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A photograph of three young people sitting on stone steps in front of a building. A woman in a white shirt is in the foreground, looking towards the camera. Two other people are sitting behind her, one in a blue shirt and one in a red shirt, both looking towards the camera.

Enhanced independent living requires health care services to be redefined

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Parallel session on innovations bringing care at home

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Overview

- › Enhanced independent living => new services needed
- › Healthcare-related services and non-medical services
 - Typology of roles
 - Four types of roles: medical and intermediating roles
- › Telecare services
 - New services due to enhanced independent living
- › Lack of understanding of these roles and services is harmful



› Increasing lifetime expectancy

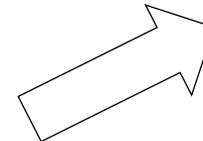
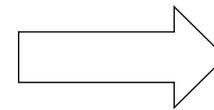
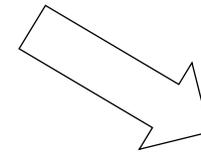
› Growth in the elderly population

› Growth health care related costs

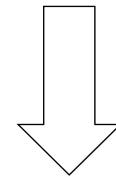
› Growth of social welfare costs

› Increase in working life time

› Changing values in the society



Enhanced
Independent
Living



Growth of services

- › Prevention
- › Intermediation
- › Non-medical care



- › Can classical theory explain Healthcare-related services?
- › Porter's value based competition leads to problems, e.g.:
 - Value model not easily applicable
 - Services such as diagnosis-without-results difficult
- › Christensen's typology (ill-defined vs well-defined problems) from Stabell and Fjeldstad, solves the latter issue. However, questions remain unanswered e.g.:
 - Why do we have hospitals?
 - Why exactly are insurers necessary?
 - What is the role of the government, and why?



Theory of Christensen on disruptive innovation

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Knowledge Shop:
Customer-specific

Value-Adding Process Chain:
Repetitive

Ill-defined problems

well-defined problems

“ordinary” innovation

“ordinary” innovation

Disruptive innovation

Very different business models and business cases



intermediate	Self Help Connecting services	Care Payer Bundling & Bridging services
medical	Knowledge Shop Problem- oriented services	Therapy Provider Value-adding Process chain services
	Ill-defined	Well -defined

Care payers are insurers, government, employers



	Knowledge shop	Therapy provider (VAPC)	Care allocator	Self Help services
Payment / incentives				
Evaluation/ quality control				
Innovation				



- › Telecare simply means, that the service is delivered from (or to) a remote place: the doctor nearby
- › However, it also allows new services and new healthcare delivery models
- › Classical services require co-location and synchronicity
- › Telecare allows a-synchronous service delivery
- › Last but not least: continuous monitoring services



- › For many therapy providers, telecare seems promising:
 - COPD, Heart, Diabetes,

- › The key service after initial treatment is monitoring

- › However, a *monitoring service* may proceed 7 x 24 hrs/wk
- › The real nature of such (remote) services are new:
 - How should this service be paid?
 - How to set quality control norms for this service?

- › Investigated in other branches (ICT, Energy) but not in Health Care



- › The service ‘monitoring’ is an *on-demand service*
- › Other examples in other domains:
 - Roadside assistance (ANWB)
 - Telcos providing connectivity
 - ICT services, e.g. in banking, authentication,....
- › Monitoring services presume associated *interventions*
- › Monitoring services and associated interventions require different contracts, service levels, payment structures, quality control measures, etc.
- › Different, but interrelated
- › In generic terms this is new, although examples exist



- › Knowledge e-shop may offer diagnosis
 - E.g. general practitioner
 - Can often be done asynchronously, except for face-to-face interaction
 - Requires sometimes co-location and synchronicity
 - E.g. emergency care
 - Can sometimes be done remotely (ambulance)
- › Knowledge e-shops may offer help for complex problems
 - E.g. comorbidity
 - E.g. psychiatric support
 - E.g. help when approaching end-of-life
 - Again, a monitoring service !



- › A municipality faces the fact, that a social problem has sometimes a medical root cause
- › Accordingly, they want their social workers to be supported by medical knowledge (e.g. a nurse)
- › By Dutch law, they have to ask the dominant insurer to contract the nurse
- › The insurer contracts a nurse from a local homecare provider
- › She will be located at the city hall
- › What is wrong here?
- › Roles not properly distinguished!



- › In NL, insurers and municipalities are main care payers
- › They contract providers of care and cure services
- › Their services *are* already e-services
- › However, they struggle with their roles and Dutch society is very negative about their performance



- › Main goal is to purchase health care and cure services
 - Allocation proceeds via medical indications
 - Assuming therapies are well-defined (DBC)

- › Selecting providers (representing clients)
 - Balancing costs and quality
 - Creating competition between providers

- › Competing for clients
 - Sharing risks
 - Guaranteeing timely high-quality service
 - Providing health-related information, products





- › Enhanced independent living needs life-style interventions
 - Gait, Nutrition, Social connecteness, etc.
 - Challenges?

- › Interventions can be delivered often as e-services
- › Such interventions are *prevention* from a medical viewpoint

- › Such services are not covered under health-care insurance
 - No medical indication for prevention
 - Prevention doesn't fit with yearly contracts
- › Often these are not delivered by health care providers



- > Main goal is to purchase and supply social services
 - No formal role to stimulate competition
- > Institutional role is to support inhabitants
 - No formal role to compete for inhabitants
 - Best positioned to provide physical facilities (dorpshuis) in addition to e-services (support)
- > They support citizens via an e-government program
 - Allocation of social support is not clearly defined
 - (in contrast to allocation of medical care)





- › Municipalities do not understand their role as care payer
 - Privacy of citizen is a problem

- › On the edge of the medical and social realm
 - Which is in itself a difficult issue
 - Example: monitoring a mentally retarding citizen

- › They sometimes play the role of knowledge shop
 - Whereas they should *organize* that a knowledge shop is involved in the patient's care
 - This allows the care payer to mitigate privacy issues



- › Many self-help developments are facilitated by e-services
 - Patient communities for rare diseases
 - Communities of parents with children as chronic patients
 - Weighwatchers, anonymous alcoholists, addicts, ...

- › Many citizens search on the web for complex problems
 - Communities of informal carers
 - Promising due to smartphone and tablet



However, we should be aware of the digital divide ...



- › Informal care is often not properly recognised as a care service including financial aspects

- › Actually, an informal care provider may both provide and consume a set of services, e.g.
 - A monitoring and intervention service provided by the informal careprovider to a patient
 - The same monitoring and intervention service provided by a formal care provider to the informal care provider

- › Municipality should keep track of informal care services



- › Enhanced independent living will grow
- › Telecare services will be needed in all service domains, and will integrate with home automation, entertainment and transport
- › Proper roles have to be taken up by knowledge shops and therapy providers, but also by care payers and self-help
- › New types of services need to be introduced and studied, both within the medical domain and in the domain of intermediaries (especially wrt prevention and informal care)
- › An interesting new service is the distant monitoring and intervention service, which emerges at many places



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Thanks !

