity care professionals and the foundation of the Perinatal Audit in the Netherlands (PAN).

- In 2009, the Steering Committee made recommendations for improving the quality of perinatal care. It requested close cooperation and better communication between all care professionals involved, and between care professionals and pregnant women and their families, in an integrated care model where also more attention is paid to prevention during pregnancy.

- The College for Perinatal Care (CPZ) was set up in 2011 to implement the recommendations of the Steering group. It works with representatives of pregnant women, all types of health care professions involved, hospitals, maternity care organisations, and health insurers, and has the mission of promoting cooperation between the various health care professionals involved in obstetric care.

- We present in this case study the Dutch model of integrated maternity care, and the experimentations with bundled payments with the objective of supporting the new integrated care models.

2. Overview of the development of the Integrated Maternity Care Organizations

In obstetric and perinatal care there is a clear division between primary, secondary and tertiary care. Primary care midwives assist women during pregnancy and childbirth when these proceed normally (low-risk women with a pregnancy without complication). General practitioners can also participate to primary maternity care; they are responsible for about 0.5% of all births, mainly in rural areas (KNOV, 2017). In case of expected complications, the midwives refer the pregnant women to secondary care. There are clear guidelines on how/when to make a referral decision. The secondary care is provided by obstetricians and clinical midwives (midwives with a higher degree) in general hospitals, and the tertiary care is provided in university hospitals. Gynecologists in secondary and tertiary obstetric care help pregnant women at increased risk, sometimes from the beginning of pregnancy, but usually after referral by the midwife (Amelink-Verburg and Buitendijk, 2010; RIVM, 2014).

The maternity care in the Netherlands is structured around the idea that a healthy woman with an uncomplicated pregnancy (low-risk) is best taken care of by a midwife. The midwifery training is four years, fulltime, direct entry education which leads to a Bachelor of Science degree (in France it is five years, fulltime, which leads to Masters of Science degree). Low-risk women can choose to give birth at home under the supervision of a midwife and a maternity assistant or in the outpatient clinic of a hospital. In this case, she has a copayment of about 300-400 euros (most complementary health plans cover this expense). The delivery will be assisted by the primary care midwife helped by the maternity assistant, and the mother and baby leave the hospital within 2-3 hours after the delivery. In case of a complication during the delivery, the midwife would refer the patient to the obstetrician. Women with a higher risk will give birth at hospital without any copayment and will be assisted by a clinical midwife and an obstetrician. Risk stratification and a clear distribution of tasks between these different strata is the essential feature of the Dutch system. While inpatient hospital deliveries (overnight stays) are rare, mothers who are usually back at home couple of hours after the delivery get regularly help at home. Home help is provided by midwife assistants who help the new parents at home during the first days (on average for a week, 38 hours and maximum of 10 days, 49 hours).

In the last decades there is an increasing number of women preferring to give birth in hospital rather than at home. In 2012, 30% of women gave birth in primary care (ambulatory birth center), of which 16% at home, while 70% of children were born in a specialist-led hospital maternity unit mostly as outpatient.

The perinatal audit, introduced in 2010, served as an instrument to guarantee and improve the quality of perinatal care. Subsequently, the College for Perinatal Care (CPZ) was set up in January 2011 to implement the recommendations of the Steering committee which advised:

- To take a broader/integrated view on maternity care, not only the point of view of midwives or obstetricians, in order to invest in integrated care pathways where health care professionals take the joint responsibility of pregnant women.
- To give pregnant women the opportunity to lead their own care and choose freely where and how to deliver; assure that they are well- informed all along the pregnancy.
- To pay more attention to prevention during pregnancy: women who do not smoke, do not drink and eat well all along the pregnancy will have more chance to deliver a healthy baby.

- To propose specific interventions for high-risk women, for example those living in low socio-economic environment.

With the support from the Ministry of Health, a research program around integrated care specific to maternity care was developed. The college of perinatal care worked with different professional and patient organizations to create a shared vision of what should be integrated maternity care.

From this first vision, a so-called health care "standard for maternity care" was produced. This document is a general framework setting care principles rather than clinical guidelines. One of the propositions of this health care standard was to provide a case manager to each pregnant woman, who is most of the time a midwife (as she is usually the first to see the patient). But the case management can move to the obstetrician if a medical follow-up is needed – the midwife will however continue to be co-responsible for the patient. In the care pathway it is also suggested to introduce a home visit by a maternity assistant (see Box) during pregnancy, before the delivery, to assess the living conditions of the future mother and potential risks.

The maternity assistant – Kraamverzorgster

These assistants have a basic after-high school education and work with the midwife at home or in birth clinic to assist with the delivery. Moreover, they are a key actor of the post-natal care: they assist the mother and the newborn the first eight to ten days after delivery. They perform medical checks, educate women in breastfeeding, and take care of light household chores (prepare meals, take care of other children, laundry, cleaning etc.). The actual tendency is to push the maternity assistant to have more medical education and provide fewer households' tasks in profit of more medical care. Their role is essential as they are the only health care worker (besides the midwives) who sees the patient at home and therefore can detect social needs or difficult situations.

This vision has also helped to reorganize obstetrical care around maternity care professional networks at the territorial level. Today, the obstetricians work in 76 regional obstetrical collaborations, which are networks of gynecologists, midwives, maternal assistants, pediatricians, and sometimes social services. They are organized around one or two hospitals and primary midwife practices. Taking into account the needs of their local population they develop activities for tackling local problems (ex: invest in smoke cessation problem in certain areas, etc.).

3. A shared vision of integrated and multidisciplinary maternity care

At every step, every stage of the project we define shared values and common goals, I believe it is the key. »

Obstetrician involved in bundle payment pilots

The bundled payment system is a result of a long process where health care professionals working together have built, step-by-step, a shared vision of how integrated maternal care should be. At each step, they defined shared values and created protocols for sharing tasks and responsibilities in an integrated birth care pathway.

As a first step, health care professionals started by describing their current practices. From these descriptions they identified what they wanted to keep, what they could improve or change according to quality items. The insurance companies, with their data, also helped them identifying on which aspects they can do better and on which activities they are too costly considering outcomes. For example, based on the analysis of patients' need and professionals' need of a better information on patients' situations, it appeared necessary to introduce a home visit before the delivery by the maternity care team. The visit is standardized and there is a summary sent systematically to the obstetrician, GP or midwife so they have all the information needed for the day of the delivery. This visit also helps the whole team to take action if a problem is detected both medically and socially. This type of action helped to create a joint responsibility.

The challenge appears to be creating the conditions of a better integrated care, including the social part, while conserving each provider's revenue. Indeed, the midwives are entrepreneurs who own their business so the new integrated organization needs to make sure that they sustain their revenues sometimes by investing in some new activities such as health promotion.

Second, in order to successfully manage the patient care and share responsibilities between different providers, they developed very clear guidelines and protocols:

- There is a case manager for each patient, the first person consulted is always responsible, even if at one point some else (e.g. the obstetrician) is more involved with the patient. It is a way to ensure the continuity of care and share the responsibility.
- The patient receives a letter in which she agrees to share her information with each professional involved in her care (they can agree to share these information just for the time of the pregnancy and follow-up but not after).
- The questions to be asked to the patient by the midwife are defined clearly, and if necessary a team meeting is organized to discuss complex cases.
- A written birth plan is prepared for each woman at the beginning of the pregnancy. Future mothers are involved in their birth plan. They can write down in detail their preferences for the delivery, and immediate care after (for example, wants music, doesn't want the baby to be washed, the father wants to cut the belly, etc.) so that there is no confusion at birth.

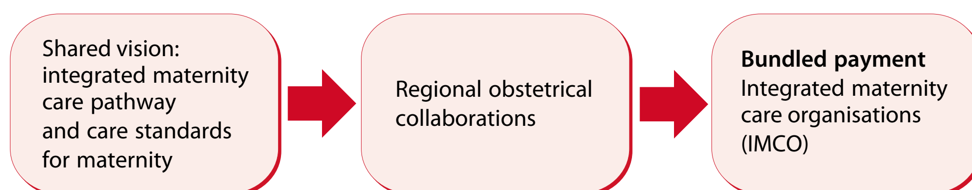
- The patient is given all the information she needs so that, the decisions are made together.
- There are reflections on developing targeted actions to reduce risk during pregnancy for the socially vulnerable women.
- Midwives are trained to do monitoring and medical check at home if necessary (eg. baby not moving much), to avoid that mothers go to hospital.

Finally, the providers working together as a group have a few "golden rules" that all agree on and that creates a real consensus. For example, in one of the regions participating in the experimentation these rules were written and signed by all care providers:

- "the patient is first"
- "we know each other and we respect everybody's expertise"
- "I trust in my colleagues and I am open for feedback"
- "we communicate together"
- "we use the SBAR methods[1] (everybody was trained for it)"
- "everybody has to know about the patient when she/he is in front of the patient (and not be asking and wondering)"
- "everybody knows what they have to do"

The bundle is therefore the last step of a long process toward integration of maternity care. It is considered by all actors as a tool to meet a common objective: improving the health of the mother and the child. This is very important as bundled payment is about trust between care providers who accept to change their practice: some professionals indeed need to give up some of their tasks to others for better care coordination.

Figure 1 Different steps leading to the bundled payment



1 The SBAR (Situation Background Assessment Recommendation) method is "a communication tool that allows a healthcare professional to structure his or her oral communication with other professionals. The objective of this standardization is to prevent adverse events that may result from comprehension errors, and to facilitate a clear, concise and documented communication to avoid oversights". (Haute Autorité de santé, "*Un guide pour faciliter la communication entre professionnels de santé*", October 2014).

4. Implementation of bundled payment for maternity care

... bundled payment is a policy tool, means to an end rather than the end itself. »

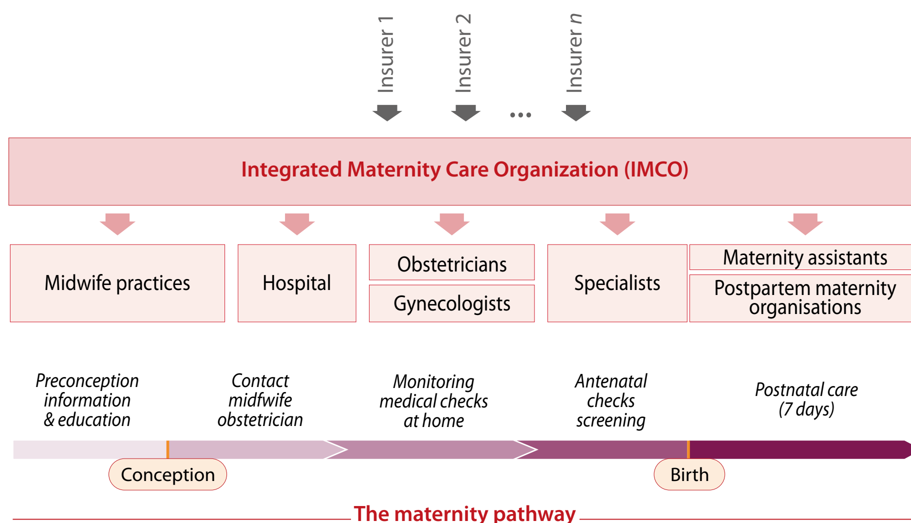
A policy advisor on maternity care at the Dutch Ministry of Health

In 2017, the Dutch Ministry of Health introduced a payment reform on an experimental basis with the objective of improving integrated care and encouraging new ways of caring for women. This voluntary payment reform consists of a bundled payment including all care services delivered by midwives, gynecologists and maternity care providers. Currently, all these providers are mainly paid on a fee-for-service basis.

The experimentation of bundled payment started in 2017 for a five-year period. Eight regional groups, out of 76, were volunteered for participating in the pilot program. In these regions, a new organization was created for allowing the experimentation of a bundled payment: Integrated Maternity Care Organization (IMCO) or "Integrale Geboortezorg Organisatie" (IGO) in Dutch. An IMCO is a new legal entity in the health care system which is formed by multiple care providers, who are often community midwife practices, gynecologists and postpartum maternity care organisations. It works as the principal contractor and assumes both clinical and financial responsibility for all maternity care delivered by the care providers participating in the IMCO. Within the experimentation, each IMCO received a subsidy of 200 000 euros from the Ministry of Health as one of payment to set up this organization. All the providers involved in the corporation (midwives, obstetricians, etc.) have voice in the IMCO board (through their representatives) which is the prime contractor in a bundle payment contract and negotiates the terms of the payments.

Midwives usually work in group practices. All regional midwifery practices have joined a new midwifery cooperation and the cooperation is represented in the board of the

Figure 2 Scheme of the IMCO contractualization



IMCOs. This maternity cooperation was not easy to establish especially knowing that outside the IMCO these group practices are competing stakeholders. The maternity assistants also established their own cooperation and joined the IMCO.

4.1. The maternity care bundles

The bundled payment for maternity care has been defined according to three phases (prenatal, natal, and postnatal), with two levels of complexity (normal or complex) leading to a classification of nine modules. The bundled payments start when women first visit a health professional who become the case manager (midwife or obstetrician) and ends, usually, a week after the delivery. The content of each module (care to be provided) is defined by the Health Care Authority, but the prices are freely negotiated between each insurer and IMCO.

Tableau 1 The nine modules of the bundle

	I. Prenatal phase	II. Natal phase	III. Postnatal phase	
Bundled payment for maternity care	**1.** Miscarriage (< 16 weeks) **2.** Standard pregnancy (> 16 weeks) **3.** Complex pregnancy	**4.** Standard delivery (at home or ambulatory) **5.** Hospital delivery without medical indication **6.** Complex delivery	**7.** Standard care **8.** Complex care	**9.** Postnatal care at home/ hour

For each pregnant woman, the IMCO will be reimbursed for four modules. For instance, a woman, without any complication, would receive the payment for the module 2, module 4 or 5, and module 7, and finally module 9. Module 9 consists of post-natal services delivered at home by the maternity assistants (see Box). Every woman will benefit from this, no matter the complexity and the way of giving birth. The care is paid on an hourly basis with a co-payment of 3 euros/hour. The module 5 corresponds to the women who wish to deliver in the hospital but without any medical reason (mostly to have epidural) which requires a copayment of about 300 euros (usually paid by the voluntary private insurances).

4.2. Bundle breakers

The freedom of choice is fundamental in the Netherlands, therefore a breach in the bundle is possible if a patient chooses to see a provider who is not in the IMCO. This can happen for instance for patients living at the frontier of two regions and who may deliver in a hospital nearby that is not in the IMCO, or if the patient moves to another region during pregnancy. So if a patient is in the bundle during prenatal phase, but gives birth in another place, the bundle applies for the prenatal phase but is broken after and the providers are paid by the previous system (by fee-for-service).

4.3. Payment of providers

In the Netherlands, health insurers and providers negotiate on price and quality of care, although competition on quality is still in its infancy. For certain types of treatments for which negotiation is not feasible (around 30% of hospital care), such as emergency care or organ transplantation (too few providers), the Dutch Healthcare Authority establishes maximum prices. Healthcare providers are independent non-profit entrepreneurs. Each pro-

fessional organization and the hospital has to deal contracts with their different insurance funds. In maternity care, the traditional fee-for-service payment structure leads to negotiations for a set of more than 200 prices. In order to implement bundled payment, the Dutch Healthcare Authority have mapped the 200 procedure/payment codes into nine modules. In the pilot phrase, the Ministry of Health has assured that there are no financial risks for the providers involved in the experimentation and the previous revenues were guaranteed for three years.

Typically, each health insurer contracts with different providers for a year based on some quality and mostly cost/quantity objectives. Under the bundled payment, the IMCO negotiates with the insurers which propose levers where they can improve quality, on which activities they can do better in terms of cost, based on outcomes. For example, ultrasound specialists own their own business and function separately. Each IMCO decide their own policy of ultrasound (how many, when, etc.) and it is the obstetrician or midwife who demands for the echography when needed (to avoid the induced demand by ultrasound specialists). IMCO organizes medical meetings to discuss together (with different providers) the need for different cases. As principle, IMCO (healthcare providers) provides a plan showing what they can do to reduce cost and improve quality/outcomes, in return the insurers accepted to provide a three-year contract instead of one year (information from an IMCO in the pilot) .

5. Barriers and enablers

Barriers

- It is not evident for the care providers to see how to govern an entity such as IMCO, which is needed as a general contractor of the bundled payment contract. The governance of IMCO requires specific knowledge with respect to insurance, finance and tax laws. Most providers lack this specific knowledge.

- The negotiations are complex due to conflicting interest between involved providers (paid by fee-for-service).

- There were uncertainties among providers regarding the financial consequences of potential organization models. Differences in purchasing policies between insurers increased these uncertainties.

- In an environment where healthcare providers are competing for the same patients, it is sometimes difficult to create trust between professionals.

- Attention can be shift to technical questions around defining bundles rather than care quality.

- It is not clear if the bundled payment is really helping to improve the integrated care model as the focus is on implementing the bundled payment. The providers involved in the pilots had already an integrated model that they were promoting, the bundled payment is just the last stage of a long process.

Enablers

- Agreement on a shared vision and shared objectives for reducing neonatal mortality and improving maternal outcomes. The production of national common health care standards for maternity care was important in standardizing care pathways.

- Better monitoring of the activity and care quality. Performance benchmarking of maternal care is part of the regular performance evaluation carried out by the National Institute of Public Health in the Netherlands. These national benchmarking and international comparisons such as those using Peristat have been important for the adhesion of health professionals.

- Creation of maternity care networks associating all health professionals at local/ regional level throughout the national territory.

- Ensuring that healthcare professionals involved in the bundled payment are financially secured, that nobody will lose in the short term. Organizational changes are costly and risky for the providers involved. The fact that

the insurers reassured the providers involved in pilots was important for convincing them to join the experiment.

- Investment in a transition fund to cover initial startup costs for supporting providers to get over the hump.

- Flexibility in local organizations leaving space for innovation. In each local area, local providers involved in IMCO have a large latitude to decide how they share tasks and responsibilities to achieve common objectives.

The evaluation of this 5-year experiment with bundle payment which started in 2017 is still in progress. There is no doubt that these results will be followed closely, not only in the Netherlands, but also in France, where new models of remuneration and organization of care are currently being tested (article 51, 2018 Social Security Finance Act/Loi de financement de la Sécurité sociale).

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Integrated Funding for Maternity Care

Lucie Michel, Zeynep Or (IRDES)

Under pressure of increasing demand for healthcare from an ageing population with multiple chronic conditions, France, as other countries, seeks to advance care coordination across primary, hospital and long-term care sectors. Specialists play an essential role in treating patients with chronic conditions, but little attention is given to their organization out of hospitals, and their role in enhancing care coordination and patient-centered care provision.

In order to investigate different ways in which specialists are working out of hospital to integrate primary and social care, we carried out case studies in five countries (England, Germany, Italy, the Netherlands, and the United States). In each study, we examined how specialist care is organised around specific health conditions for integrating care in community. These case studies, carried out through site visits between June 2018 and March 2019, explore the organisation of care around patients by describing the coordination of roles and tasks between specialists and other health professionals involved in patient care, with a special attention to their innovative features and underlying financial models. A synthesis of results across five countries is available at: www.irdes.fr/recherche/2020/qes-248-decloisonner-les-prises-en-charge-entremedecine-specialisee-et-soins-primaires-experiences-dans-cinq-pays.html

This case study looks at the organization of maternity care in the Netherlands, and describes the experimentations with bundled payment which aims to support integrated maternity care models.

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