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SOPHISTICATED FUNDING MODEL KILLS THREE BIRDS WITH ONE STONE

Clever incentives make healthcare more efficient

The cappuccino model - layered funding consisting of population funding, a treatment tariff and an innovation tariff - delivers more health and better care at the same price.

Behavioural economics has generated a raft of ideas about the way in which consumers can be influenced into choosing certain products or services (see 'Behavioural economics' below). Many of those ideas can also be used to encourage consumers to take responsible decisions about their health. Financial 'nudges' can be given to encourage people to adopt healthy behaviour. I can give four examples.
The South African healthcare insurer Discovery is working with a points system. When insured people buy healthy food and sports equipment, they earn points. They can exchange their points for a lower healthcare insurance premium or use them to buy healthy products from the Discovery webshop. During an evaluation it was found that many of the healthcare insurer's customers are taking part in the points programme, that it is encouraging the participants to lead a healthier lifestyle and resulting in lower costs for the insurer. Menzis, a Dutch healthcare insurer, has introduced a similar programme. The second example is a financial reward at the end of a stop-smoking course. In the United States, this reward system is encouraging even habitual, confirmed smokers to give up smoking.
Example three: In Germany, patients with a chronic disorder such as diabetes or COPD who attend annual sessions about living with their disorder, do not need to pay any 'own risk' contribution for primary care. When this is embedded in a disease management programme, it leads to quality improvement and to cost reduction. The fourth example of a financial nudge is a tax-related healthcare policy designed to break through lifestyle solidarity. In this case, the VAT or the excise duty on tobacco, alcohol, lemonade and fat would be increased. A 10 percent price increase reduces consumption by 5 percent. Fiscal policies of this type are already in force in various European countries and American states. The Dutch Scientific Council on Government Policy [*Wetenschappelijke Raad voor het Regeringsbeleid*, WRR] recently advocated even more nudging in relation to the purchase of salty, fatty and high-calorie foods.

The cappuccino model

The cappuccino model is a funding model that includes nudges to encourage professional behaviour towards three goals: 1. improving the health of the population served; 2. raising the quality of care provided by professionals and their healthcare organisations and 3. stabilising the per capita cost of care for members of the population served. These three simultaneous goals are referred to in American literature as the 'Triple Aim goals'. Just like a real cappuccino, the cappuccino funding model consists of three layers. The first consists of population-focused funding on the basis of characteristics of the patient population to be served. This layer helps achieve the three goals, because there is no longer an incentive to increase 'production' once payment per treatment has been abandoned. Within population-focused funding, the payment for not treating, just listening and looking, is on a par with the payment for treatment.
If healthcare professionals' incomes are completely dependent on population-focused funding, they are working on a budget funding system. They receive a set amount per capita per annum, irrespective of the 'amount' of care used. One disadvantage of budget funding is that waiting lists can occur if the budgets are too tight. Because of past experiences with budget funding, the cappuccino model therefore incorporates a second nudge alongside the population-focused funding: a low treatment tariff. This encourages the professional to be productive, to treat when necessary. The third nudge in the cappuccino model is the innovation tariff. This portion covers transformation costs such as expenses in the preparation phases for innovation, start-up losses, the cost of training for professionals, the cost of investing in new software and equipment, the cost of evaluating the innovation and disseminating it both in and outside the organisation. The innovation tariff has two advantages. Firstly this nudge inspires healthcare innovation. Secondly, in his renowned best-seller *The Innovator's Prescription*, Christensen shows that dissemination of an innovation is only really successful if it is backed up by an innovative revenue model - in other words, a business case. In his view, and mine, healthcare innovation goes hand in hand with financial innovation. Within the cappuccino model, the population-focused funding forms the greatest source of income (85% for example), followed by the treatment tariff (10% for example) and the innovation tariff (5% for example).

For GPs, the cappuccino model brings only minor changes. The registration tariff and the bundled payments for condition-linked treatment are already based on the volume and characteristics of the practice's patient population. There is already a

BEHAVIOURAL ECONOMICS

Fast and slow thinking

Behavioural economics evolved in the nineteen nineties. This domain integrates the theories of market mechanisms with those of psychology. In 2012, Kahneman provided a good foundation for behavioural economics in his book entitled Thinking, Fast and Slow. This Nobel prize-winner distinguishes two systems used by the brain to form our thoughts.

System 1 thinks quickly, in stereotypes and emotions; it works subconsciously and autonomously. System 2 is slow, calculating logically and is consciously. An example: people use system 1 to learn to speak their mother tongue, but to learn a foreign language they use system 2. The homo economicus in marketing theory thinks by way of system 2. In daily life, people think using both systems. Based on his experiments, Kahneman has observed that system 1 falls short when it comes to appraising risks: people have an overly optimistic image of their future. They expect that they will undoubtedly remain healthy, even if they continue to smoke, drink too much and consume too much fat.

Framing

Kahneman uses the concept of framing to show that people allow themselves to be misled when it comes to making rational choices. Framing illustrates that context and vocabulary influence a person's actions and reactions. Marketing is based on framing: via system 1, fast thinking, the marketer tries to create a short-term association that will tempt someone to choose a particular product or service. Framing also comes into play when healthcare professionals offer patients information about treatment options. Midwifes, for instance, usually use more positive words to emphasize the advantages of a home birth than gynaecologists do.

Nudge

Finally, behavioural economics has adopted the English concept of nudge, a gentle push or prod. Thaler and Sunstein published a standard work on the subject in 2008. They observed that small changes, or nudges, in the offer of goods and services could significantly alter consumer behaviour. Moving healthy food to the front of the shelves in a cafeteria has a positive effect on sales of such food, for example. It is small, seemingly trivial details like this that focus the consumer's attention in a particular direction. This gentle pushing and shoving of the consumer into rational, long-term thinking via Kahneman's system 2 is known as libertarian paternalism.

The consumer's freedom of choice is not curtailed in any way by libertarian paternalism. The paternalistic aspect comes to the fore because the providers/sellers persuade the consumer to consider his long-term interests (system 2), while he would normally be more strongly influenced by system 1.

modest treatment tariff of EUR 9.01 per consultation (2014). Some healthcare insurers already offer separate funding for innovation, to encourage walk-in surgeries at GP practices, for example, or to facilitate the purchase of specific software. The greatest change is that the population-focused funding will become a larger proportion of the practice's revenue: around 85 percent. At present is stands at approx. 50 percent. The shift will have to be effected gradually. For medical specialists and hospitals, however, the cappuccino model will bring greater changes. The first step will be to disentangle hospitals into units that serve specific populations or target groups and are responsible for their own results.

An average hospital has six target groups:

1. expectant mothers, young parents and children
2. people with acute health problems
3. people with or suspected of having cancer
4. people with a need for care-on-demand or elective care
5. people with one or more chronic illnesses and, finally,
6. people with psychological/psychiatric problems.

Each target group has its own network of healthcare pathways which sometimes overlap with those of other target groups. Partnerships or departments usually work for various target groups: a surgical partnership, for example, might work for target groups 2, 3 and 4. The units in this model are not only responsible for their own spending, but also for their incoming revenue. As the anticipated major innovations are primarily of a logistic nature, this division into target groups and healthcare pathways produces more experience in logistics management and more opportunities for sharing care with other care providers. Each unit has its own cappuccino model, with its own indicators for the target group; the model must offset all the unit's spending. The units receive a tariff for each condition-linked treatment or directly observed therapy that is much lower than the present tariff. Innovations are supported by means of an innovation tariff. In this model, the governing bodies ultimately enter into long-term contracts about population-focused funding. This offers certainty to patients, employees and banks alike. The volume of treatments and the innovation tariff will be negotiated annually within the framework of the institution's long-term vision.

Are behavioural economics, *Triple Aim*, disentangling and the cappuccino model going to encourage better healthcare and better health at no extra charge to each inhabitant of the Netherlands? For each segment of the population there are plenty of innovative ideas available that can save money, improve health AND raise the quality of healthcare. Some of these come under the heading of introducing financial nudges to encourage people to behave in a more health-conscious way. These have been touched on above. Others can be found in the domain of digital innovation, redistributing tasks, combatting over-diagnosis and eliminating double work. This type of innovative change can be stimulated by cappuccino funding. If these nudges and innovations can be realised, healthcare in the Netherlands can be managed at the same level of costs for quite a few years into the future. If they cannot be realised, the shortfalls of today will only increase year on year, and healthcare costs will continue to rise. ■

This article is based on the book entitled "Zorginnovatie volgens het cappuccinomodel" (Healthcare innovation based on the cappuccino model), published (in Dutch) by Thoeris Publishers, Amsterdam, on 31 October 2014.

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