Report of the seminar

"Financing integrated care and population health management"

Organised as a pre-conference event of ICIC18 – the 18th International Conference on Integrated Care

22 May 2018, The Hague, the Netherlands

1. Introduction

The event was organised jointly by the European Commission's Directorate-General for Health and Food Safety (DG SANTE); the International Foundation of Integrated Care (IFIC); the Dutch National Institute for Public Health and the Environment (RIVM); and Leiden University Medical Center Campus The Hague. It took place as a follow-up to the seminar "*Strategic investments for the future of healthcare*", which the European Commission DG SANTE held in February 2017 (https://ec.europa.eu/health/investment_plan/events/ev_20170227_en).

Approximately 140 stakeholders attended. These included representatives of national and regional health authorities, healthcare managers, service providers, international experts in integrated care, as well as public and private investors.

The objectives of the event were to:

- Create awareness of financing possibilities for deployment of integrated care and population health management solutions, including the opportunities offered by EU financial instruments.
- Discuss about the range of investments needed for integrated care (for aspects such as infrastructure/facilities, technologies and services).

- Discuss the challenges in investing in these elements and the options which can be considered by the stakeholder community.
- Inform about the support mechanisms available from the European Commission for the financing and implementation of health reforms.

2. Main remarks from the presentations

Mr Ernst van Koesveld, *Deputy Director-General for Long-Term Care and Director of the Health Insurance Department, from the Ministry of Health, Welfare and Sports of the Netherlands,* opened the meeting with an overall presentation of the challenges which the Dutch health system faces. He indicated that integrated care and population health management are goals of the Dutch policy in health. Provision of care in individual health domains is good in the Netherlands, but integration of care lags behind. There is understanding that in order to treat health problems in an appropriate manner a more holistic approach is needed.

Discussions over quite a long time in the Netherlands resulted in consensus on the challenges that need to be tackled. It is known "what" needs to change, but not much is known on "how" to change. Commitment to act was made as well, although the Netherlands needs to reinforce the commitment to change. When it comes to investments, the question is how the financial institutions may contribute to the change.

Mr Martin Seychell, *Deputy Director-General for Health, DG Health and Food Safety, European Commission*, emphasised two main pre-conditions for the transformations in health systems to scale-up and ultimately deliver the expected benefits: (i) sufficient mobilisation of investments and (ii) having the necessary know-how and capacity to design and implement new care models.

Moving away from the traditional hospital-centred model, to more person-centred approaches requires investments into new types of physical infrastructure as well as "soft" investments into less tangible elements. The latter may be for instance: investments in prevention programmes, in patient empowerment programmes, in integrated care services, in training the healthcare workforce, in new patient pathways and in digital tools such as mHealth apps. Many investors see the above as high-risk investments, while many health authorities do not possess sufficient knowledge of financing instruments and capacity to develop investment strategies.

Mr Seychell referred to the support which the European Commission can provide for health system reforms, both in terms of capacity building and financing. This includes the provision of resources such as good practices and tools to support implementation, "twinning" projects for the transfer of knowledge and good practice, the dedicated Structural Reform Support Service that offers technical assistance for implementation of reforms, and new instruments such as the European Fund for Strategic Investments which aims to incentivise public and private investors to co-invest in high-risk investments.

Professor Gregg Meyer, *Chief Clinical Officer, Partners Healthcare System in Boston, Massachusetts, USA,* presented experiences from integrated care programmes in Boston and the investments required for their implementation. In Massachusetts, policy makers decided to look

for programmes which achieve the "triple aim" (improve population health, result in better patients' experience and bring savings) and also improve the care providers' experience. The Integrated Care Management Programme has demonstrated 20% reduction in hospitalisation rate, 4% lower patient mortality and 7% cost reduction. Another programme, the Behavioral Health Integration (BHI) succeeded in treating both physical and mental problems at primary care level, lowering costs of care and improving health outcomes.

Lessons from analysing these programmes suggest that it is crucial to invest in a range of ICT tools which best serve the needs of the target population, the clinicians and the health system. These include ICT infrastructure such as patient portals, remote patient monitoring tools, Electronic Medical Records with clinical decision support, care management software, enterprise data warehouse, analytical/reporting tools etc. The total investment was around $75.5 million, coming from Federal/State funds and from the health provider (an amount equal to 1.6% of their budget). For every $1 spent, the programme saved at least $2.65.

Dr Lieve Fransen, *Senior Adviser on health, social and migration policies at the European Policy Centre*, outlined the main findings and recommendations of the report of the High-Level Task Force on Investing in Social Infrastructure in Europe. The level of investment in health and long-term care in the EU is estimated at €75 billion annually. But this is not enough to meet the needs; there is a funding gap of approximately €70 billion per annum. Investing in health infrastructure is only part of the solution. Financing of services, training and human resources represent the largest part of the costs in health and long-term care. There is need to crowd in more private investments; making long-term investment plans can help in this regard. Freeing public resources used for infrastructure can accelerate the development of integrated care models. Ultimately, integration must go beyond health and social care, to include areas such as housing or education too.

Most Member States do not need more hospitals, but investors are not aware of this. Neither do investors know well enough the real needs in health and long-term care, which arise from the demographics. Population ageing, with an increase in life expectancy but not in health life years, means that social services will have to adapt and investments in reformed social services are therefore necessary. Investments in digital technologies that can support new care models are also important. Population well-being needs differ across regions, not only across countries. This means that certain investments should be planned at regional level to meet the local needs; this may not be possible if investment decisions are made at national level only.

Important recommendations include: a) boosting long-term investments; b) bundling of small projects to create more attractive investment propositions; c) blending of financing instruments; d) building capacity and technical know-how; e) establishing investment platforms; f) enhancing the role of national promotional banks and institutions; and g) prioritising social infrastructure financing for regions with the highest needs.

Prof. Dr Volker Amelung, *President of the German Managed Care Association*, indicated first that a solid financial situation in the German health system does not offer much incentive for change and process innovations. Despite this, there are challenges which need addressing. Lack of overall integration and coordination of care is one of them. This means that the system does not function as efficiently as it could. Many solutions exist only on paper or are announced in legislation; this is inter alia the case of eHealth, the use of which can improve.

An Innovation Fund has been established making available €300 million annually for innovative projects; with €225 million per year going to innovative concepts of care. Large pilot projects are financed for 3-4 years duration. The pilots cannot be developed individually; they need to be collaborative projects and, typically, they involve consortia of around 10 partners from health organisations, IT organisations and payers/insurers. The main areas are digital health, patient stratification, case management, and addressing needs of vulnerable groups. The law stipulates that the successful pilots should become standard practice and be implemented in the whole country. How this will be done is unclear. The Innovation Fund is expected to have a leverage effect on investments, but know-how on system re-organisation is needed too.

Ms Dana Burduja, *Senior Health Economist, Projects Directorate, European Investment Bank (EIB)*, started with presenting the EIB's role in health investments. The EIB has provided over €28 billion of loans to the health sector in the period 1997-2017. The main areas of EIB's health investments are health infrastructure; innovation and medical research; medical education and training; community and integrated care; and equipment, technology and data solutions. Ms Burduja further presented the European Fund for Strategic Investments (EFSI), which is the financial instrument of the Investment Plan for Europe. EFSI can offer opportunities for public and private investors to join together in high-risk health investments, for example, in areas such as new facilities (e.g. primary care and community care centres); new service models and new technologies (e.g. eHealth and mHealth solutions for remote management of patients with chronic conditions); and capacity building and system re-organisation (a "soft" component often forgotten by financial instruments).

Paradoxically, the countries and regions which need more investments may get less because they lack the capacities needed for applying for financing and for project management. This situation changes slowly, also thanks to EIB's activities and the European Investment Advisory Hub (EIAH). The EIAH helps assess investment gaps and offers advisory services and technical assistance for preparing investments, also through the use of partner hubs in Member States. Ireland invested in setting-up a number of primary care centres, with the inclusion of private investments in physical infrastructure through a public-private partnership scheme. At the request of the Irish government, the EIB provided funding support for this scheme.

Experience suggests that the due diligence process for hospital investments has sometimes required the care authorities to prepare more comprehensive plans for their health system reforms and service delivery. This exposed capacity gaps and, subsequently, the EIB and EIAH provided the relevant technical assistance to care authorities for these purposes.

Ms Madeleine Clarke, *Chair of the European Venture Philanthropy Association*, presented two examples of philanthropic investments in health and social care. The first example was from Italy, the Centro Medico Santagostino affordable healthcare model. This model aims to provide high quality medical services (e.g. dentistry and rehabilitation) at affordable prices, offering a third option between the National Health Service and high-cost private healthcare providers. The majority investor is Oltre Venture. Oltre collects investments from individuals, foundations and corporations that choose to make their "calm and responsible capitals" available to unique and innovative projects. Centro Medico Santagostino aims to become an economically sustainable alternative health model, replicable in other cities and countries.

The second example concerned Genio, an Irish-based organisation managing public and philanthropic funding to bring about positive and lasting change in the lives of vulnerable and disadvantaged people, through the transformation of publicly funded social services. Reform and continuous improvement of public services is challenging but they can be helped enormously when even modest amounts of private funding are used as a catalyst for change. Many philanthropic organisations are committed to improving the lives of those who need opportunities to live as valued and participating citizens, but are limited by what they can achieve without collaboration with the public sector. Genio works with philanthropy as a catalyst to refocus public budgets to secure sustainable improvements at scale. They recently established a Service Reform Fund (SRF) to implement and scale mental health, disability and homelessness service reform at a national level in Ireland. This fund represents a total investment of €45m in a collaboration between two key government departments, the national Health Service Executive (HSE), the Atlantic Philanthropies and Genio. Genio's model can be applied to any social service area where public resources need to be refocussed to achieve better outcomes more efficiently. It also has potential application within and across multiple countries.

Mr Thomas Kergall, *Technical Advisor for Health, Council of Europe Development Bank (CEB),* presented the CEB's strategy for health investments in view of supporting protection of health, social cohesion and sustainable and inclusive growth. CEB financing comes typically in the form of sovereign loans to public authorities. As is the case of other institutions, the CEB has been investing mainly on "bricks and mortar" projects for many years. While being already more and more involved into the preparation of projects, the challenge is now to put more weight into the "soft" aspects of capital investments.

One way to achieve this is through the provision of technical and advisory assistance for e.g. workforce training and improvement of service delivery, which can prompt the reallocation of public funds to priority areas. Another approach to be developed is to blend the loans with social impact bonds, as is the case of a future CEB public sector financing facility in social services in Madrid. The CEB is also reaching out via lending to commercial banks. An example is the Rabobank-CEB collaboration in introducing an impact loan in the Netherlands with which local authorities can integrate health and social care services in primary care centres.

3. Take away messages

The main messages from DG SANTE's investment event in 2017 are recalled:

- The importance of developing long-term investment strategies which consider the investment needs for infrastructure, innovative technologies and new care models together.
- The need to blend financing from various sources.
- The need for health authorities to look beyond local, regional and national budgets and EU grants, to develop partnerships with new stakeholders and to learn how to manage new financing instruments.
- The importance of contracting and payments models between service payers and service providers. As these models can determine whether the investments will turn into

successful delivery of effective services or not, they need to be considered in conjunction with the planned investments.

In addition, further elaboration and new messages relate to the following:

- To succeed in the transformation of health systems, support is essential on two fronts:
  a) sufficient mobilisation of investments in order to reach large scale transformation;
  b) know-how and capacity to design and implement new care models.

  EU institutions can provide support to national and regional authorities on both fronts.
- Patients and communities should be engaged in the design of innovative care approaches and in different stages of the investment process. Their input is helpful in identifying priorities and informing about desired outcomes.
- To deliver on better outcomes, new contracting approaches and incentives may be required, as well as investments in areas outside health. It is doubtful that the currently popular way of contracting health services, i.e. paying when an illness occurs and is treated, contributes to any lowering of costs. With the current financial models, prevention does not bring financial gains despite being more effective than treatment.
- There is large need for capacity building and technical assistance, both for mobilising investments and for implementing health reforms. There is specific need for technical support to enable health institutions to use European Structural and Investment Funds (ESIF).
- Among others, technical assistance can bring in independent expertise (which can be very useful in capacity building), help formulate strategies, identify advantages and opportunity costs, finance the exchange of people to help transfer of knowledge, and train human resources in new roles and skills.
- It is crucial to convince stakeholders about some changes or reforms, but it is not always feasible. It would be useful if support for showcasing were possible. For example, investing in prevention can be very profitable; however this is not common knowledge.
- The challenges which health and social care systems face require more "soft" (non-infrastructure) investments. To date, infrastructure investments have had clear priority, not only as a consequence of the way care systems have functioned (with the focus on institutionalisation) but also of the fact that infrastructure investments are more visible for political purposes.
- It is important to invest both private and public funding in order to scale innovations to reach whole populations of need.
- Care authorities can consider impact finance strategies, using social impact bonds to bring private financing in difficult areas. Social impact bonds are among the new sources of financing and can be good solutions in situations with high performance providers.
- Blending loans with social impact bonds is an option for financing health and social care services. There is scope for blending ESIF with other financial instruments.

- Good examples of integration can be found in cities, where local authorities integrate financing.
- Many projects, especially for non-infrastructure aspects, can be rather small to attract interest from investors. Bundling small projects together is an option for creating larger and more attractive investment propositions.
- Investment platforms can be a promising mechanism to crowd-in private investment, finance projects with high risk profile, bundle projects, blend different sources of financing and also provide access to specialised advisory services.
- It can be too much for public authorities (national and regional governments) to invest in infrastructure, in the set-up and the operational costs. Blending public and private financing can help. Making long-term investment plans and a stability of long-term policies are key to attracting private investors.
    - Collaboration with government or state agencies is best established at the start of a change programme, in order to secure their input, buy-in and long-term commitment.
    - Public authorities can lease facilities from private developers and free up public financing for public delivery of health services.
    - The use of private investments in physical infrastructure provides opportunities for reallocating some public funds to other priority areas, such as financing workforce training and the provision of prevention and integrated care services.
- Some investments in physical infrastructure are inherently linked to provision of services. For example, the construction of primary care centres in the context of primary care reforms is associated with the hosting of multidisciplinary care teams for the provision of coordinated care and disease prevention.
- As part of an investment strategy, it can be useful to distinguish the responsibilities of the public and private parties and, if necessary, split the packet of services and create conditions for private entities to invest in service provision. Investments in prevention are more likely to come from public financing, whereas private investments are more likely to be directed to care and cure.
- It is equally important to disinvest from and de-list what does not bring added value. The use of Health Technology Assessment can be helpful in this case. Enabling disinvestment or shifting of priorities would help in concentrating the investment on identified needs. This would result in using money which is already in the system and, consequently, limit the demand for additional resources.