



Waarop gemeenten en zorgverzekeraar elkaar moeten vinden

Voordracht van prof. Guus Schrijvers bij de aftrapbijeenkomst over convenanten tussen Gemeente Den Haag en Zorgverzekeraars op donderdag 30 april 2015

Vier verschillende aanpakken



Guus Schrijvers

- VGZ: lokale netwerken
- Menzis: SamenGezond
- Achmea: uitkomstfinanciering en scherp inkopen
- CZ: proeftuinen



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- Zorg dichtbij geregeld
- Wij geloven dat je mensen het best kunt helpen met hun gezondheid via een wijkgerichte aanpak van zorg en welzijn. We noemen dat wijknetwerken. Hulpverleners in de wijk creëren één centraal aanspreekpunt, het wijkteam, dat mensen op de juiste manier helpt.



Met de wijkteams verbinden we welzijn en zorg met elkaar. We ondersteunen de wijkteams in hun werk en zetten projecten op, samen met gemeenten en andere maatschappelijke partners. Dankzij deze aanpak groeien sociale problemen in een wijk niet uit tot gezondheidsklachten, en andersom. De wijkteams houden ook rekening met wat mensen en hun naasten (familie, vrienden of de buurt) zelf nog kunnen. Zo ontstaat er een betere integratie van zorg en welzijn in de wijk.

Vraagstukken voor gemeente Den Haag en zorgverzekeraars over wijknetwerken



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1. Inzetten op zelfredzaamheid
2. Nieuwe toegang tot zorg en welzijn
3. Integratie zorg en welzijn
4. Aparte jeugdteams of 0 -100+ teams?
5. Positionering S1 (40 mln euro) en S2 verpleegkundigen (3.1 mld euro): bij huisarts? Bij grootste zorgaanbieder?; In wijkteam? Budget per wijk? Onafhankelijke coöperatie?)
6. ICT?
7. Afstemming inkoop rond knelpunten: transferbureaus; spoedzorg? Respijtzorg?
8. Data verzameling per wijk tbv gezondheidsbeleid
9. Gezamenlijke monitoring

Het wijkgerichte werken: vooralsnog een academisch vraagstuk



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Vijf maal wijkgericht:

1. Sociale wijkteams voor Wmo en Participatiewet
2. De eerste lijn
3. De basis GGz
4. De jeugd(gezondheids)zorg en Centra voor Jeugd en Gezin
5. De VVT sector

Zie hoofdstukken 5, 6, 7, 8 en 11

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- Punten sparen met gezond gedrag en aankopen bijvoorbeeld door niet te roken, vragenlijsten in te vullen over leefstijl of als u aangeeft dat u in het donorregister staat geregistreerd. En door gezonde apps te gebruiken zoals RunKeeper, de fiets-app Strava of de wandel-app van Natuurmonumenten.
- Beloning trouwe klanten

Punten sparen:



- U uploadt een foto van uw gezonde lunch.
- U uploadt een foto van het zwemdiploma van uw kind.
- U uploadt een foto van de gezonde traktatie van uw kind.
- U volgt een gezonde online cursus, zoals kinder-EHBO of mentale fitheid.
- Zorgen voor een ander:
 - U geeft aan dat u mantelzorger bent.
 - U geeft aan dat u vrijwilliger bent.
 - U geeft aan dat u geregistreerd staat in het donorregister.
 - U heeft een account op [WeHelpen](#). Een online marktplaats voor het vragen, vinden en organiseren van hulp.

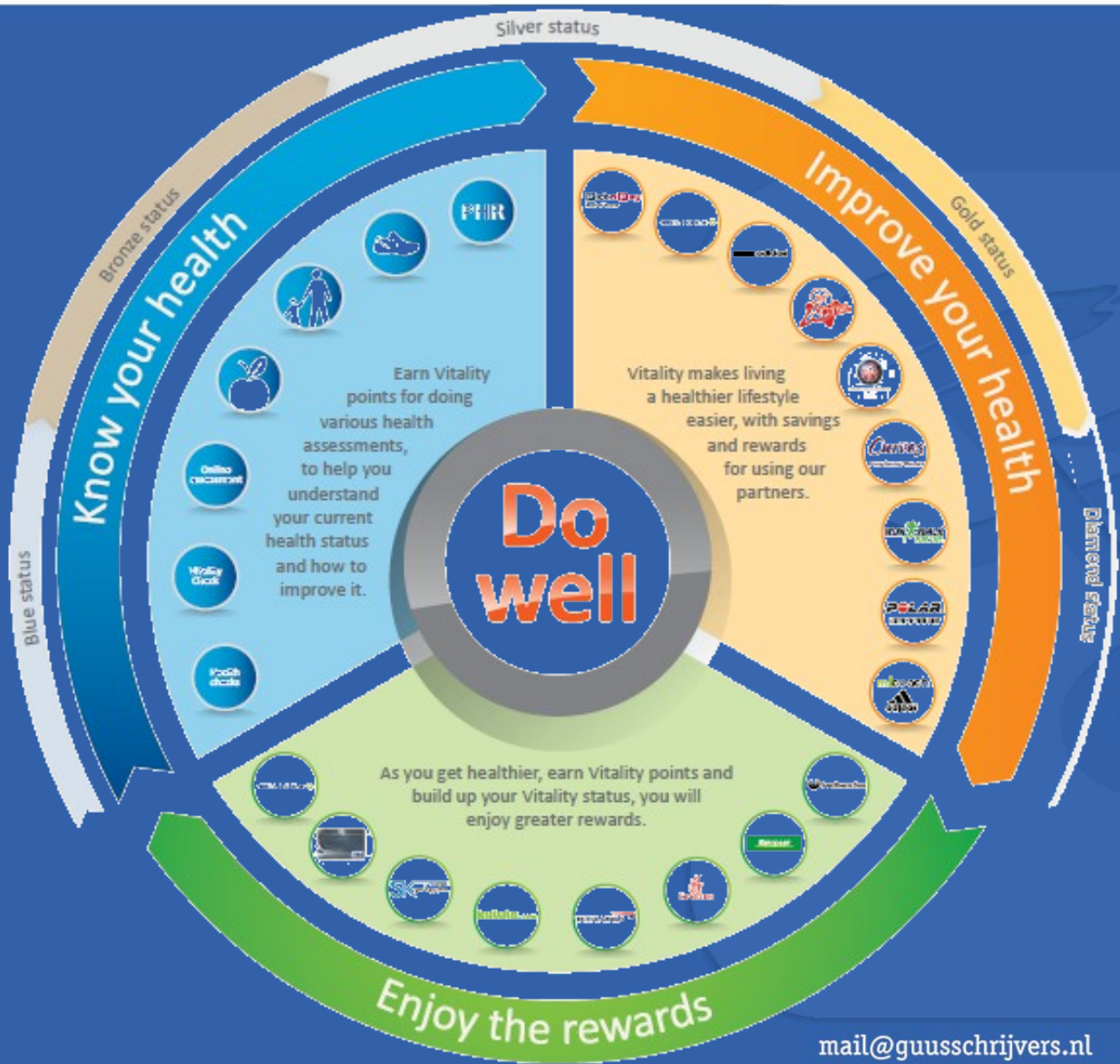
1000 punten is 10 euro



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- Er op uit
- Culinair
- Hobby en sport
- Gezonde lunch
- In het algemeen: leuke dingen





Publication of Vitality studies

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Cross-sectional

Longitudinal

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Financial Analysis

The Association Between Medical Costs and Participation in the Vitality Health Promotion Program Among 948,974 Members of a South African Health Insurance Company

Deepak N. Patel, MSc¹; Estelle V. Lambert, PhD, Rosanne da Silva, BS, Hons, MSc²; Mike Greyling, MSc; Craig Nossel, MBBCh, Adam Nsouh, BSc; Wayne Derman, PhD; Thomas Gaziano, PhD

Abstract

Purpose: Examine the association between the level of participation in an incentivized health promotion program (Vitality) and reported medical claims among members of a major health insurer.

Design: A 1-year cross-sectional, correlational study of engagement with a health promotion program and hospital claim expenditure (admission rates, days in hospital, and admission cost) of members of a national private health insurer.

Setting: Adult members of South Africa's largest national private health insurer, Discovery Health. Insured members were eligible for voluntary membership in an incentivized individual health promotion program, Vitality Health. The study sample included 948,974 adults in the Discovery Health plan for the year 2008. Of these, 391,231 (41.1%) were also members of the Vitality health promotion program.

Measures: The study design was cross-sectional based on enrollment and claims data for the Vitality health promotion program and on the Vitality self-reported health assessment data for the year 2008. Members were divided into 4 groups based on their level of participation in the Vitality program, self-reported health status (Healthy, At-Risk, and Unwell), and high engagement (75.5%). High engagement was defined as a person in the accumulation of an arbitrary number of points in the Vitality program, allowing greater levels of activity (Healthy, At-Risk, and Unwell) related to activities, assessment and coverage, and health status. Hospital admission costs, the number of days in hospital, and hospital admission rates were compared among high-report members and those members who were not enrolled in the program, unenrolled, and study groups. Data were normalized for age, gender, prior type, and chronic disease status.

Results: High-report members had lower rates for patients, shorter stays in hospital, and fewer admissions compared with other groups ($P < .001$). Low or no engagement was not associated with lower hospital rates. Admission rates were 2.7% lower for cardiovascular disease, 7.2% lower for cancer, and 20.7% lower for diabetes and metabolic disease in the high-report group compared with each of the other groups ($P < .01$).

Conclusions: Engagement in an incentivized health promotion program, offered to health insurer, was associated with lower health care costs. Cost Health Promotion (CHP) program, which offers a health insurer, was associated with lower health care costs. Cost Health Promotion (CHP) program, which offers a health insurer, was associated with lower health care costs.

Key Words: Health insurance, Wellness Programs, Health Risk Assessment, Chronic Disease, Prevention Research. **Manuscript received:** October 13, 2009. **Manuscript accepted:** November 16, 2009. **Address correspondence to:** Dr. Estelle V. Lambert, PhD, Discovery Health, 100 Oldenburg Drive, Sandton, South Africa. Telephone: +27 (0)21 731 1234. E-mail: estelle.lambert@discoveryhealth.co.za. **Reprints:** Contact the American Medical Association, 535 North Dearborn Street, Chicago, IL 60610. **Permissions:** Contact the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923. **DOI:** 10.1001/jama.2010.2494

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INTRODUCTION

Health care costs are increasing globally.¹ Among the major reasons for burgeoning costs are advances in health technology, newer and more expensive drugs, increasing costs of hospitalization, and the increasing burden of chronic diseases requiring more intensive treatments.^{2,3} The increase in chronic diseases can be partially attributed to an aging population, particularly in developed countries, but combined lifestyle risk factors such as smoking, tobacco use, obesity, and physical inactivity share considerable responsibility for the increase.⁴

Recently some insurers have begun to offer incentive-based health promotion programs in an attempt to change health behavior and improve the health of their members.⁵ It is reasoned that improving the health of members is a more sustainable way of reducing long-term health care costs.⁶ Numerous public health approaches or strategies have been suggested to improve health behavior in the general population and among select population groups.⁷ The approaches that private organizations such as health plans offer may complement government actions, but there are limits to the scope of interventions that private organizations can adopt.

Moreover, in most countries, legislation prevents programs from requiring members to participate.⁸ Interventions offered by health plans to

PREVENTING CHRONIC DISEASE PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY

VOLUME 6 • NO. 4 OCTOBER 2009

ORIGINAL RESEARCH

Fitness-Related Activities and Medical Claims Related to Hospital Admissions—South Africa, 2006

Estelle V. Lambert, PhD; Rosanne da Silva, Deepak Patel, MD, MSc; Libero Fatfi, PhD; Tracy Kolbe-Alexander, PhD; Adam Nsouh; Craig Nossel, MBBCh, MBA; Wayne Derman, MBBCh, PhD; Thomas Gaziano, MD, MSc

Suggested citation for this article: Lambert EV, da Silva R, Patel D, Fatfi L, Kolbe-Alexander T, Nsouh A, et al. Fitness-related activities and medical claims related to hospital admissions—South Africa, 2006. *Prev Chronic Dis*. 2009;6(4). http://www.cdc.gov/pmc/issues/2009/oct/06_0226.htm. Accessed [date].

PEER REVIEWED

Abstract

Introduction: We report on the effect of an incentive-based wellness program on medical claims and hospital admissions among members of a major health insurer. The focus of this investigation was specifically on fitness-related activities in this insured population.

Methods: Adult members of South Africa's largest private health insurer ($n = 948,974$) were grouped, a priori, on the basis of documented participation in fitness-related activities, including gym visits into inactive (80%, equivalent to ≥ 3 gm visits/week), low active (1.0%, 4–23 gm visits/week), moderate active (5.2%, 24–48 gm visits/week), and high active (7.8%, > 48 gm visits/week). We compared medical claims data related to hospital admissions between groups after adjustment for age, sex, medical plan, and chronic illness benefits.

Results: Hospitalization costs per member were lower in each activity group compared with the inactive group. This same pattern was demonstrated for admissions rates.

There was good agreement between level of participation in fitness-related activities and in other wellness program offerings; 50% of people only nominally engaged in the wellness program also were low active or inactive, whereas 84% of those in the high active group also had the highest overall participation in the wellness program.

Conclusion

Participation in fitness-related activities within an incentive-based health insurance wellness program was associated with lower health care costs. However, involvement in fitness-related activities was generally low, and further research is required to identify and address barriers to participation in such programs.

Introduction

Physical activity can reduce illnesses and deaths linked to chronic diseases (1). The health benefits of physical activity increase with increasing frequency, duration, and intensity of exercise (2–4). Data from longitudinal cohort studies suggest that physical inactivity is associated with at least a 1.5-fold to 2.0-fold higher risk of most chronic diseases of lifestyle, such as coronary heart disease, type 2 diabetes, and hypertension (1,5), and accounts for an estimated 13% of lost disability-adjusted life-years worldwide. Furthermore, studies corroborate the public health recommendation that 30 minutes of accumulated, moderate-to-vigorous intensity physical activity on most days is protective for these chronic diseases (6). The associated risk of inactivity is similar in magnitude to many other well-known risk factors, such as overweight, smoking, hyperlipidemia, and low fruit and vegetable intake (1,6).

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Financial Analysis

Participation in Fitness-Related Activities of an Incentive-Based Health Promotion Program and Hospital Costs: A Retrospective Longitudinal Study

Deepak Patel, MD, MSc; Estelle V. Lambert, PhD; Rosanne da Silva, BS, Hons, FFA; Mike Greyling, MSc; Tracy Kolbe-Alexander, BSc; PhD; Adam Nsouh, BSc; Jaco Conradie, BSc; Craig Nossel, MBBCh, MBA; Jill Borresen, BSc; PhD; Thomas Gaziano, MD

Abstract

Purpose: A retrospective, longitudinal study examined changes in participation in fitness-related activities and hospital claims over 3 years among members of an incentivized health promotion program offered by a private health insurer.

Design: A 3-year retrospective observational analysis measuring gym visits and participation in documented fitness-related activities, probability of hospital admission, and associated costs of admission.

Setting: A South African private health insurer, Discovery Health, and the Vitality health promotion program. Participants, 394,674 adult members of the Discovery medical plan, 192,667 who were enrolled for the health promotion program and 191,997 members who were not on the program.

Measures: Members were measured for fitness-related activities on the basis of the frequency of gym visits. Measures included an objectively determined gym visit and registered participation in fitness-related activities over 3 years and measures of admission status, change in participation (years 1–3) and subsequent possibility and cost of hospital admissions (years 4–3). Hospital admissions and associated costs were based on claims related from the health insurer database.

Results: The probability of a claim related to gym visits was lower for high-report members and for those who were not on the program (1.3% and 1.0%, respectively) compared with those who were not on the program (1.6%).

Conclusions: Participation in fitness-related activities within an incentivized health insurance wellness program was associated with lower health care costs. However, involvement in fitness-related activities was generally low, and further research is required to identify and address barriers to participation in such programs.

Introduction: We report on the effect of an incentive-based wellness program on medical claims and hospital admissions among members of a major health insurer. The focus of this investigation was specifically on fitness-related activities in this insured population.

Methods: Adult members of South Africa's largest private health insurer ($n = 948,974$) were grouped, a priori, on the basis of documented participation in fitness-related activities, including gym visits into inactive (80%, equivalent to ≥ 3 gm visits/week), low active (1.0%, 4–23 gm visits/week), moderate active (5.2%, 24–48 gm visits/week), and high active (7.8%, > 48 gm visits/week). We compared medical claims data related to hospital admissions between groups after adjustment for age, sex, medical plan, and chronic illness benefits.

Results: Hospitalization costs per member were lower in each activity group compared with the inactive group. This same pattern was demonstrated for admissions rates.

INTRODUCTION

Physical inactivity and sedentary living are major lifestyle factors that contribute to the growing burden of disease globally.¹ The effects of the increasing prevalence of inactivity are most evident in the increase in non-communicable chronic diseases of lifestyle, such as hypertension, type 2 diabetes, cancer, and coronary heart disease.² There is compelling evidence for the beneficial effects of physical activity in the primary and secondary prevention of a large number of chronic diseases. Diseases such as type 2 diabetes,³ hypertension,⁴ cardiovascular disease,⁵ certain cancers,⁶ mental illness,⁷ and osteoporosis⁸ are directly impacted by increasing physical activity. All-cause mortality, as well as deaths as a result of cardiovascular diseases and cancers, are significantly decreased with increased levels of physical activity.^{9–11}

Physical activity has also been shown to mitigate the effects of other risk factors. For example, overweight individuals who are fit have greater longevity than those normal-weight individuals who are unfit.¹² Likewise, it has been shown that physically active smokers have a lower risk of dying than non-smoker smokers.¹³ The enormous burden of diseases related to physical inactivity or sedentary living has significant direct and indirect economic consequences for the individual and for society.^{14–16}

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Achmea's inkoop beleid



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- Uitkomstfinanciering (werkt niet)
- Jaarlijkse contractering
- Doelgroepsgewijs inkopen
- Meerjarige afspraken in opkomst



Triple Aim:



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1. Betere gezondheid
2. Hogere kwaliteit van zorg
3. Gelijk blijvende kosten

Aanbevolen literatuur:

Berwick D.M. et al., The Triple Aim: Care, Health, And Cost, Health Aff (Millwood), 2008; 27(3): 759-69.

Bisognano M. et al., Pursuing the Triple Aim. Seven Innovators Show the Way to Better Care, Better Health and Lower Costs, San Francisco: Jossey-Bass, 2012.

Hildebrandt H.T. et al., Triple Aim in Kinzigtal, Germany: Improving population health, integrating health care and reducing costs of care – lessons for the UK 2012, Journal of Integrated Care 20 (4): 205-222.

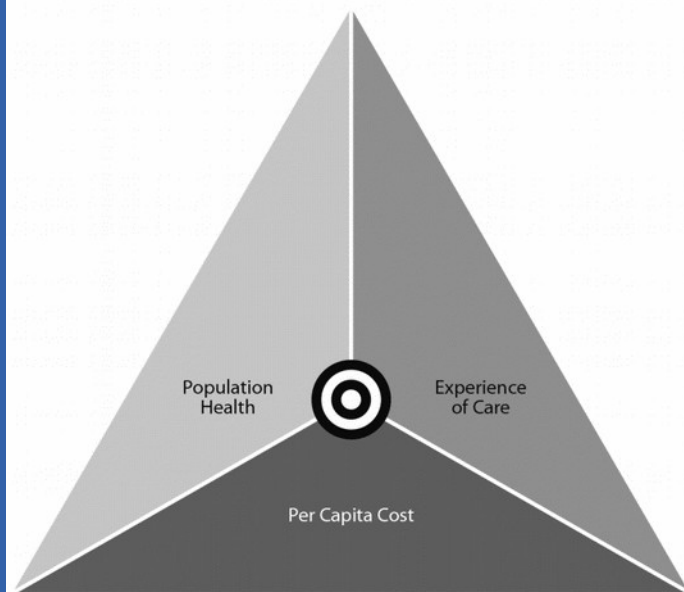


Begrippen bij het Cappuccinomodiel: Triple Aim (2)

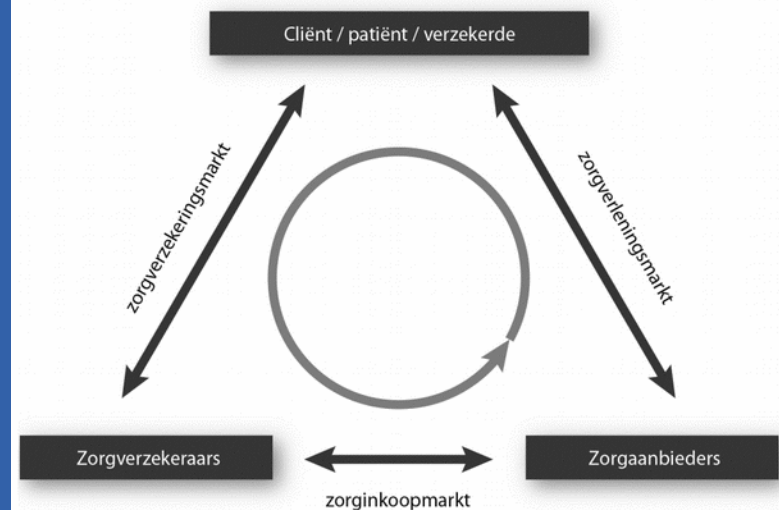


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Afbeelding 1.2 Het Triple Aim model



Afbeelding 1.3 Het model van de marktwerking



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ambitieuze organisaties die samen werken aan zorg & welzijn in 2022



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Medische Staf Huisartsen



Medische Staf ZorgSaam



Regionaal geestelijk gezondheidscentrum Zeeuws-Vlaanderen



zorgt in zeeland SVZ

Goedleven



grote uitdagingen voor proeftuinen

- uitstijgen boven organisatiegrenzen
- het belang van burger/patiënt
- praten met mensen in plaats van over mensen
- investeren in relaties



IN 2022

Gezondheidswinst

levensverwachting gemiddeld hoger
in goed ervaren gezondheid

Zelfredzaamheid

zelfredzaamheid
van volwassenen en ouderen beter

Kostenbeheersing

totale kosten
stijgen jaarlijks gemiddeld minder snel

Toegankelijkheid

goede basiszorg dichtbij
hoogwaardige specialistische zorg bereikbaar

The question is



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werken aan de toekomst versus prioriteiten van vandaag

**er is beslist een *coalition of the willing* maar
participanten worden in hun denken en doen
tegengehouden door overvolle agenda's en
prioriteiten van vandaag**

overleven versus nu investeren in middellange termijn resultaten

Meer informatie



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En als het niet lukt om te komen tot samenhangende covenanten: Eisen te stellen aan zorgverzekeraars



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1. Uniformering van gegevens uitvraag
2. Geen eigen kwaliteitscriteria hanteren
3. Vrijheid bij professionals om patiënt te adviseren over te kiezen zorgverzekeraar
4. Niet terug naar het ziekenfonds: geen budgetpolissen
5. Kaders stellen en geen gedetailleerde regelgeving
6. Marginale toetsing van kwaliteit en niet rechtstreeks mee bemoeien
7. Zorgkosten informatie per wijk en per individu
8. Verplichtende nascholing van professionals over substitutie vraagstukken en mantelzorgbevordering
9. Cocreatie: geen beleid zonder gezamenlijke voorbereiding



Waarom?

- Betere oplossingen
- Grotere kans op draagvlak
- Meer aandacht voor het probleem dan voor de oplossing

Wat houdt het in?

1. Collectieve ambitie
2. Open communicatie tussen alle partijen
3. Heldere verdeling van verantwoordelijkheden en taken
4. Helder design management
5. Eerst discussienota en daarna concept-beleidsnota
6. Zorgverzekeraars werken met kaders
7. Gezondheidswet 1902





Ik dank jullie voor de
aandacht



Contact?



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