VINTURA VBHC REPORT

Value-Based Healthcare: working together for real change

Gérard Klop

In collaboration with
Edward Beerthuizen and Pim Kooreman

VINTURA

Foreword

Vintura has been a strategy and organisation consultancy firm in healthcare and life sciences since 2000. VBHC is close to our heart, from talking about it to doing it!

VINTURA: AN INTRODUCTION

Vintura is a specialised consultancy firm in healthcare and life sciences with a diverse team of 25 experienced consultants. The firm was founded in 2000, and since then we have been supporting our clients with their strategic and organisational challenges and changes. Together with our clients, i.e. healthcare providers, pharmaceutical companies, manufacturers of medical devices and healthcare insurance companies, we increase the value of healthcare. Our mission is: 'Creating meaningful impact in healthcare together'.

WHY VBHC DRIVES US

We believe that the best healthcare must be available and affordable, and must remain that way for all patients. To achieve this mission, we see the need for substantial change within healthcare. Within healthcare, we will have to start focusing on providing value and not on just providing services and completing tasks. We believe that value-based healthcare (VBHC) is the solution for a sustainable healthcare system in which patient outcomes are improved while the costs of healthcare are controlled. For this reason, VBHC is perfectly in line with our mission.

WHAT DO WE WANT TO ACHIEVE WITH THIS REPORT?

More than ten years have passed since Porter published his book *Redefining health care*[1], and with it he gave the green light for the transition to VBHC. VBHC has since become a much-debated subject within healthcare. We see, however, that in practice organisations are still struggling with the question of how to deal with the implementation of VBHC, and which role they can play in the changing healthcare environment. Right now, organisations are confronted with specific hurdles standing in the way of value-driven healthcare.

1. Redefining Health Care – Michael E. Porter and Elizabeth Olmsted Teisberg, Harvard Business Review Press, 2006

Because we believe in the concept and principles of VBHC, we investigated why some organisations are moving in the direction of VBHC while others are not, and also which hurdles are hindering its implementation. Solutions can be identified and implemented based on this knowledge. This also contributes to the actual achievement of value-driven healthcare. As Vintura, we play an active role in this. This report outlines concrete problem-solving approaches that organisations can use to get started.

WHAT WERE OUR SOURCES FOR THIS REPORT?

For this report, we conducted market research for which we interviewed 30 people in total. They are representatives from hospitals, healthcare insurers, the pharmaceutical and medical devices industry and patient associations in the Netherlands. The interviews were conducted in two phases: the first phase was exploratory, the second in-depth. In addition, we drew upon our broad experience in solving and managing VBHC-related projects in healthcare and life sciences.

The main research question was: How can we achieve VBHC in hospitals? To answer this main question, we sought answers to the following sub-questions:

- What are the main drivers for VBHC?
- What are the hurdles preventing the move towards VBHC?
- What are the roles and responsibilities of everyone involved in VBHC?

VBHC concerns the entire healthcare system. For this research project, we deliberately opted to first explore how VBHC can be implemented in hospitals. We did so because hospitals can initiate the change due to their central role within the healthcare system. Having said that, implementing VBHC across the board in hospitals is not possible without involving internal and external stakeholders. The same applies vice versa: it will not be possible to implement VBHC effectively if hospitals do not cooperate.

We have deliberately chosen to focus on the Netherlands. The Netherlands is one of the front runners in the field of VBHC. The lessons learned from Dutch practice can also be used as an inspiration for implementing VBHC internationally.

Be the change you want to see in the world – Mahatma Gandhi

Executive Summary

Our healthcare system as it stands now is no longer sustainable in the long term. We have identified five underlying key issues. If we are going to tackle these problems, we will have to implement a collective and substantial change in order to make our healthcare sustainable, accessible and more patient-oriented. Value-based healthcare (VBHC) will accomplish this.

VBHC is a call to measure patient value, which is done by dividing the healthcare outcomes delivered by the costs incurred, and subsequently making these costs transparent. The value delivered must be rewarded based on this transparency instead of on the procedures and treatments, i.e. volumes. This creates a cost-aware and patient-oriented system that rewards value for the patient and by doing so enhances patient value. Organisations that can put this into practice effectively will be the differentiating healthcare providers of the future.

Vintura has conducted market research in the Netherlands, a front runner in VBHC. The lessons learned by Dutch hospitals, healthcare insurers, the pharmaceutical and medical devices industry and patient associations, can be used as an inspiration for implementing VBHC internationally. The market research shows that improving patient value is *the* common driver and a connector for initiating the transition to VBHC. As it stands today, the various organisations involved tend to approach VBHC from their own perspective and based on their own specific drivers. However, if VBHC is to be implemented successfully, the parties involved will have to join forces to shape it. For this, the shared driver – the objective of increased patient value – must always be at the forefront.

Even though the various stakeholders in our healthcare system support VBHC principles, the effective implementation of these principles on a large scale has failed to materialise. This is apparent from the fact that Porter published the basis for VBHC in his book *Redefining health care* in 2006, and his VBHC value agenda in 2013, yet the principles have been applied on a very limited scale. This is because Porter's publications outline the optimal VBHC outcome, which is ambitious and conceptual by nature. It is not always clear 'how' this can be achieved.

The transition to VBHC must be seen as a growth path. Focusing on Porter's value agenda, we can distinguish three main elements, starting with controlling and integrating care. These two elements can be seen as two axes on which steps can be taken to create the optimal outcome for VBHC. The third element concerns the external enablers. These must be set up in such a way that the transition to VBHC can be accelerated. Once VBHC is applied and starts to move along the two axes mentioned previously (control and integration), managing the change will be an important area requiring special attention. That is why change management is a crucial fourth element that must be included on the value agenda.

In the market research, we studied the most significant hurdles within these four elements that affect the implementation of VBHC and how these hurdles can be overcome.

Control and integration of healthcare: internal hurdles are the complications faced when integrating healthcare or controlling it based on outcomes. These internal hurdles are generally practical in nature, and can therefore be solved. Overcoming these hurdles calls for vision and perseverance.

Change management: VBHC requires an integrated perspective. Until now, VBHC has mainly been approached from a content perspective, but in fact it is primarily a challenging process of change: it requires a change in culture and mindset as well as adopting a different leadership style. We should therefore view VBHC as a serious change, one that is often underestimated.

External enablers: many of the external hurdles mentioned involve financing. That said, besides changing financial incentives, efforts must be made at the national level to increase the transparency of healthcare. This transparency will be a driver for the further improvement and integration of healthcare. The patient will ultimately benefit the most.

Improving our healthcare system is something that is relevant to all of us, and it is something in which those involved will have their own role to play. We have to achieve this through a joint effort; it is not something that can be dealt with and developed in isolation. It demands clear roles and expectations. Based on this, a shared ambition and plan of action can be defined.

There may be many reasons not to do anything; often there is only *one reason* to do something. In the case of VBHC, that very reason is important: more transparency and value for patients. The expectation is that the successful healthcare providers of the future will be those organisations that were the first to proactively start changing and focusing on continuous improvement, and who communicated this and hence attracted more patients.

In short, enough said, let's get to work!

Chapter 1
VBHC: not a hype but a must

Our healthcare system in its current state is no longer sustainable. We are going to have to implement real changes to make our healthcare sustainable and patient-oriented. VBHC provides answers as to how we can organise healthcare differently. Organisations that can put this into practice effectively will be the differentiating health-care providers of the future.

WE HAVE TO GET MOVING

The way our healthcare system is currently organised is no longer sustainable and acceptable in the long term. There are five important core problems that require substantial change in our healthcare system. This also means that organisations and policymakers that are part of the system will have to adapt.

Key challenge 1: rising costs through ageing and new technology

The ageing of the population is causing an increase in the demand for healthcare. At the same time, technological developments are making more treatments available. If nothing is done, these two developments will drive the costs of healthcare up (Figure 1.1). Fragmented adoption of technologies and a lack of standardisation and collaboration do not really help when it comes to optimising expenditure on new technologies. In many countries, the growth of GDP is not keeping pace with increases in healthcare costs. That means that healthcare budgets per patient are tighter. There is a risk that future technological innovations and new treatments will no longer be affordable. This means patients will not have access to the best possible care.

On the other hand, many healthcare costs can be prevented through the use of certain technologies. For instance, costs can be reduced through the use of new technologies in prevention, self-management, telemonitoring, and home care and by keeping patients better informed and involving them more.

FIGURE 1.1

INCREASING PRESSURE ON HEALTHCARE BUDGETS

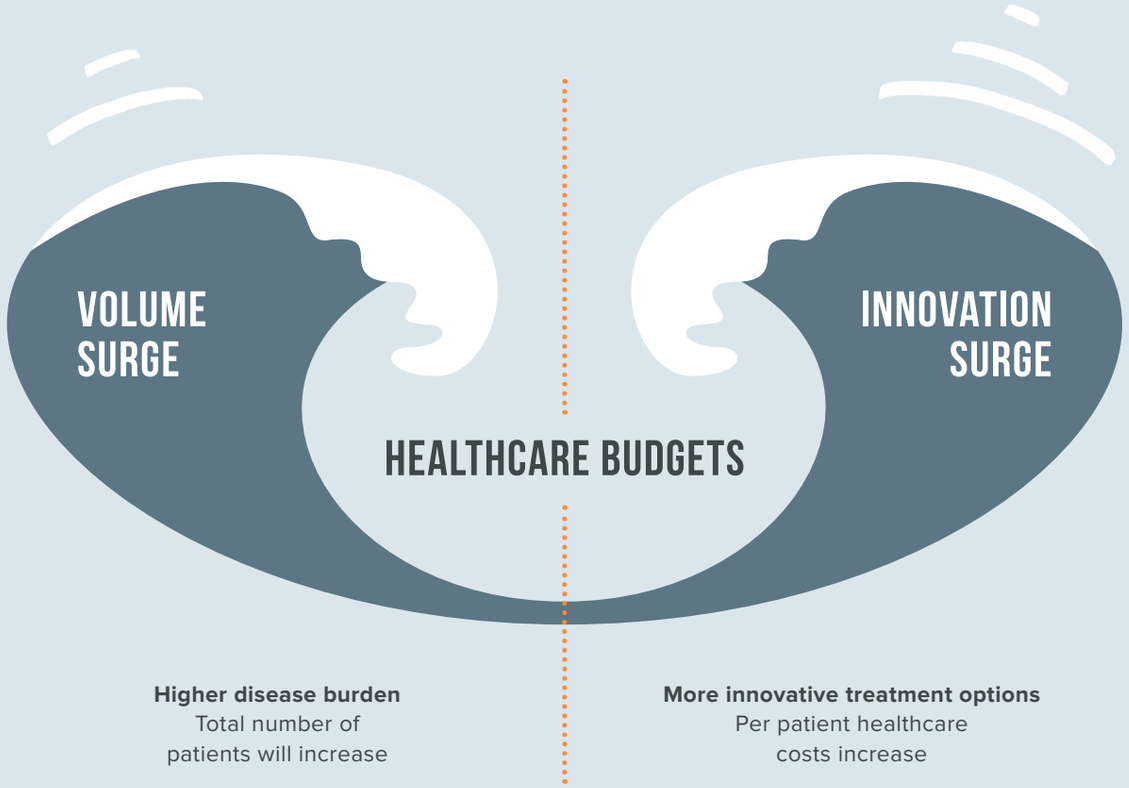
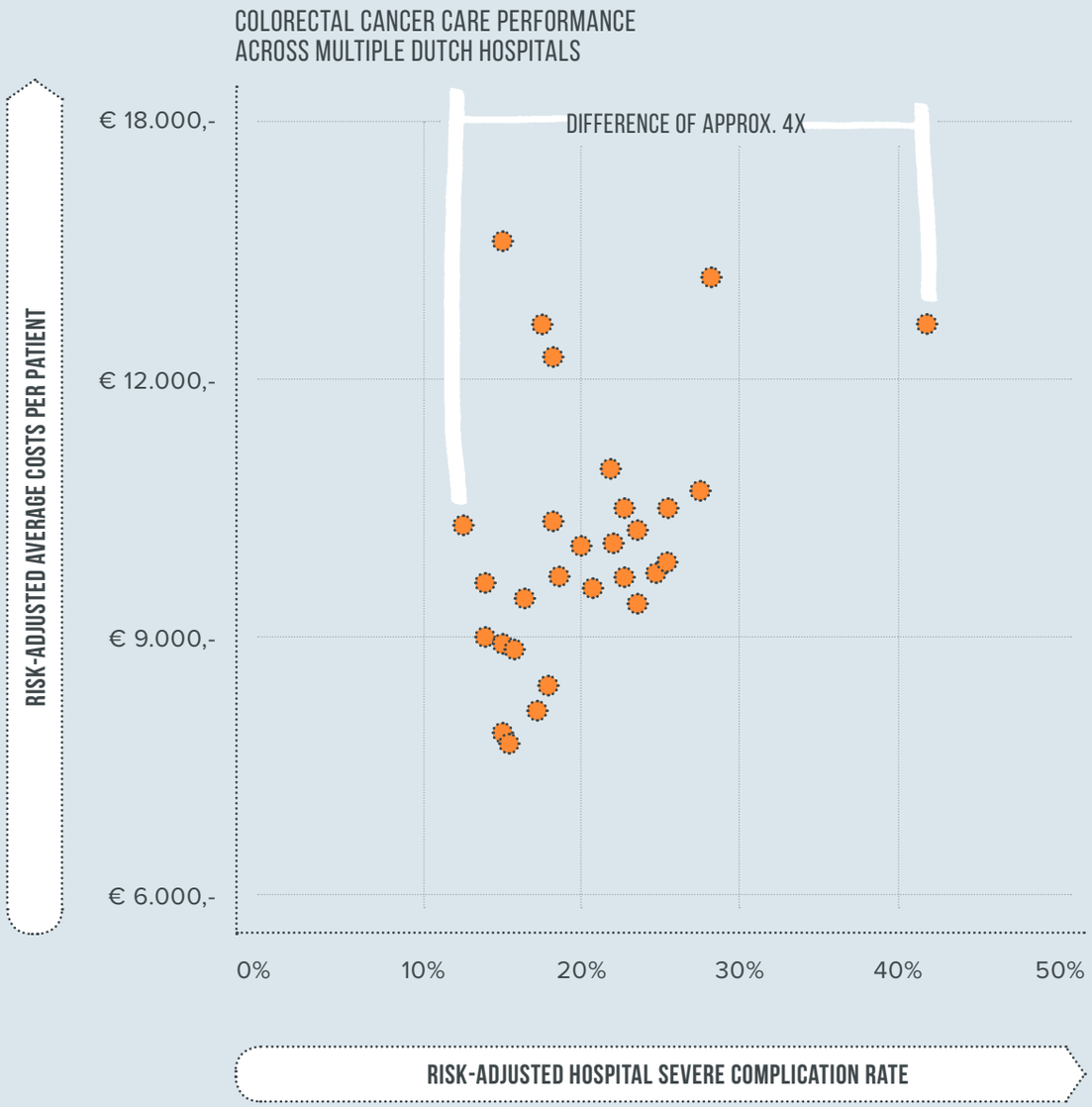


FIGURE 1.2

VARIATION IN QUALITY



Source: J.A. Govaert, Value-based healthcare in colorectal cancer surgery: Improving quality and reducing costs, 2017

Key challenge 2: no reward for quality

As it stands currently in the existing Dutch system – as is the case in so many countries – volume is rewarded instead of quality. This may lead to perverse incentives in the system. On the one hand, it does nothing to curb the rising costs of healthcare (Core Issue 1). On the other hand, there is no direct incentive to deliver quality and to continuously improve. Many healthcare professionals will argue that they have the best interests of the patient at heart. However, 'unconscious incompetence' is often an issue because the person concerned simply is not aware that things can be done better, for instance, by observing the good practices of other healthcare providers. Providing funding for quality will help to increase awareness and promote further movement towards continuous learning and improvement.

Key challenge 3: insufficient transparency in quality

The quality of care is increasingly being measured, but it is still not transparent. Failing to make healthcare outcomes transparent means that there is no incentive to share good practices and to learn from one another. As a consequence, discrepancies in quality and costs remain. Indeed, healthcare that is substandard and/or much too expensive remains hidden from view and can continue unintentionally.

In a recent thesis[2], J.A. Govaert looked at the variation in complications as a consequence of colorectal surgery in Dutch hospitals (Figure 1.2). This research revealed major differences between the best- and worst-performing hospital. The number of serious complications differs between the two by a factor of four. In addition, the costs of these complications are significant. The study showed that 31% of the costs are related to complications. Moreover, the worst-performing hospital was also one of the most expensive healthcare providers.

2. J.A. Govaert, Value-based healthcare in colorectal cancer surgery: Improving quality and reducing costs, 2017

At the end of the day, transparency is also an ethical issue. Patients are entitled to know where they can get the best healthcare. It is unacceptable that patients do not know which healthcare provider is best for them, and therefore cannot make the best choices concerning their health.

Key challenge 4: fragmented healthcare provision

As it stands now, healthcare in the Netherlands is organised around functions and not around disease profiles. As a consequence, there is no integrated approach to the patient or the clinical features of the disease and the funding flows along operational lines. That in turn means that there is no integrated insight into costs, there are many inefficiencies and mistakes are made in transfers, there are duplications, no one feels that they have to claim full ownership for the end result and the confused patient is sent from pillar to post between the various functions and/or healthcare providers. This fragmentation does not help to improve the costs, quality and transparency of healthcare. The situation unintentionally contributes to Core Problems 1, 2 and 3.

Key challenge 5: the focus is not on the patient

Last but not least, the patient, the most important stakeholder, is not the focus. There is no other industry in which the involvement of the 'end user' is as low as it is in healthcare. This is paradoxical, because after all, what is more important than our own health? We are more involved and informed when we buy a house, a car or a mobile phone. For these items, the range of products is transparent and homogeneous, and differences in quality are minor. This is not the case in our range of healthcare options.

This means that patients cannot be involved unless they put effort into getting the necessary information through all kinds of channels and in a very roundabout fashion. Progress is being made in terms of making patient information accessible, having patients participate in treatment plans and patient-reported outcome measures (PROMs). But it is still very diffuse, fragmented and dependent on the hospital or physician. It must be better organised and more structured if patients are to be more involved. This would ensure that there is a healthy dialogue and feedback loop between the patient and the person or institution treating the patient. In turn, this would enhance the quality of care and patient participation, and also increase self-reliance within the treatment process.

VBHC AS A SOLUTION FOR SUSTAINABLE HEALTHCARE

The VBHC vision fundamentally addresses the five core problems mentioned above. VBHC is a call to measure value, which is done by dividing the healthcare outcomes delivered by the costs incurred, and subsequently making these costs transparent. For this, outcomes must be defined as 'patient outcomes', whereby the patient is involved in defining these outcomes. The value delivered must be rewarded based on this transparency instead of on the procedures and treatments, i.e. volumes. This creates a cost-conscious and patient-oriented system that rewards value for the patient. Further integration of healthcare based on disease profiles and the patient will provide further improvements to quality and efficiency.

Through this transparency and these financial incentives focused on patient value, a self-learning and self-improving healthcare system is created in which the patient is the focal point. At the same time, the ratio of quality to costs will improve because more providers will be compelled to optimise it. Over time, the system will head towards an optimal balance between quality and costs according to medical conditions. Healthcare providers will learn from one another and will adopt good practices, encouraged by healthcare insurers in the process. A sustainable healthcare model, one in which the focus shifts more to the patient, will be the result.

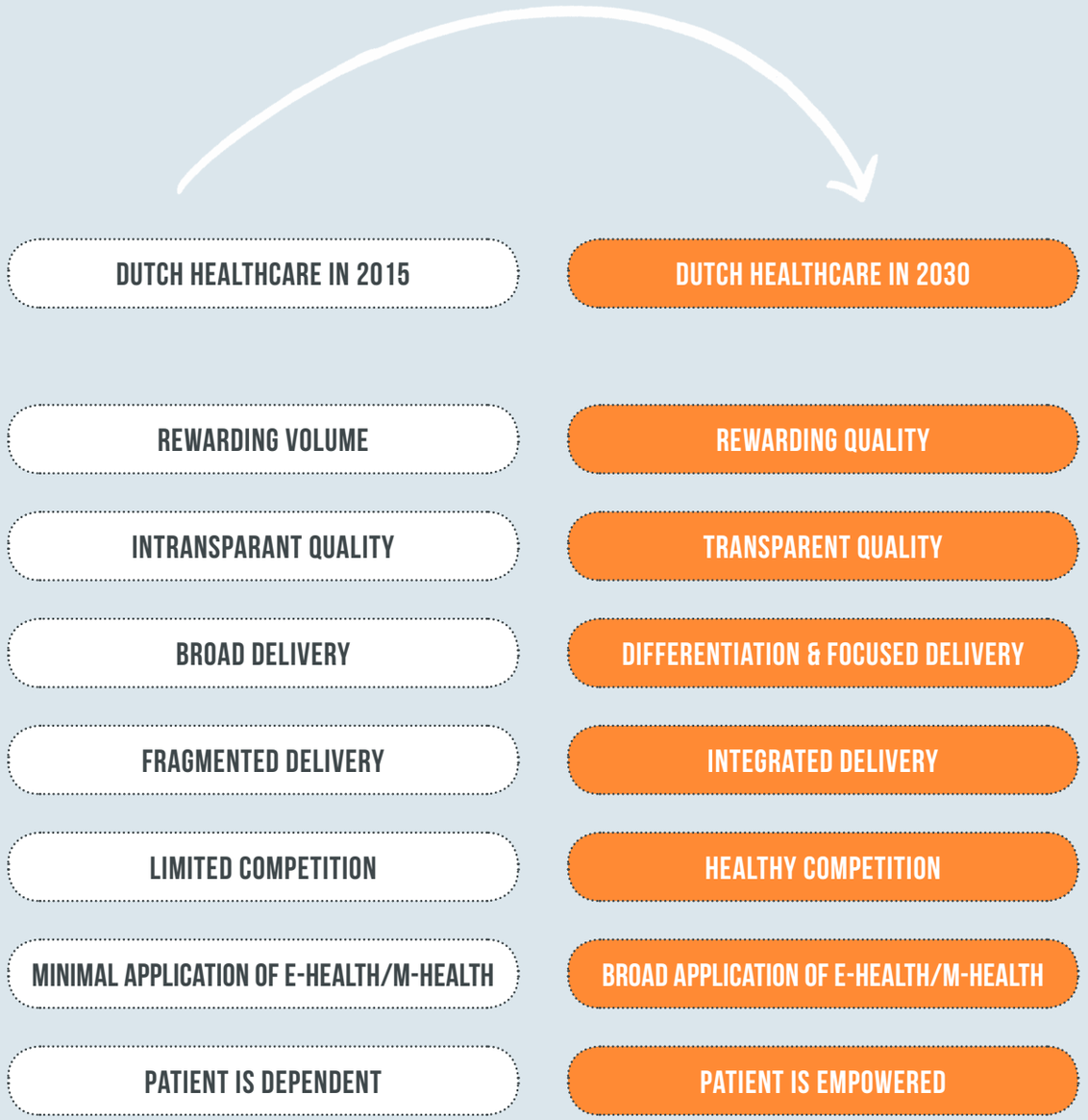
WHAT IF YOU FAIL TO MOVE WITH THE TIMES?

VBHC will transform the healthcare landscape. Figure 1.3 shows what our healthcare system will look like in the future once we have fully embraced and implemented the VBHC principles. It will involve a fundamental transformation of our healthcare system, and with that a substantial change for all the stakeholders involved.

Those organisations that are the first to implement change and embrace the VBHC principles will distinguish themselves in a positive sense. The healthcare providers of the future are those organisations that are the first to proactively take steps and demonstrate that they offer the highest added value. When starting to move, it is important to choose a profile that suits the organisation in the long term. Healthcare providers who can demonstrate that they provide more patient value will ultimately attract more patients. Those lagging behind will face difficulties because they can merely respond. For certain medical conditions, they will not have the patient numbers required to guarantee quality.

FIGURE 1.3

HEALTHCARE SYSTEM OF THE FUTURE



In order to provide sustainable benefits for patients, and by doing so achieve a sustainable position within the healthcare system of the future, healthcare providers will have to make choices and adapt to the changing environment. Failure to move forward does not mean stagnation, but decline.

> **It is not the strongest of the species that survives, nor the most intelligent. It is the one that is most adaptable to change** – Charles Darwin

WHAT IS VALUE-BASED HEALTHCARE?

The founder of the VBHC concept is Professor Michael E. Porter. Together with Professor Elisabeth Olmsted Teisberg, he published *Redefining health care: Creating value-based competition on results* in 2006. In this book, he analyses the problem of rising healthcare costs and outlines the solution: competition based on patient value.

In the VBHC context, patient value is defined as the outcomes that are relevant to the patient divided by the costs that are required to achieve these outcomes.

Measuring and making this value transparent will ensure healthy competition within healthcare, with quality and costs being brought into the correct balance with each other VBHC is in fact an incentive for the healthcare sector to evolve further into a mature market model similar to those we are familiar with in other sectors. In the process, quality and costs will be permanently optimised due to pressure from the market and the requirements of the 'end user'. Providers that offer the best price/quality ratio will secure the best competitive position. In order to achieve these market dynamics with their underlying continuous improvement processes, multiple providers are required to ensure sufficient transparency with respect to costs and quality.

Chapter 2
Drivers for implementing VBHC: value unites

Patient value is the driver that the various parties share, and it is a strong unifying factor. As it stands now, the various organisations involved tend to approach VBHC from their own perspective. However, if VBHC is to be implemented successfully, the parties concerned will have to join forces to shape it.

VBHC UNITES THE VARIOUS PARTIES IN HEALTHCARE

In Redefining health care (2006), Porter wrote that 'Value-based competition on results is a positive-sum competition in which all system participants can benefit.' That is, once everyone focuses on patient outcomes, everyone stands to benefit from a value-driven healthcare system.

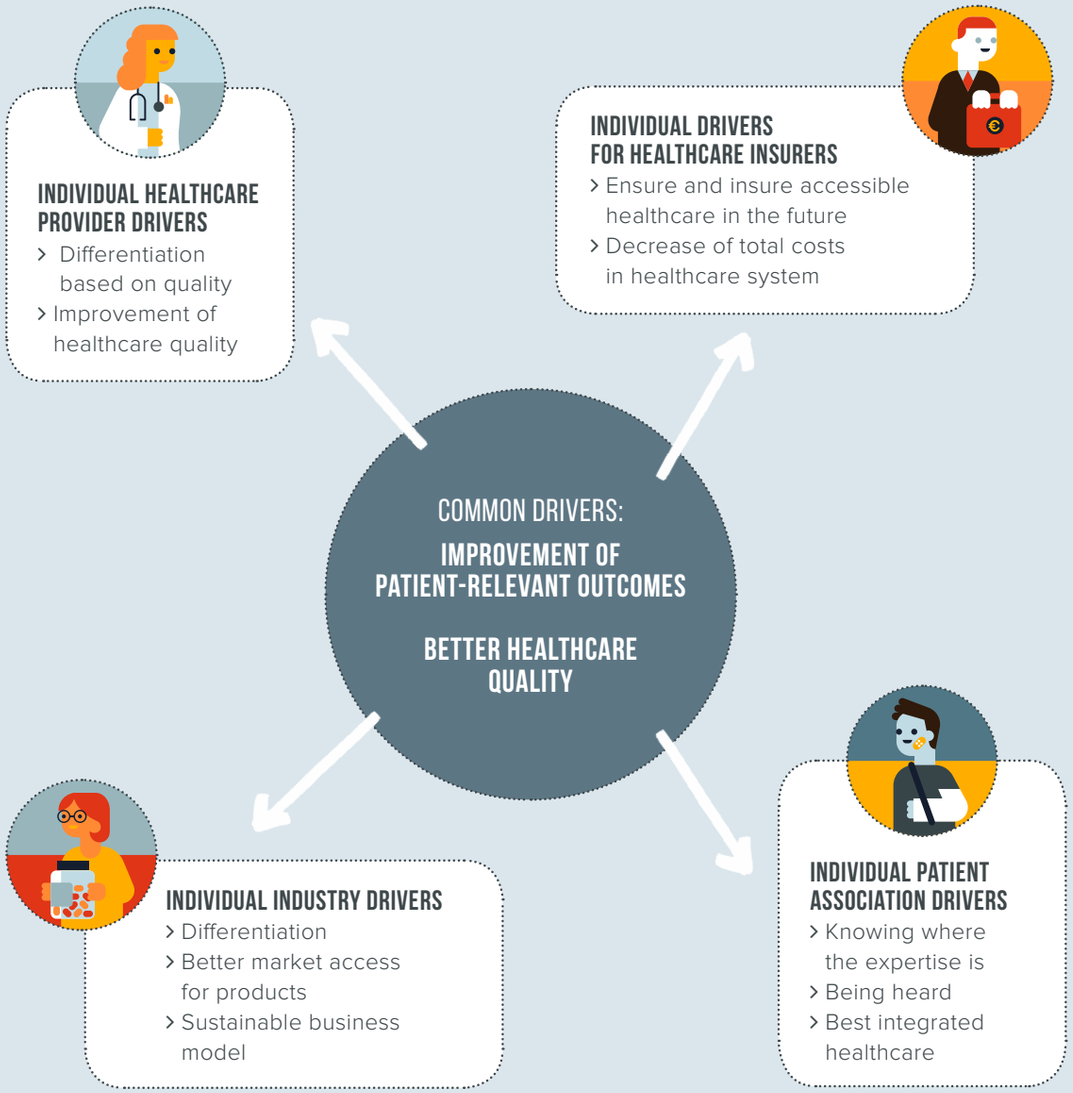
The interviews showed that the VBHC concept is widely supported. VBHC is referred to as the ideal method for uniting the various stake-holders: in a hospital, VBHC is the unifying factor between the various specialisms and between the healthcare professionals and management. VBHC is also the unifying factor between the pharmaceutical industry and the hospital, or between the hospital and the healthcare insurer. Prioritising patient value unites those involved and ensures that the discussion is about what it should be: how to achieve the best outcomes for the patient at optimal costs.

> **"VBHC is the unifying factor between the board of directors and the medical specialists"**
>
> Stefan Kroese, director of operations, Reinier de Graaf Hospita

Market research shows that there is a great deal of overlap in the drivers that organisations mention for moving in the direction of VBHC. The common ground that they share is mainly to be found in providing patient value and improving the quality of healthcare (Figure 2.1). This means that is patient value is indeed the most important unifying factor that connects the various parties.

FIGURE 2.1

DRIVERS



EACH ORGANISATION ALSO HAS ITS OWN ADDITIONAL DRIVERS

Besides the shared drivers, those involved also have their own separate drivers (Figure 2.1). For healthcare insurers, VBHC is an opportunity to get better healthcare quality for the same or even lower costs. As such, VBHC is a way for healthcare insurance companies to keep healthcare affordable and accessible, but also to distinguish themselves in a positive way. For the pharmaceutical industry, VBHC is an opportunity to demonstrate the value of their products and, by doing so, to get better market access for their products. In addition, they can distinguish themselves positively as partners working towards the improvement of healthcare instead of merely being product suppliers. *Healthcare providers*, too, view VBHC as an opportunity to distinguish themselves positively based on quality, in addition to improving the quality of healthcare. *Patient associations* see VBHC as a platform to make themselves heard, and as a move towards more transparency and integration in healthcare.

So, many stakeholders view VBHC as an opportunity to distinguish themselves positively within healthcare. In fact, this is exactly what VBHC is aiming at: stimulating competition based on patient value (quality delivered versus costs).

Individual drivers need not obstruct the move towards VBHC as long as those involved are open about their own motivations from the beginning. If these drivers surface later, this may compromise the trust base that underlies the VBHC initiative. It is important that the individual parties involved are immediately transparent about their own drivers.

FROM ONE'S OWN PERSPECTIVE TO THE PATIENT'S PERSPECTIVE

Within VBHC, those involved are all aiming for the same goal: achieving maximum patient value. At this point in time, each player is approaching the goal from their own perspective and with the associated individual objectives. All those involved have to work together to shape VBHC so that the shared drivers dominate the process and the patient really is the focus. For this, the various parties have to work together from the beginning and must be open about their individual objectives.

Value unites! – Michael Porter

Chapter 3

VBHC as a growth path: from a major concept to bite-size portions

VBHC is an ambitious concept. Porter's value agenda[3] describes the final destination but not the road to get there. We see VBHC as a growth path. This growth path makes VBHC manageable; the optimal outcome does not need to be achieved in one go.

THE ENTHUSIASM AND DRIVERS FOR VBHC ARE PRESENT, BUT IMPLEMENTATION IS STILL LIMITED...

VBHC is an ambitious concept that is going to question quo. The existing healthcare system has to be organised quite differently if VBHC is to be realised. The sheer scale of the operation may be daunting to many. One aspect that does not help matters is that changing the status quo affects the professionals involved and the organisation itself: established positions and existing earning models will be challenged. What will replace them? And what will the end result be?

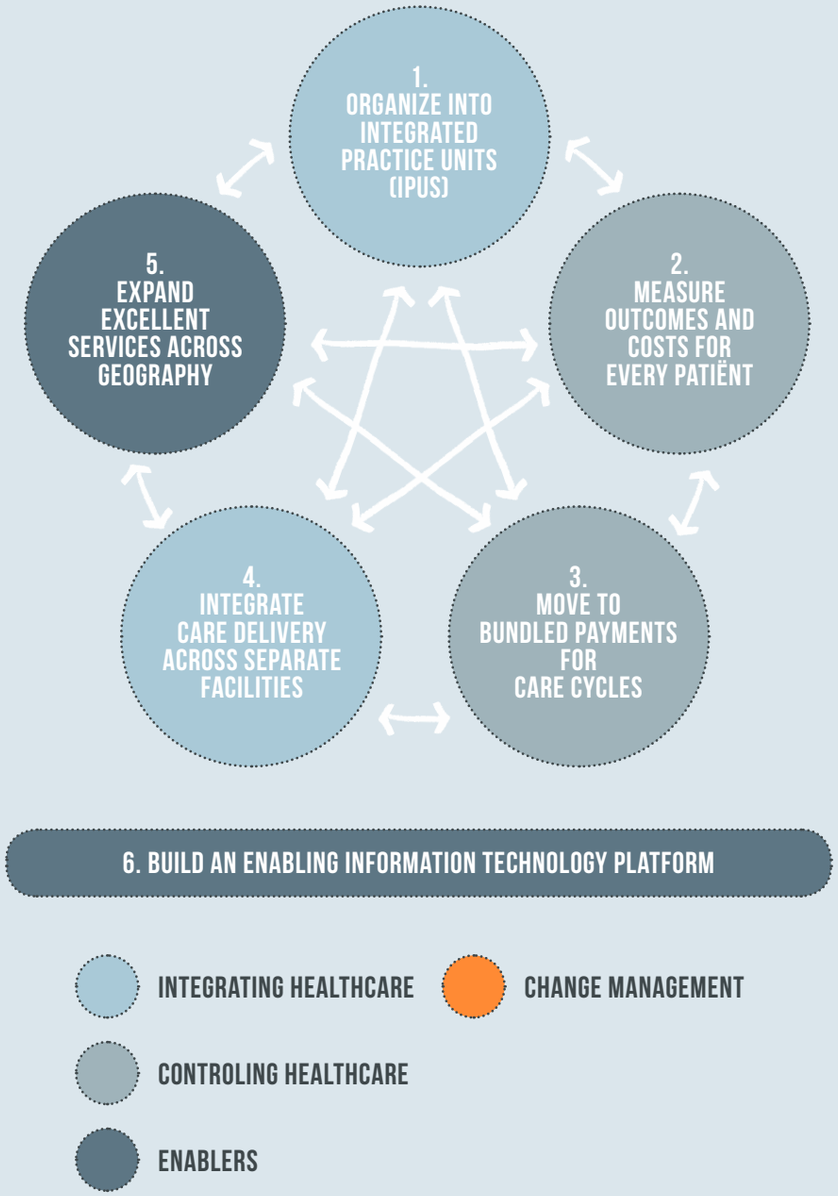
In his article, 'The strategy that will fix healthcare',[3] Porter describes the value agenda: a strategic agenda to create a value-driven health-care system (Figure 3.1). This strategic and conceptual agenda describes the ultimate goal of VBHC: an integrated healthcare organisation within which patient outcomes are realised, where costs and outcomes are known and continuously improved, and integrated funding takes place based on the overall healthcare process and the end result delivered.

So, the optimal outcome has been described. But how do you get there? Which steps do you have to take to arrive at this optimal outcome?

3. Source: M.E. Porter et al. The strategy that will fix health care. Harvard Business Review 2013

FIGURE 3.1

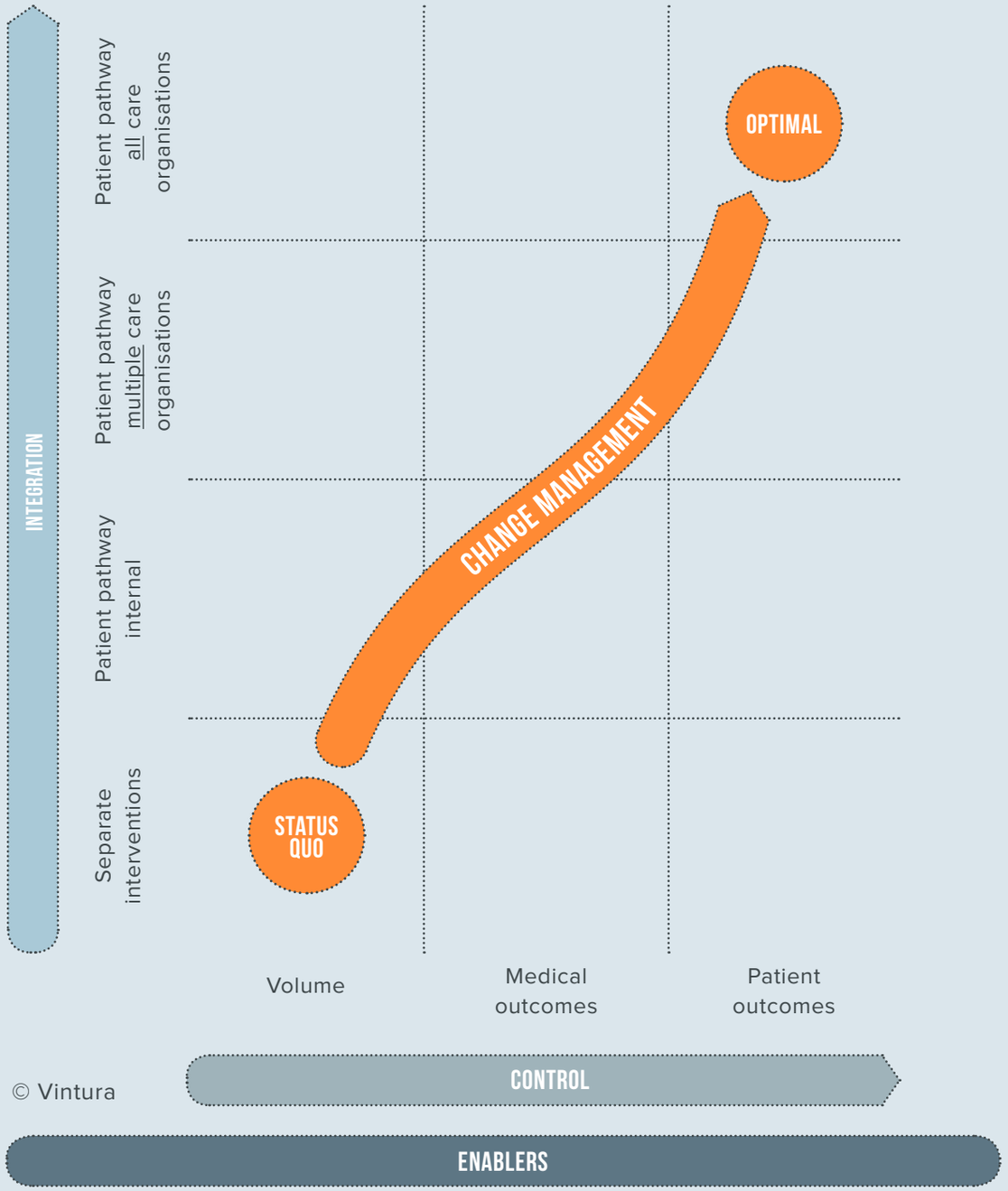
VALUE AGENDA



Source: M.E. Porter et al. The strategy that will fix health care. Harvard Business Review 2013

FIGURE 3.2

GROWTH PATH TO VBHC



WE SEE THE IMPLEMENTATION OF VBHC AS A GROWTH PATH

Focusing on Porter's value agenda, we can distinguish three main elements: control of healthcare, integration of healthcare and enablers for improvement (Figure 3.1). These core elements indicate 'what' VBHC entails, but they say nothing about the 'how'. Once VBHC is applied, managing the change will be a fourth important element. That is why change management is a crucial element that must be included on the value agenda. It is an important factor, one that is required to start the journey along the growth path, and to take the next steps towards the optimal outcome that Porter has outlined.

These four elements underlie the VBHC growth path (see Figure 3.2). The steps to be taken for controlling healthcare are shown on the horizontal axis. Controlling includes the measuring, administering and costing and funding of healthcare. The steps for integrating healthcare, i.e. from individual treatment to a fully integrated care cycle, are shown on the vertical axis. IT infrastructure and geographical expansion are the external enablers that make it possible to initiate and/or accelerate change. The final element – change management – is all about how to handle change and which internal conditions need to be created to enable change: a vision, a need and capacity (funding, resources, people). More on this in Chapter 5. Porter's value agenda outlines VBHC's optimal outcome (top right in the model).

The growth path shows that it is not possible to accomplish the optimal outcome in one go. A more realistic approach is to take a first step based on the existing situation, and to progress from there. Taking a learning by doing approach generates internal and external trust: change takes place one step at a time. The good news is that each small step on the growth path can add value. The path to the optimal outcome is not predetermined: all those involved set the course together.

ONCE YOU START TO HEAD DOWN THE VBHC GROWTH PATH, YOU WILL FACE CHALLENGES

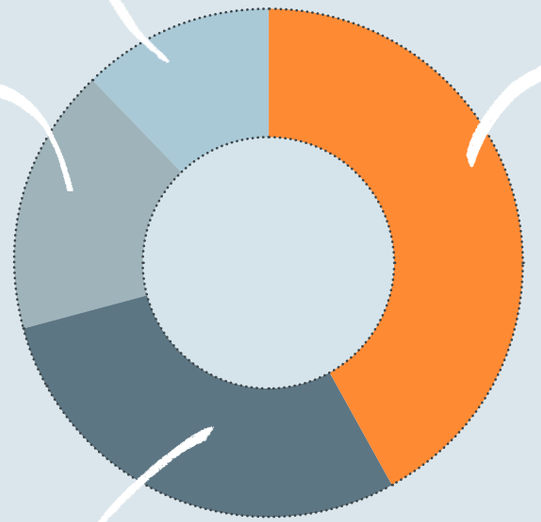
One of the important issues we raised in the market research concerned the hurdles to the implementation of VBHC. As soon as the VBHC growth path is taken, hurdles will stand in the way of positive movement. So what are these hurdles? And how can they be overcome?

The hurdles mentioned during the market research can be placed within the four elements of the VBHC growth path. Figure 3.3 shows the percentage distribution of these hurdles across the four elements. This immediately demonstrates the advantage of introducing change management. Most of the hurdles mentioned (42%) are related to this important additional element. In the following chapters, we will be discussing in greater detail the specific hurdles and possible problem-solving approaches.

The journey of a thousand miles begins with one single step - Lao Tze

FIGURE 3.3

HURDLES ALONG THE GROWTH PATH



12%

HURDLES IMPEDING INTEGRATION

- Lack of trust between various departments / healthcare professionals
- Unaccustomed to working collaboratively outside of own medical field
- The current organisational structure lacks the flexibility required to organise healthcare differently

17%

HURDLES IMPEDING CONTROL

- Concerns about the consequences of transparency
- There is still no standardised set of outcomes
- VBHC requires new contracts with healthcare insurers

42%

HURDLES IMPEDING CHANGE MANAGEMENT

- No time and money for implementing the change (and no willingness to invest in it)
- Medical professionals fail to see the benefits for their own practice
- The concept is too ambitious

29%

HURDLES IMPEDING ENABLERS

- Funding based on quality is not yet the norm
- Budget silo's limit opportunities for innovative solutions and contract types
- Funding and quality of healthcare are two separate worlds: the systems are not linked

Chapter 4

Internal hurdles to VBHC: practical and solvable

Internal hurdles are the complications faced when integrating and controlling outcome based healthcare. These internal hurdles are generally practical in nature, and can therefore be overcome. This calls for vision and perseverance.

HEALTHCARE CONTROL: LEVERAGE EXISTING TOOLS AND STRUCTURES

Healthcare control based on VBHC principles involves measuring and improving costs and outcomes relevant to the patient, and financing healthcare based on these outcomes. The following things are required for this: a set of outcomes, a measurement and reporting methodology, an improvement cycle and a financial agreement with the healthcare insurer. Figure 3.3 shows the three most frequently mentioned hurdles to outcome-based healthcare control. Seventeen per cent of the hurdles mentioned fall into this category.

Hurdle 1: concerns about the consequences of transparency

Measuring outcomes and making them completely transparent could expose the healthcare provider or even the caregiver. It will be immediately evident how the hospital or the doctor performs in relation to other hospitals and/or colleagues. What does this mean for their own positions? Are they as good as they think they are? What if it appears that others perform better? These are all questions that can invoke resistance to creating transparency for outcomes.

> **"Asking the healthcare provider which outcomes are relevant appeals to his or her medical professionalism"**
>
> Paul van der Nat, senior consultant on the Hospital Management Board

Solution

There are several ways to deal with concerns about transparency. Starting an improvement cycle is key to this: start with anonymised information and give doctors time to improve their outcomes. Don't impose the criteria on which individual doctors will be judged; instead ask the group as a whole what the right outcome parameters should be. This way has proven to be extremely successful in various hospitals. Healthcare insurance companies sometimes also deliberately decide to aim for *improving* outcomes, instead of focusing on the outcomes themselves.

Hurdle 2: there is still no standardised set of outcomes

This is a very practical and tangible hurdle. There is a willingness to launch VBHC, but there is still no standardised set of outcomes for the medical condition. Defining the outcomes is the very first step in the implementation of VBHC.

Solution

Begin with what is already available. The International Consortium for Health Outcomes Measurement (ICHOM)[4] defines international sets of outcomes for a wide range of medical conditions. These sets of outcomes are freely available. If the medical condition is missing from the ICHOM sets, there may be existing sets of outcomes that other agencies or healthcare providers have developed. If this is not the case, practitioners may decide to define their own set of outcomes. We highly recommend that they do not attempt to do this in isolation. Professional bodies can play a leading role in this, thus enabling the set of outcomes to be rolled out more broadly straight away.

4. See also www.ichom.org

Hurdle 3: VBHC requires new contracts with healthcare insurers

In the Netherlands, most contracts between healthcare providers and healthcare insurers are currently based on price and volume agreements, with annual settlements based on the number of procedures. Funding based on outcomes is substantially different and requires different types of contracts. The main challenges in this respect relate to defining healthcare outcomes and the long period of time over which these outcomes manifest. Examples include retreatment after x number of years, or the resulting quality of life. These new types of contract must therefore be long-term contracts.

Solution

Healthcare insurers have since accumulated some experience with new kinds of contracts dealing with outcomes financing. Pilot projects are being conducted or are planned in various places in the Netherlands. Quite a few healthcare insurance companies are experimenting with purchasing based on value, which entails contracting at the level of the institution (e.g. hospital), medical condition or population.

INTEGRATING HEALTHCARE: NEGOTIATE CLEAR AGREEMENTS

It sounds obvious: working together to realise the best possible outcome for the patient. In practice it is challenging. The fact is that it involves accepting someone else's authority or expertise, aligning interests and creating trust. The move towards greater integration has begun. Not by taking giant steps, but by taking one step at a time: trust has to grow. Figure 3.3 shows the three most frequently mentioned hurdles to integrating healthcare. Twelve per cent of the hurdles mentioned fall into this category.

Hurdle 1: there is no trust between the various professions/healthcare professionals

There may be several reasons for the lack of trust, such as the lack of a shared vision, conflicting interests, a clash of personalities, egos or old grievances.

Solution

The saying 'Trust is hard to earn and easy to lose' certainly applie here. In practice, too, building trust takes a great deal of patience. And if it does not work at first, try in another region or with other people. It is essential to get all the interests out into the open, and to aim for a win-win situation. Making the patient the priority helps in creating shared objectives and aligning interests (see Chapter 2). A lack of trust is no reason not to join forces and start the process. Failing to make a start means that trust will not develop. Trust is something that must grow during the process of further collaboration, and will require constant attention. VBHC as a process of change will be discussed in detail in Chapter 5.

Hurdle 2: uneasiness about working and collaborating outside one's own medical field

Multidisciplinary teams are certainly not uncommon in hospitals. But this is not the same thing as integrating healthcare. In addition, a particular medical condition has to be selected. In the process, healthcare providers and other stakeholders, where applicable, have to share roles and responsibilities and define a formal collaborative arrangement. Furthermore, if a shift of responsibilities has to take place, there has to be enough trust to allow this to occur.

Solution

The journey towards integrating healthcare is a long one. Real integration equires a different organisational structure, shared ambitions, a change in culture, and a different mindset and way of working. Clear objectives and good mutual agreements are the basis for every collaboration, especially across organisational boundaries. Integration starts by mapping out the entire patient path. The transfer of responsibilities along this path must be clearly marked, because it is during these transitions that things often go wrong. It is also essential to ensure that the underlying communication with all its interactions is clear, because effective communication will help to ensure smooth transitions between organisations and/or responsibilities.

Hurdle 3: the current organisational structure lacks the flexibility required to organise healthcare differently

With its emphasis on operational aspects, the organisational structure within many Dutch hospitals does not support the organisation of healthcare around the patient. The traditional operational model is geared to optimising operational activities and not to optimising the treatment path, an integrated care outcome or the overall patient experience.

Solution

Change is definitely possible, sometimes even within the existing organisational model. For example, ParkinsonNet has managed to set up a network within its existing organisational structure. Ultimately, however, the integration of healthcare often calls for a change to the organisational model. We have noted the following three main directions:

1. a structural change in the organisation model, such as the structural set-up for patient paths within hospitals;
2. a merger or takeover between different healthcare providers, i.e. forward or backward integration within the healthcare system;
3. a virtual network organisation based on very clear agreements between individual parties regarding the allocation of roles and responsibilities, and the quality/service to be provided.

THE INTERNAL HURDLES ARE MAINLY PRACTICAL IN NATURE AND CAN THEREFORE BE OVERCOME

Various internal hurdles were mentioned during the interviews. Mention was also made of various best practices and good examples of internal hurdles that had been overcome and working solutions that were found. Most of the hurdles mentioned are practical in nature and can therefore be overcome. That said, attention and perseverance are required to achieve this, particularly if collaboration between multiple parties is involved, since this adds to the complexity.
The transition towards VBHC is not always easy but the good news is that it is indeed possible, provided those involved have defined a clear vision and fully support it.

Behind these more practical hurdles, however, there is a much bigger challenge: VBHC not only concerns substance, it is also primarily a change process. And it is this change process in particular that is challenging and complex. It no longer concerns developing the more content-related elements; but is more about managing the less tangible ‘soft side’. VBHC is also mainly about changing leadership and management style, culture, mindset and, with this, behaviour. More on this in the following chapter.

The secret of change is to focus all of your energy, not on fighting the old, but on building the new - Socrates

Chapter 5
VBHC as change: challenging and underestimated

VBHC requires an integrated perspective. Until now, VBHC has mainly been approached from a content perspective, but in fact it is primarily a challenging process of change: it requires a change in culture and mindset as well as adopting a different leadership style. We should therefore view VBHC as a serious change, one that is often underestimated.

CHANGE MANAGEMENT IS A SERIOUS CHALLENGE

If change is to be successful, it requires a *vision*, a *need* for change and finally the *capacity* to bring about the change. No fewer than 42% of the hurdles mentioned during the market research concerned change management (see Figure 3.3, Chapter 3).

Porter's VBHC principles only outline 'what' VBHC entails, not 'how' it can be achieved. This is despite the fact that applying VBHC demands substantial change. This is no easy task! The three hurdles regarding change management mentioned most frequently were:

Hurdle 1: no time and money for implementing the change (and no willingness to invest in it)

This hurdle is about the *capacity* required to implement the change, i.e. funds, resources and people. Implementing VBHC requires extra time and money. If there is no willingness to invest in it, change will not happen or it will be extremely difficult. Apparently hospital administrators and healthcare insurers are not adequately acknowledging the advantages of VBHC, or they do not have enough financial leeway.

Hurdle 2: medical professionals fail to see the benefits for their own practice

This hurdle relates to the *need* for change. For the individual medical professional, there is currently not enough urgency: patient numbers are fine. Also, due to the absence of transparency, there is no collective awareness or adequate comparison with other medical professionals when it comes to the potential for improvement, or more serious quality issues. Medical professionals don't feel sufficient need to change the status quo.

Hurdle 3: the concept is too ambitious

This hurdle is directly related to the vision required to set the right course for change and stick to it. VBHC is a concept on a grand scale, and thus difficult to make manageable. The implications are also major. What specific direction do we want to take from the perspective of our role? What are the logical first steps? There is a general lack of shared vision as to how the VBHC concept can be achieved.

These top three hurdles do not exist in isolation and all three already mentioned preconditions (vision, need and capacity) are necessary to effect successful change. There is not much point in addressing individual solutions for each hurdle here, as we did in the previous chapter. Change is an integrated process involving elements that affect one another. The market research interviews demonstrate that the challenge presented by change is strongly felt. How do you change successfully?

CHANGE MANAGEMENT IS UNDERESTIMATED

It is a mistake to think that you can accomplish change just like that, alongside your daily activities. This is certainly the case with a concept like VBHC, which basically involves a shift from controlling and organising healthcare volumes to managing and organising patient value. This process challenges the objectives, processes, structures and the financial incentives. It therefore requires a major change.

The pitfall in this is that the content experts, usually the healthcare professionals themselves, also have to guide and lead the change. Regardless of the importance of input and enthusiasm in the workplace, the question is whether or not to make the healthcare provider responsible for the change process. It goes without saying that healthcare providers and professionals must be involved but, because they are already responsible for providing healthcare on a daily basis, you cannot expect them to simply take on this kind of major change in the course of their work. You can hardly ask someone to steer the boat while mending the sails.

Moreover, the change often has to take place within the available means and budgets. Change takes time and energy and therefore requires additional resources, manpower and budget (Hurdle 1). Not making the change process an independent process ultimately leads to delays and many content-related discussions, without leading to real acceptance and actions. Defining, planning and budgeting for the change are essential steps.

CHANGE MANAGEMENT REQUIRES A STRUCTURAL APPROACH

Change management is therefore a project in itself. It requires a structural approach to the three elements: mindset, culture and leadership. We will briefly review each element below, giving for each one examples of good practices that we have identified at successful organisations:

MINDSET

Implementing VBHC successfully means that improving patient value becomes the core of daily work, not something that is done alongside it. VBHC is not the goal; instead it is the means of continuously improving patient value. VBHC is not an independent project; instead it requires a change of mindset. It is a matter of linking processes, work meetings and decision-making to the improvement of patient value, and these aspects must be experienced and felt (Hurdle 2).

A good example of this is the way in which the Bernhoven Hospital has radically reorganised its healthcare, striving for 'Better healthcare through less healthcare'. A change in the financial incentives is leading to a change in mindset among specialists. For example, virtually all 150 specialists have been employed by the hospital since 2015. They were also given the opportunity for financial participation in the hospital, and doctors are taking part in the hospital's management. "This allows for a much more holistic approach. The interests of the hospital and the doctors are becoming equal. It's no longer about the individual partnerships, but about the hospital as a whole."

Source: Peter Bennemeer, managing director Bernhoven, FD March 2016

CULTURE

Medical professionals are trained to make decisions and to act autonomously. Focusing on patient outcomes and making them transparent can be very daunting. It directly affects the way medical professionals act. In addition, these professionals lose some of their autonomy. The implementation of VBHC goes hand in hand with bringing about an improvement culture in which making 'mistakes' is not bad as long as we are open about it. It is all about seeing 'mistakes' as opportunities to learn and improve the quality and/or cost of healthcare. This requires a major change in culture, from a culture that judges people to a safe improvement culture, creating openness for the purpose of improvement rather than punishment. An improvement culture can only be achieved if all professionals are guided by the will to learn, grow and improve. It helps to start out with anonymised data that only reveals variations.

The improvement culture created at the Martini Clinic in Germany shows that it is possible to create an open and transparent learning environment. The medical team there discusses patient outcomes every week. Discussing outcomes is seen as an opportunity to become even better: if a junior surgeon demonstrates better outcomes than a senior surgeon, the senior surgeon in question will assist this younger colleague in order to learn from him or her.

LEADERSHIP

Strong leadership is needed to accomplish cultural change: the hospital's management board must actively promote and practice VBHC. This includes supporting and promoting enthusiastic pioneers, rewarding good behaviour, embracing and promoting the previously mentioned improvement culture, and emphasising patient value in all communications. Decisions must be made with the patient in mind. Patient value that is achieved structurally must be discussed and monitored regularly in the boardroom.

At the St Antonius Hospital (in the Netherlands), the management actively asks after the patient outcomes for each of the various departments. The management focuses on improving these outcomes instead of judging people based on the outcomes themselves. It is really about actively improving relevant outcomes and encouraging people to learn from one another.

Strong leadership also involves giving enthusiasts space to act. Start implementing VBHC in those places where enthusiastic medical professionals work. Support them with the knowledge and skills needed to realise VBHC (such as training) and support the relevant professional group with the necessary resources, time and money.

A good example of this is the Maxima Medical Centre, a Dutch hospital that sent seven enthusiastic medical specialists to Harvard to attend a VBHC seminar.

CHANGE MANAGEMENT ADDED TO PORTER'S VALUE AGENDA

In short, change management must be an integral part of implementing VBHC, which is why we have expanded Porter's value agenda by adding change management (Figure 3.1, Chapter 3). The VBHC growth path that we have suggested (Figure 3.2, Chapter 3) should make the VBHC concept more manageable. By breaking down the VBHC concept into logical steps and putting it on the time axis, it becomes more tangible and manageable. This should also address Hurdle 3, i.e. the concept is too ambitious. In short, nothing is stopping us from starting VBHC.

Everyone thinks of changing the world, but no one thinks of changing himself – Lev Tolstoy

Chapter 6

External enablers for VBHC: a national growth path for acceleration

Many of the external hurdles mentioned involve financing. That said, besides changing financial incentives, efforts must be made at the national level to increase insight into and the transparency of healthcare. This transparency will be a driver for the further improvement and integration of healthcare. The patient will ultimately benefit the most.

MONEY WORKS WONDERS?

VBHC initiators can largely get started themselves based on the areas of focus mentioned above. In addition, it is important that a number of external enablers are created at system level. Of the hurdles mentioned during the market research, 29% involved external enablers.

It is worth noting that the top three hurdles concerning external enablers are all related to funding. This is logical given that funding flows largely determine the incentives in the healthcare system, and thus behaviour.

Hurdle 1: funding based on quality is not yet the norm

It is true that healthcare is still largely purchased on the basis of volume. Broad experience with procurement based on quality is still lacking.

Solution

This hurdle can be ‘simply’ solved by increasing the number of contracts between healthcare providers and healthcare insurers based on value instead of price and volume. Last year, there was a significant increase in the number of initiatives and pilot projects between healthcare insurers and healthcare providers regarding quality-based contracts. Several examples are outlined in Chapter 4. The challenge here is to get these initiatives beyond being local pilot projects by scaling them up to the regional and national levels.

Hurdle 2: funding silos limit opportunities for innovative solutions and contract types

This hurdle leads to suboptimal solutions within partial budgets because it is not possible to consider care cycles as a whole. Savings or improvements that cross funding silos literally fall through the cracks. These are savings and improvements that are directly related to the treatment path, as well as savings at a macroeconomic level. This can include things like returning to work sooner. Both the costs and the proceeds are divided. Within this system, there is also no profit for the payer/investor.

Solution

This second hurdle is more difficult to solve because it calls for a system change regarding the way healthcare is organised and managed within the government and healthcare insurers. In practice, they find ways around this by entering into separate contracts that cross existing funding silos. These are the exceptions to the existing budgeting structure. If we want to accelerate the process, budgets will have to be set and organised integrally around medical conditions.

Hurdle 3: the funding and quality of healthcare are two separate worlds: the systems are not linked

There is a great deal of data available about quality and costs, but this information is often still found in multiple separate systems. This data is usually not linked, which makes it difficult to aim for value (quality per unit cost). This hurdle primarily concerns control within the hospital or institution (and subsequently across various parties in the chain). It includes an IT component, but also a cultural and management component. The cultural and management components are discussed in Chapter 5.

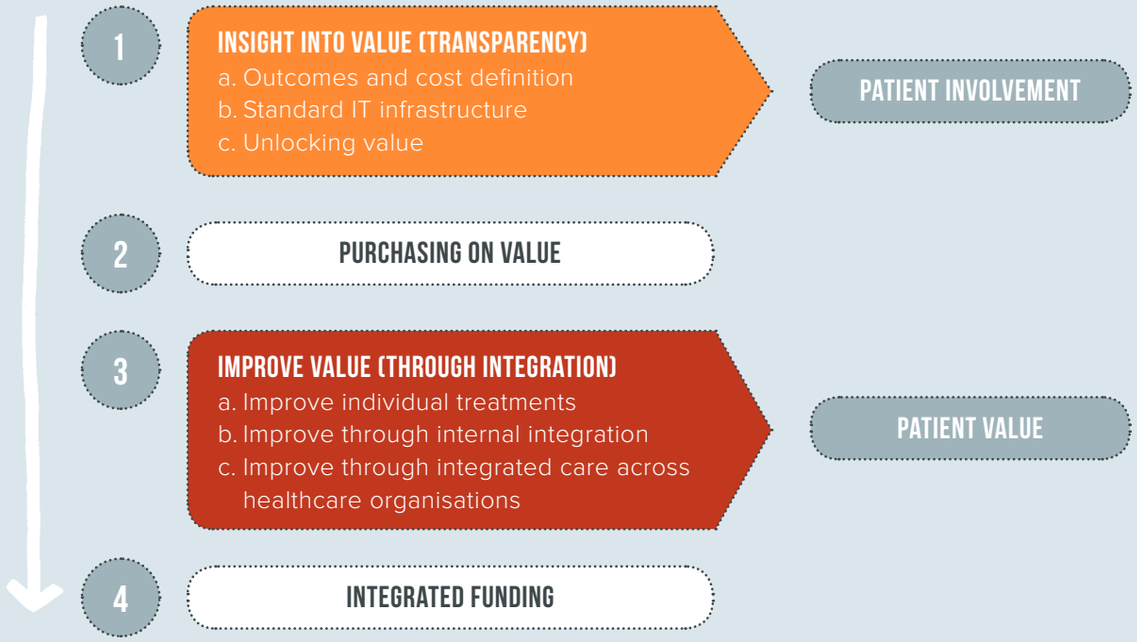
Solution

As far as IT is concerned, it is expected that the financial and administrative systems that we have now will increasingly be supplemented and linked to quality systems, with better support and monitoring of the workflow between the attending healthcare professional and the patient. Data on quality and cost are separate from each other because not all the systems have been linked yet. Integrated and user-friendly dashboards, whereby the quality in relation to the costs can be monitored for each medical condition, still have to be developed. The technology is available, but it will take time to build all the links and to provide access to uniform data and information.

Money is therefore an important factor in creating the right incentives in the system. Despite this, the current financing structure is not the only enabler that we have to do something about at a system level.

FIGURE 6.1

THE NATIONAL GROWTH PATH FOR VBHC



THE NATIONAL GROWTH PATH

The three important underlying VBHC objectives are efficiency (i.e. lower costs), repeatability (i.e. better quality) and comparability (i.e. more transparency). A national scale and/or volume is necessary for all these objectives.

At the moment, there is heavy reliance on local initiatives and leadership, and little central coordination. Despite the fact that we need all the local enthusiasm we can get to take the first steps and to learn, this goes hand in hand with a serious threat: fragmentation. Fragmentation hinders economies of scale, and therefore efficiency, repeatability and comparability. Ultimately, a lack of central coordination may severely hamper attempts to achieve VBHC objectives. An example of this is that we may soon end up with different outcome definitions and different IT infrastructures. This will impede the comparability and exchangeability of data, and will thus compromise transparency in quality. This will result in integrated funding for quality (Hurdles 1 and 2) being unnecessarily complicated and seriously impeded.

In short, there is a need for greater central coordination at a national level. This will not only prevent fragmentation, it will also accelerate the broad implementation of VBHC. To this end, we have defined a *National Growth Path* (Figure 6.1), which outlines several developments related to external enablers; these developments will follow each other logically over time (with overlap). For this, the government and healthcare insurers must take on the task of central coordination and/or play a facilitating role.

FROM INSIGHT TO IMPROVEMENT

The *National Growth Path* consists of four different phases (Figure 6.1). The first phase entails gaining insights into the value (quality versus cost) of healthcare so that it can be improved based on these insights. Healthcare insurers play an important role in gaining insights, namely: in reaching national outcome definitions and standards (1a) and providing insured persons with access to the results (1c).
The government can play a facilitating role in creating a nationwide IT infrastructure (1b) for electronic patient dossiers, supplemented by quality indicators, patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs). This will result in more efficient registration, better data exchange and transparency.

Once healthcare insurers start purchasing on a national scale according to healthcare value and based on the insights gained and transparency created (2), this will be an incentive to improve healthcare even more (3). Healthcare providers will try to save more and make more improvements through further integration between self-care, primary care, secondary care and tertiary care, with home and self-care taking on an increasingly important role. Over time, integration will shift the focus for improvement from individual treatment to the internal care cycle, and finally to the integration of the entire chain (3a, 3b, 3c). Ultimately, complete funding of our healthcare will also become possible (4).

The end result of these developments will be *more involved* patients through better insight into value, and patients who are *better served* because value has improved. The patient will ultimately benefit the most.

HOW WILL THE NATIONAL GROWTH PATH PROGRESS IN THE NETHERLANDS OVER TIME?

Insights into value will promote ongoing improvements to healthcare. The expectation is therefore that the trend towards more insight into value will lead to a trend of far-reaching improvements through integration (Figure 6.2). One will stimulate the other. Large-scale purchasing by healthcare insurance companies will be a further incentive to improve healthcare, and in cases where this has not yet occurred, the medical condition will be thoroughly investigated.

In the Netherlands, the Ministry of Health recently announced its ambition to ensure that 50% of the range of treatments on offer will be completely transparent in five years time. Based purely on this objective, and alongside several other developments, our estimate is that in five years time there will be transparency in value of around 100% for the *most important* medical conditions in the Netherlands. Further improvement and far-reaching integration of healthcare will follow. Due to the complexity of the integration between multiple healthcare providers, our estimate is that full integration of healthcare for the *most important* medical conditions will only be reached in 10 years' time.

FIGURE 6.2

EXPECTED VBHC ADOPTION CURVE IN THE NETHERLANDS

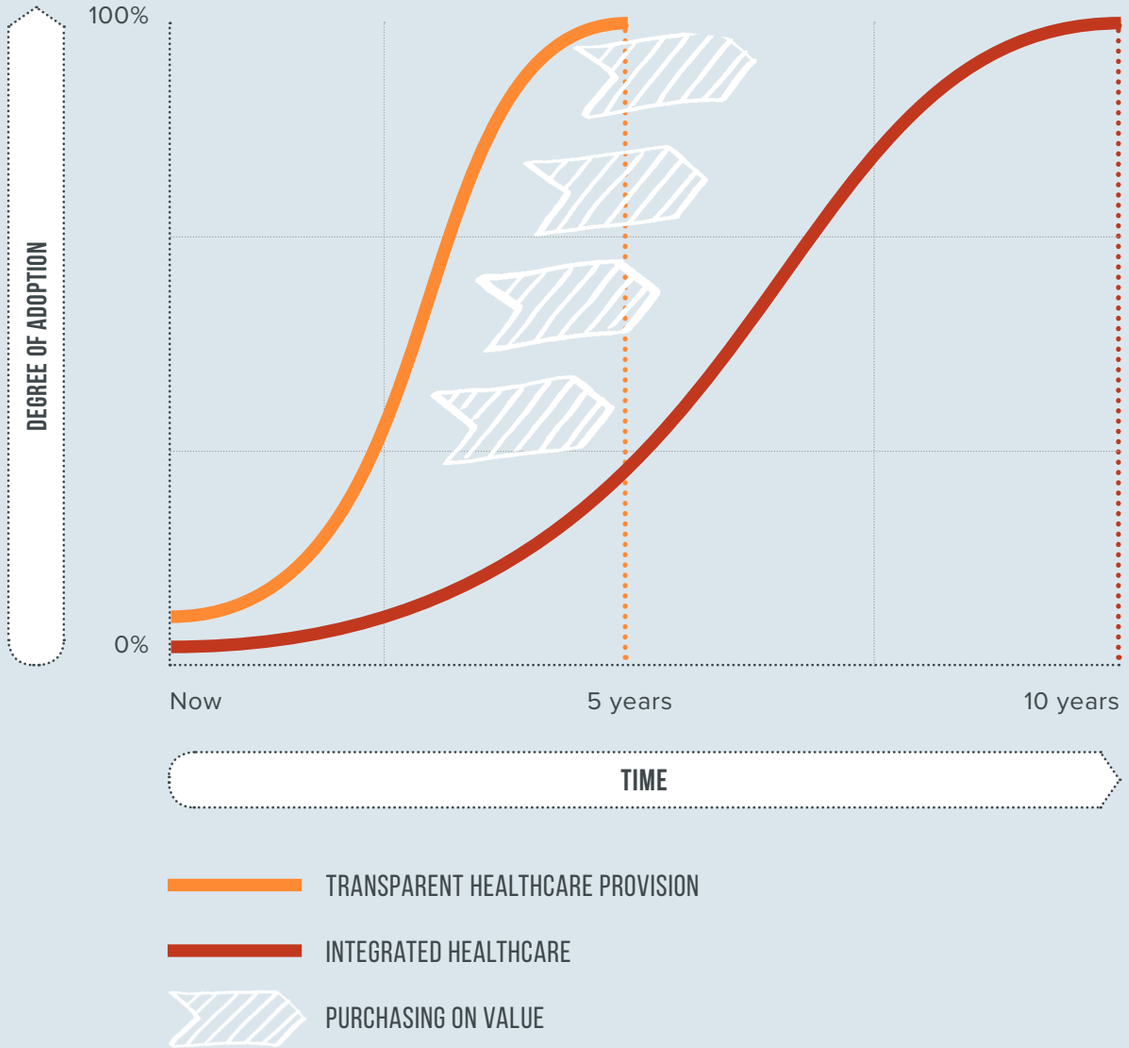
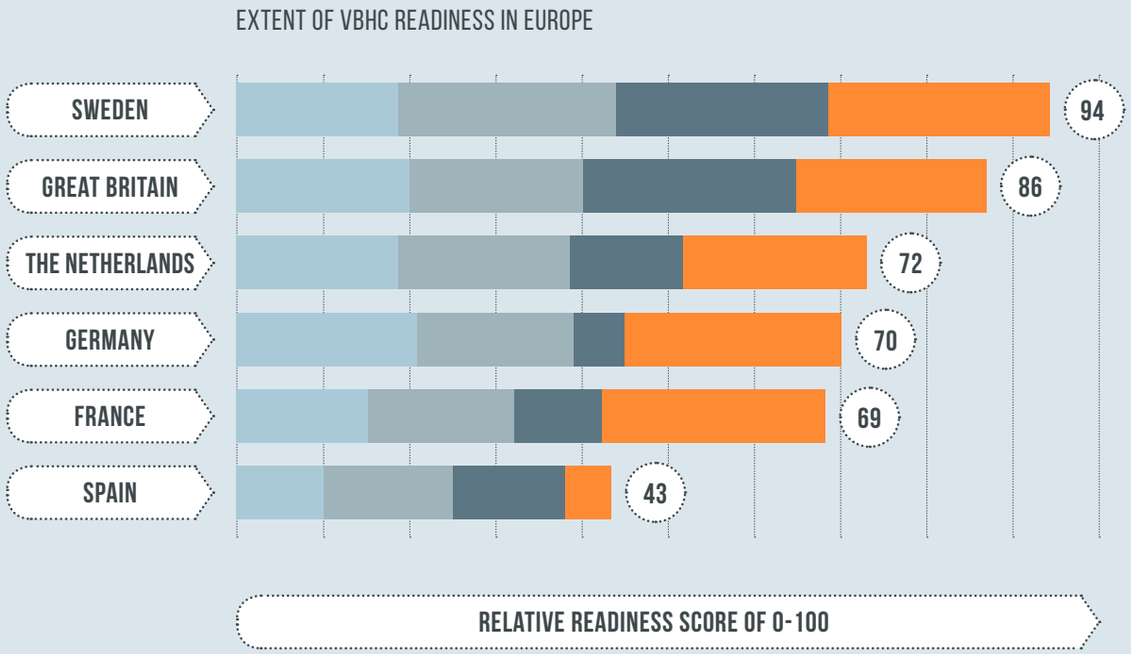


FIGURE 6.3

THE NETHERLANDS AT NUMBER 3 ON THE INTERNATIONAL VBHC LIST



VBHC readiness is scored on 4 groups of indicators that add up to a maximum of 100 points:

- Context, policy and institutions that enable value in healthcare
- Measurement of costs and outcomes
- Integrated and patient-focused healthcare
- Funding based on outcomes

Source: Economist, VBHC Global Assessment, 2016

10 YEARS SOUNDS FAR AWAY, YET IT IS AMBITIOUS

If these timelines are to be achieved, everyone involved must roll up their sleeves and get started. Healthcare insurers and the government must take on the role outlined previously to ensure the right enablers at the national level and accelerate the movement that has already been made. In addition, professional groups, patient associations, hospital administrations and the pharmaceutical industry will have to join forces to produce clear definitions and make arrangements that leverage what is already available (such as ICHOM). If the Netherlands wants to maintain or, better yet, improve its international position[5] as number 3 in the adoption of VBHC (Figure 6.3), all those involved must act decisively and with focus as they start the process, and combine forces.

5. Source: Economist, VBHC Global Assessment, 2016

Good teachers never say anything. What they do is create the conditions under which learning takes place – S.I. Hayakawa

Chapter 7
VBHC as a collaboration: make a start together

VBHC is primarily about collaborating. It is not something that can be dealt with and developed in isolation. It demands clear roles and expectations. Based on this, a shared ambition and plan of action can be defined. And, above all get started, because practice makes perfect!

MAKING THE CHANGE TOGETHER

Healthcare is changing, and the transition to VBHC has begun. As a result, the various parties involved will also have to change. The goal of the VBHC growth path is to make the ambitious VBHC concept *manageable* by turning it into a journey that can be planned. As noted in the preceding chapters, it is a process with many content-related challenges. But what VBHC demands first and foremost is change management. Those who are about to set things in motion will raise questions like: 'Where to begin? Who to involve? How to begin?'

START BY MAKING CHOICES

The first step is generally the most important one. We recommend starting by making clear choices. Decide what the initial *focus* will be: for which medical conditions do we want to apply VBHC? And which specific patient population are we selecting for this? Pay attention to things like high volumes and the number of comorbidities to keep a balance between an achievable impact and complexity. But also: Is an ICHOM set available? And where are the motivated frontrunners who want to get started on VBHC? Addressing these questions will lower hurdles and increase feasibility.

After that, ensure that there is a clear demarcation, i.e. *scope*: what part of the care cycle is involved? Are diagnoses and treatment included? What about screening and follow-up? And which other players must be involved? These players could include patients, patient associations, other healthcare providers, healthcare insurance companies, the pharmaceutical industry, and data and IT specialists. And appoint a healthcare cycle owner, i.e. an independent internal or external person who can manage the process, and can oversee the various individual interests.

Join forces and together decide what your *ultimate aim* is: What is our ultimate goal? What is the corresponding position on the VBHC growth path (Figure 3.2, Chapter 3)? And what is the goal for the coming two to three years? This may entail a relatively small step, but one which will allow you to add a great deal of value. Or it may be a big step, one which may accomplish major organisational change. The ambition determines which concrete steps have to be taken. In the process, take into consideration the hurdles and solutions outlined in Chapters 4 and 5.

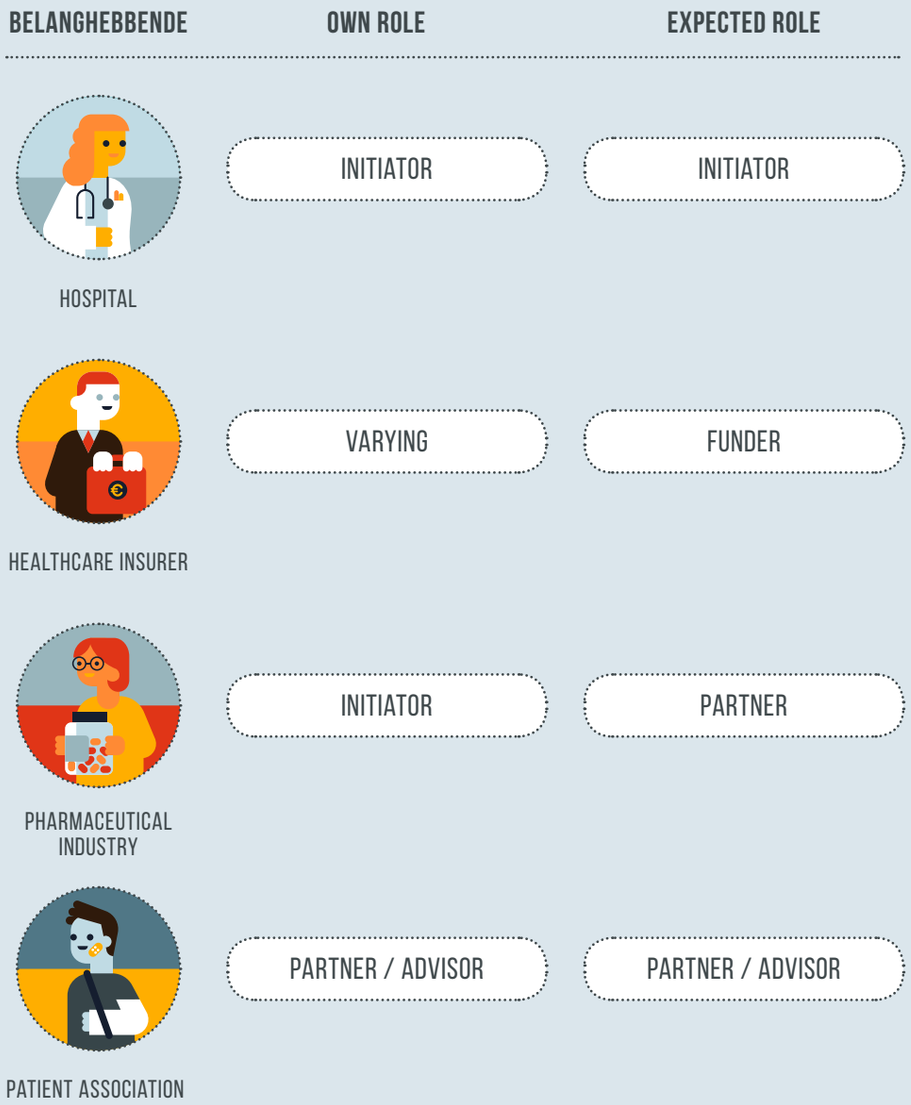
WORK TOGETHER WITH OTHERS

Healthcare is for everyone and everyone has his or her own role in it. The transformation to VBHC is significant and requires cooperation between the various stakeholders. What do we expect of ourselves? And what do we expect of others? Who can play a role? Take these aspects into consideration from the start. Bear in mind that you have to draw up a shared agenda, and be transparent about what those involved expect of one another.

During the interviews, we asked who should play which role to accomplish VBHC. We then asked the respondents, 'What role do you think your own organisation should play?' The responses to this question are given in Figure 7.1. If your own role is close to what others expect, then there will be little or no confusion. If not, then it is crucial to be transparent about what you expect from one another.

FIGURE 7.1

OWN ROLE IN RELATION TO ROLE AS EXPECTED BY OTHERS



For each stakeholder, within a specific VBHC initiative, we see roles for the following organisations:

- Hospital: the hospital sees itself as an initiator and everyone expects this from the hospital.
- Healthcare insurer/pharmaceutical industry: the role for the healthcare insurer and the industry is not as clear cut. They see various roles for themselves and their mutual expectations are also not always clear. This makes it all the more important for the parties involved to discuss these expectations.
- Patient association: patient associations are expected to play an active role in the collaboration. This has consequences for the degree of organisation and professionalism. Involving patient associations in VBHC initiatives is important and requires these associations to be available and to have the necessary expertise.

The government is not considered to be a stakeholder that is directly involved at an initiative level; instead it is a catalyst for VBHC at a system level. This means that it must create the right enablers to facilitate and promote VBHC (see Chapter 6).

> **"You need other parties to make a success of VBHC"**
>
> Silvia Bakkers, Director VBHC, Janssen Pharmaceutica

Our advice is: Define your role and seek contact with other stakeholders. In this, be clear about your own role and what you expect of the other party. Depending on the difference between your own role and the expected role, different actions may be required (see Figure 7.2)

THERE IS NOT ONE RIGHT WAY TO DO IT, MAP OUT A COMMON PATH AND SET THINGS IN MOTION!

The road to VBHC does not follow one ‘correct’ route. What is certain is that it is a fundamental change that you cannot implement in isolation. Work together based on clearly defined roles and expectations. Determine your shared ambition and chart your own path, one that will lead to the set objective. The VBHC growth path, and the solutions outlined in Chapters 4 and 5, will provide points of reference. And most important of all: get started! ‘Practice makes perfect’ certainly applies to VBHC.

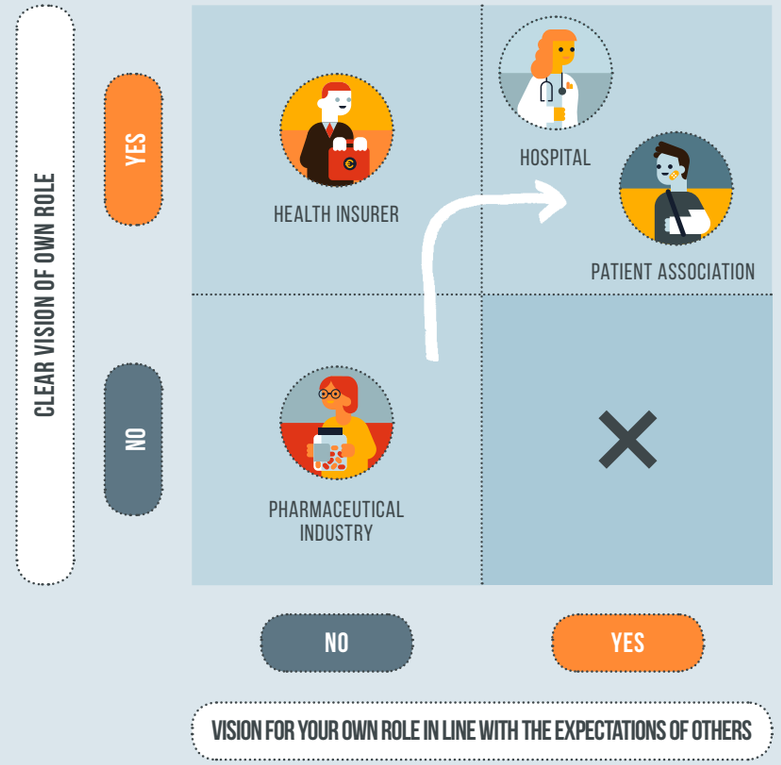
Coming together is a beginning; keeping together is progress; working together is success – Henri Ford

FIGURE 7.2

OTHER ACTIONS DEPENDING ON DIFFERENCE IN OWN VERSUS EXTERNAL EXPECTATIONS

Make the choice to go for either a ‘push’ or ‘pull’ strategy. Push strategy: create further support for the desired role by clearly communicating this role and demonstrating the behaviour associated with it.

Your vision for your own role is clear and agrees with what others expect from you. Establish this and get started!



Pull strategy: talk with external parties to further define your own role. Agree on the role you want to take, create further support for this role by clearly communicating about it and demonstrating the behaviour associated with it.

Chapter 8
VBHC: get to work!

There may be many reasons not to do anything; often there is only one reason to do something. For VBHC, the objections can generally be addressed and that one reason to aim for it is very important: more transparency and greater value for patients. In short, enough said, let's gets to work!

YOU DON'T HAVE TO WAIT ANY LONGER

Do you want to be part of the new healthcare system based on VBHC principles? And, if you do, as a leader or a follower? Timing is crucial. The expectation is that the successful healthcare providers of the future will be those organisations that were the first to proactively start changing and focusing on continuous improvement. When they prove that they provide more patient value (quality versus costs), they will ultimately attract more patients, and with this they will acquire a more sustainable position.

It is clear that VBHC demands a long-term vision, commitment and process. There are many reasons for not starting, but there is one very *important* reason to do so: to improve patient value and transparency within our healthcare system. Many of the objections and hurdles mentioned can be overcome.

In short, we invite you to begin your challenging VBHC journey.
It is a journey that is more than worth it!

Whatever you can do, or dream you can do, begin it. Boldness has genius, power, and magic in it. Begin it now

– Johann Wolfgang von Goethe

2nd revised edition

Author **Gérard Klop**
In collaboration with Edward Beerthuizen and Pim Kooreman

Concept and design **Ready for take-off**
Translation **The Language Lab**
Illustrations **Wijtze Valkema**