



HealthPros

International Training Network for
Healthcare Performance Intelligence Professionals



BUSINESS MODEL FOR EFFECTIVELY INVOLVING PATIENTS IN THE FINANCIAL DECISION-MAKING OF HEALTH INSURANCE FUNDS.

A guide to healthcare insurers on fostering the engagement of citizens based on recent experiences in the Netherlands.

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PREFACE

HealthPros is a H2020 Marie Skłodowska-Curie Innovative Training Network for Healthcare Performance Intelligence Professionals under grant agreement No 765141, running from January 2018–April 2022. Healthcare performance intelligence can be defined as a structured approach to acting on health policies, using knowledge and information generated through scientific methods and health data to systematically measure indicators of health system performance. The network set out with the aim to train a first generation of Healthcare Performance Intelligence Professionals (HealthPros Fellows) that can make effective use of available healthcare performance data in countries to improve integrated services delivery, patient engagement, equality in access to healthcare, health outcomes and reduce waste in healthcare.

Since 2018, HealthPros Fellows have completed innovative research and multidisciplinary training in Canada, Denmark, Germany, Hungary, Italy, the Netherlands and the United Kingdom. As part of their training, Fellows also completed secondments at partner organizations as an opportunity to obtain local guidance and conduct applied research.

Throughout the programme, HealthPros Fellows have worked to develop tools and implement methods to streamline healthcare performance measurement, develop and apply performance-based governance mechanisms and optimize the use of healthcare performance intelligence by different end-users. Topics explored through a healthcare performance intelligence lens in their work include: actionability of performance indicators; composite measures; integrated care; corporate governance tools; patient and citizen engagement; nudging; use of routine databases for performance improvement; and, long-term care. As the COVID-19 pandemic paralleled the HealthPros programme, many Fellows and the network at-large, sought opportunities to conduct a number of COVID-19-related studies at pace with the pandemic's changing context.

Outputs of the HealthPros programme have continuously been published as open access studies in international, peer-reviewed journals. Additionally, Fellows have actively contributed to webinars, conferences, the delivery of courses, policy dialogues, direct country support, and media engagements, among other types of dissemination to continuously share new findings throughout the programme.

This **Healthcare Performance Intelligence Series** represents the culmination of key research findings by the network into a collection of reports providing methodological, practical, and policy guidance. Reports in the series are tailored to different audiences, ranging from policy-makers, hospital



managers, clinicians, and the general public. The development of each report in the series has relied on close collaboration across the HealthPros network. The range of topics and resources making up this series includes the following:

- Practical experience with implementing disparity and composite measures in large-scale routine quality improvement work to support transferability to other HC systems (No. 1.2 2022)
- A practical guide towards actionable healthcare performance indicators: Selecting healthcare performance indicators that are fit for purpose and use for various stakeholders (No. 1.3 2022)
- Policy guidance on advancing the performance assessment of integrated healthcare systems (No. 1.4 2022)
- Policy guidance on the use of PREMs to improve health system performance (No. 2.2 2022)
- Policy summary report on the value of results-based tools in health care management-Lessons learned from COVID-19 dashboards (No. 2.3 2022)
- Business model for effectively involving patients in the financial decision-making of health insurance funds- A guide to health care insurers on fostering the engagement of citizens based on recent experiences in the Netherlands. (current)
- Policy summary report on best practices for linking financial incentives to health care performance at individual health care provider, institutional and regional level- A business case for value-based health care systems based on performance intelligence (No. 2.5 2022)
- Policy recommendations on the role of nudging for health care performance assessment agencies (No. 3.2 2022)

The full series of reports can be found online (<https://www.healthpros-h2020.eu/>). For questions related to the series or HealthPros network please contact Dionne Kringos, PhD (d.s.kringos@amsterdamumc.nl).

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1. Introduction

In recent years, there has been an increased focus among policymakers, health care insurers, and care providers towards maximizing value and reducing waste in healthcare. In this regard, two central concepts have emerged: quality of care (QoC) and value-based healthcare (VBHC). QoC emphasizes the importance of care delivery that is compliant with the best possible standards, taking into consideration the norms and values in a society, and aligned with the healthcare service users' needs, expectations, and preferences [1-3]. The VBHC agenda, similarly to the QoC, puts forward citizens' values regarding health and care outcomes, stressing their engagement in decision-making processes [4]. The construct of patient-centredness emerges as a sub-dimension of those two concepts (QoC and VBHC) [5]. However, the inclusion of a people-centred perspective in VBHC is not without tensions as VBHC is a concept derived from management theories, with a clear conceptual focus on the costs [6]. To strengthen people-centredness and strive towards QoC and VBHC, health care system stakeholders (e.g., health care insurers and care providers) should commit to the value agenda supported by people-reported data informing on health care service users' needs, expectations, and preferences [7-9]. Hence, citizen engagement has become crucial to gain insight into one's voice and inform the decisions of those key stakeholders.

A broad engagement of stakeholders in decision-making processes is key to steer health care insurers towards creating value. In that scope, the use of terms such as citizen, patient, customer/client, and insured encompass different roles; these roles shape both relationships and behaviours [10]. A citizen is one who, regardless of their legal status of citizenship, is an active participant in a democratic society and their scope of concern is wider than their individual experience, i.e., they are concerned about the well-being of their communities or what health care they wish for society at large. On many occasions, citizens are also patients (or users) of health (care) services as recipients of care. They share a part of citizens' concerns which are shaped by their care experiences when interacting with the health (care) system. A customer/client is one who voluntarily seeks a service; it conveys the notion of regular commercial transactions where individuals should have choices and their needs and expectations met. An insured is a person whose interests are protected by an insurance policy. Clarifying these roles is relevant to understanding which perspectives are considered in decision-making cycles and by doing so, strengthening the broad public acceptance of and trust in the decisions made on health care.

1.1. Value-based health care and the Tripe Aim

The value-based health care model [1] and the triple aim of the Institute for Healthcare Improvement [2], emphasize that sustainable financing should incorporate the creation of value for citizens. In insurance-based health care systems, procuring and purchasing health care services is one of the main tasks of health care insurers. Thus, health care insurers play a major role in the financial sustainability of the health care system, including the purchase of care that adds value to the system. However, negotiating price, volume, care quality, and outcomes is a demanding and time-consuming process for insurers [3-5], and often more short-term and specific services-oriented than focused on long-term system sustainability through value creation. Health care insurers, in fulfilling their function of procuring and purchasing health care services following people-centred value-based principles, are maturing their data pipelines to gain insights on how their insured define value, particularly via patient-reported data [6]. The data custodian role of a health care insurer can support transitioning the health care system towards a more people-centred system. Yet, there is a chasm between the data health care insurers collect from the insured and how data are used towards realizing people-centred value-based health care. Thus, a structured approach to performance intelligence anchored in citizen engagement can inform health care insurers towards people-centred policies and care [7].

1.2. Patient-reported data: outcomes and care experiences

The most collected patient-reported data are those related to outcomes and experiences of care. Patient-reported outcome measures (PROMs) can be either used to measure the outcome of a specific disease or to assess the general health status of a person, and they are commonly used by clinicians and hospitals [11]. Other uses are those related to drug reimbursement schemes [4, 12, 13] and health technology assessment [14]. On the other hand, patient-reported experience measures (PREMs) refer to a person's experiences while interacting with the health care system (e.g., to receive care) [9]. Research and policy discussions on PROMs and PREMs have predominantly focused on the use of patient-reported data by health care providers to improve clinical practice [15-17]. For example, the work of the International Consortium for Health Outcomes Measurement (ICHOM) has contributed to setting international standards for outcome measures that matter most to patients on varying diseases [18]. Also, the Organisation for Economic Co-operation and Development (OECD) had been implementing the PaRIS project, which focuses on developing indicator surveys that capture PROMs and PREMs, notably of people with breast cancer, hip- and knee surgery, or mental health problems, as well as the development of new tools to people with multiple chronic conditions treated in primary

care settings [19, 20]. However, less is known about the use of patient-reported data by health care insurers in supporting people-centredness for QoC and VBHC [21, 22].

1.3. How to use this guide?

This guide is designed to support health care insurers in engaging citizens in health care procurement decision-making. The specific context of the Netherlands will serve as case study, where recent political efforts have been developed towards increasing the power of insurees in health care insurers' business models, namely health care procurement. This guide aims 1) to map the evidence on the use of patient-reported data by health care insurers; 2) to explore how patient-reported data are utilized by health care insurers; 3) to clarify the reasons why patient-reported data are collected by health care insurers; 4) to explore how citizen engagement by Dutch health care insurers can be embedded in the Dutch health care system, and 5) to explore how Dutch health care insurers operationalize their role of engaging citizens in health care procurement decision-making.

The guide draws on findings of a scoping review [23] and a two-phase exploratory qualitative study [24] on the use of patient-reported data by health care insurers. The latter started off by consulting academic and policy experts to create a basis understanding of the role of health care insurers in the Dutch context; thereafter, six focus groups were convened with a purposeful sample of representatives of the four largest Dutch health care insurers. During the focus groups, representatives of health care insurers reflected on the developments in the Dutch context regarding citizen engagement in health care insurers' decision-making. The considerations listed can be applied, to some extent, to other insurance-based healthcare systems.

2. The use of patient-reported data by healthcare insurers

In a scoping review carried out by researchers involved in the HealthPros project, forty-two documents have been identified on the uses of patient-reported data by insurers. Much of the literature retrieved highlight the contexts of Germany, the USA, and the Netherlands. Patient-reported data most often collected by health insurers are PROMs, followed by PREMs and satisfaction measures. These data are mainly used for procurement and purchasing of services; quality assurance, improvement, and reporting; and strengthening the involvement of insured people.

2.1. What kind of data do health care insurers use?

The use of PROMs is the most spread among health insurers, relative to PREMs or satisfaction measures. Often, PROMs are applied in combination with clinical indicators. Also, generic measures on patient satisfaction are often complemented with specific PREMs or PROMs. From the structure-process-outcome perspective, the use of process indicators and clinical outcome indicators by health insurers are frequently mentioned in the literature. On the other hand, the use of structure indicators, such as the availability of specific disease programs or the existence of quality assurance certification, is less frequent applied and often used in combination with process indicators.

2.2. How do health care insurers use patient-reported data?

Three main areas of use of patient-reported data by health care insurers have been identified in the scoping review: 1) procurement and purchasing of services; 2) quality assurance, improvement, and reporting; and 3) strengthening the involvement of insured people. Besides these, other key uses and functions are measuring the performance of providers, profiling, and product/program development.

Procurement and purchasing of healthcare

In the context of procurement and purchasing of healthcare services, the use of PROMs is the most prevalent. Only a few examples have been found for the use of PREMs [25-27], or satisfaction measures [28] in procurement and purchasing processes.

Selective contracting

In general, selective contracting refers to the contractual agreement between a health care insurer and a provider, where the former selects those providers that meet certain QoC expectations. In the literature, varying terminology is used for selective contracting: the term 'selective contracting' is mainly deployed in Dutch literature, while other terms used are 'outcome-based purchasing', or 'quality contracting' (predominant in German literature), and 'value-based purchasing' or 'payments' (predominant within the US literature).

The inclusion of QoC indicators in contracting is highly dependent on the availability of data; hence, the most common data used in these contracts are based on volume and costs [28, 29], and only recently some insurers started incorporating PROMs (and in a lesser extent, PREMs) [30, 31].

Mostly, selective contracting is used in the context of value-based purchasing or in value-based payment programs (VBP). Notwithstanding, improvements on QoC at large are also an objective of selective contracting, with a special focus on dimensions such as effectiveness, efficiency, and safety. Findings from the scoping review, however, suggest patient-centredness is not one of the major areas health care insurers are striving for.

In general, different patient-reported data are required for selective contracting and for pay-for-performance programs (P4P). The former requires data that enables comparisons across providers to contract those that are performing best; the latter requires data that enables health insurers to compare the performance of a provider with a predetermined target, norm, or past performance [25].

Quality assurance, improvement and reporting

Patient-reported data are often used for quality assurance, improvement, and reporting purposes, but most frequently for quality reporting of the performance of providers (of mainly inpatient services, but of late also outpatient services). Two perspectives on the reporting of the QoC of providers has emerged: 1) as an ancillary instrument to inform the decisions of insurees; 2) as a means of supporting and enhancing quality improvement via providers' benchmark [32, 33]. Terminology about quality reporting often varies in the literature: 'public reporting', 'hospital ranking', 'quality reports', 'doctor assessment portals', or 'performance comparison'. Different tools have been used for quality reporting, such as the Dutch Consumer Quality Index and the German Patients' Experience Questionnaire. PREMs and PROMs are also often used for quality reporting. However, the use of structure and process measures for quality reporting was featured far less, relative to PROMs and PREMs.

Prediction models

Health care insurers use prediction modelling to forecast and profile enrolees who are likely to incur high medical costs [34-39]. The documents identified by the scoping review often applied the term 'self-reported data' when referring to health behaviour, health care utilization, morbidity, and health status data, which were often combined with claims data. For example, Hornbrook and Goodman (1996) [35] and Fleishman et al. (2006) [36] used PROMs in their profiling studies, namely the RAND-36 and SF-12.

Other purposes

Alongside the uses of patient-reported data by health care insurers reported so far, other uses have been identified from the literature, such as the engagement of insured people in decision-making and the development of products/programs. The first stresses the role of health care insurers in research by granting access to their data (e.g., claims data) [40] and by developing novel PREMs and PROMs that are both fit for purpose and use [41-43]. The second depicts the role of a health care insurers in the development or co-creation of health care projects that incorporate patient-reported data, such as those portrayed by Franklin et al. (2017) [41] and Nickel et al. (2010) [44].

2.3. Why do health care insurers use patient-reported data?

Quality of care

The objective of most of the uses of patient-reported data is to improve QoC at large or a particular dimension of QoC, such as effectiveness, efficiency, access, patient-centredness, equity, or safety [2, 3]:

- **Effectiveness of care** mostly refers to cost-effectiveness and effectiveness of care. Efficiency refers to economic efficiency, cost-efficiency, allocative, and technical efficiency [27, 29, 33, 44-46]. Some sources also use efficiency in relation to the efficient targeting of patients with high healthcare needs [37].
- **Patient-centredness** is often mentioned in relation to the appropriateness of an intervention or service [27, 29, 30], interventions that are centred around the patient [47], and as a goal of using PROMs [46].
- **Patient safety** is also discussed, alongside to effectiveness, as key to selective contracting and measuring the quality of a provider. Occasionally, the term 'patient safety' is used to judge the performance and quality of health services for diverse purposes, or to refer to requirements of treatments to guard patients' safety.
- **Access** is often a topic in relation to equity [34] and accessibility of healthcare for people with disabilities [45].
- **Equity** is the least mentioned concept regarding the use of patient-reported data.

Value-based healthcare (VBHC)

VBHC has been identified in the literature as another important reason for employing patient-reported data. One approach views VBHC as the value of a health care service for a patient, whereas a second approach focuses on the purchasing or payment methods. Some studies present how patient-reported data can be used for value-based payments and value-based purchasing. For example, Dohmen and van Raaij (2019) [28] showed how Zilveren Kruis, a Dutch health care insurer, was piloting a method (best-value procurement) to purchase services from care providers that do not only focus on volume and cost. Similarly, Squitieri et al. (2017) [46] explored how to integrate PROMs in value-based payment reforms to measure the performance of health care providers from a patient's perspective.



**Procurement and purchasing of
health care and selective
contracting**



**Quality assurance, improvement,
and reporting**



Prediction models

3. Citizen engagement by health care insurers in the Dutch health care system

In this section, we explore the increasing power of insurees in health care insurers' business models. We focus on the specific example of the Netherlands, where recent political efforts had been developed towards the enforcement of citizen engagement in health care procurement of health insurers. The evidence herein builds on consultations with academic and policy experts and six focus group discussions with representatives of the four largest Dutch health care insurers (24 participants employed at participating health care insurers and 5 insured people with seats at the council of insurees of each of the participating health care insurers). During the focus groups, representatives of health care insurers reflected on the developments in the Dutch context regarding citizen engagement in health care insurers' decision-making.

3.1. The role of health care insurers in the Dutch health care system

Health care insurance in the Netherlands has its roots in solidarity. It developed from the financial assistance from guild “collecting-boxes” for specific groups in the 17th century to a social insurance model with Sick Funds for part of the population under a certain income level since 1941, and more recently towards a population-wide social health insurance model since the introduction of the Health Insurance Act in 2006 [48-50]. The Health Insurance Act steered the functioning of financing and purchasing of medical care to be organised and governed via three regulated competitive markets: 1) a health care insurance market, between health care insurers and the insured; 2) a health care purchasing market, between health care insurers and care providers; 3) a health care provision market, between care providers and citizens and patients [51, 52]. Despite this organization, the regulated markets should reflect the societal values regarded worthy such as solidarity, which is rooted in an underlying risk-sharing approach from the time of sickness funds.

3.2. The current state of citizen engagement by health care insurers in the Dutch health care system

Currently, health care insurers are focusing on other aspects of care beyond cost containment and cost-effectiveness; they are also involved in assuring the adequacy of care delivery and planning for improved health of the (insured) population, thus, becoming a proactive purchaser of care quality and person-centred care [52]. As of January 2021, an amendment to the Health Insurance Act strengthens the influence of the insured on health care insurers [53]. Citizen engagement is key in a regulated competitive market to steer actors towards realizing a people-centred value-based health care system [54].

Experts involved in our study recognized that health care insurers, via competition mechanisms of the regulated market, serve the interests of insured patients, but also those of insured citizens (e.g., by assuring the affordability of health insurance premiums). However, tensions were also noted in the health care purchasing and insurance markets because of a misalignment between the expectations of what the role of a health care insurer should be and that observed/experienced by other actors, such as care providers and citizens. For example, while citizens expect health care insurers to be more involved with health promotion and preventive care, these functions are not yet fully embedded in health care insurers’ business models.

Some experts signalled that the amendment to the Health Insurance Act (de Zorgverzekeringswet) builds off public pressure on health care insurers, as part of a broader discussion about the benefits of the regulated market. Two key aspects underpin these discussions: first, how to make health care insurers accountable for the engagement of their insured. Most of the experts noted that health care insurers had already been engaging their insured in decision-making (and, to some extent, citizens in general) before the amendment to the law, but possibly citizen engagement was not occurring at all levels and fast enough. Second, discussions also focus on how to address the low institutional trust of the public in health care insurers in the Dutch health care system. Overall, experts did not expect the amendment to the Health Insurance Act to stand as a game changer towards accelerating citizen engagement; rather, they expect the legislation to mainly enhance how health care insurers document what they have already been doing towards operationalizing citizen engagement.

During the focus group meetings, the representatives of the health care insurers recognized a changing context in the Dutch health care system, which supports an evolution from being a health care insurer towards becoming a health insurer. This evolution entails a greater focus on people-centred value-based principles, including a broadening of the services covered by health care insurers such as preventive care. Health care insurers stated that the general societal and political momentum were instrumental in shaping this change, rather than market forces. Preparing for this evolution, however, is not yet fully embedded in the corporate culture and strategy of some of the participating health care insurers. Notwithstanding, all representatives of participating health care insurers agreed on the central role of citizen engagement for this evolution to occur.

3.3. The viewpoint of the health care insurers' representatives on the operationalization of citizen engagement

We identified that health care insurers were following four strategies towards operationalizing citizen engagement: 1) broadening the population health orientation of the health care insurer; 2) empowering the insured; 3) strengthening features of data governance; 4) implementing financing mechanisms (Table 1). Both experts and representatives of health care insurers accounted that the context of a health care insurer and their corporate culture shape the initiatives and the extent whereby health care insurers operationalize citizen engagement.

Table 1 Identified strategies and initiatives used by health care insurers to operationalize citizen engagement in the Dutch health care system

Strategy	Identified factors contributing to the success of citizen engagement initiatives	Illustrative cases
Population health orientation	<ul style="list-style-type: none"> • A well-established relationship with municipalities before the rollout of any initiative • Sufficient regional market share of the health care insurer • Broad support of stakeholders in the community (e.g., GPs) • The design of initiatives should be evidence-based 	<ul style="list-style-type: none"> • Collaborating with municipalities on aiding people with financial problems • Convening focus groups of citizens for thematic discussions • Offering preventative programmes and e-health solutions promoting healthy lifestyles
Empowering the insured	<ul style="list-style-type: none"> • Moving towards a <i>professionalization</i> of the council of insurees • Diversify communication channels and use clear-cut messages to help inform citizens' decision-making • Ability to connect and to communicate with citizens sharing similar needs, within the provisions of the law 	<ul style="list-style-type: none"> • Engaging the council of insurees early in the health care procurement and purchasing process • Informing insurees on provider benchmarking results in regular newsletters • Omnichannel support to insurees who need assistance regarding navigating in the health care system
Data governance	<ul style="list-style-type: none"> • Data fitness for purpose and use • Data linkage between health information systems and actors at national and regional level • Data availability on value for patients 	<ul style="list-style-type: none"> • Measuring care providers' performance towards supporting quality assurance and monitoring initiatives • Regional profiling of communities • Monitoring insurees' care experiences and satisfaction by conducting complaints management
Financing mechanisms	<ul style="list-style-type: none"> • Sufficient regional market share of a health care insurer may lead to a representation model (i.e., a health care insurer negotiating with providers on behalf of other health care insurers) • Sharing of benefits among actors who invest in prevention and health promotion 	<ul style="list-style-type: none"> • Incentivizing value-based health care by offering to selected providers a multi-year or volume-free contract • Testing new approaches to health care procurement and purchasing (e.g., selective contracting)

Population health orientation

Dutch health care insurers are broadening their population health orientation by partnering with other actors towards improving the health status and outcomes of communities. This broadening is facilitated by regional partnerships and coalitions of health care insurers, such as those with municipalities and citizen-led movements. Another illustration is the broadening of health care insurers from bulk collective contracts with employers to working together with the municipality, targeting specifically people with financial problems in exploring other ways of addressing preventive care and health promotion needs. From the health care insurers' lenses, four features were identified critical for the success of regional interventions: 1) a well-established relationship with the municipalities involved; 2) sufficient regional market share of the health care insurer; 3) broad support of the stakeholders in the community (e.g., GPs); 4) robust anchoring in scientific evidence. However, key challenges are yet to be addressed to optimise the collaboration among actors, particularly in terms of clarifying stakeholders' responsibilities in the collaboration.

Empowering the insured

All health care insurers shown initiatives towards strengthening the voice of the insured in decision-making processes. For example, initiatives are pursued to engage local communities in decision-making, but these are still challenging to operationalize. Health care insurers were at different stages of exploring the full potential of their council of insurees; some health care insurers had more mature models than others, but the amendment to the Health Insurance Act may bolster opportunities to explore different approaches to engaging this council in health care procurement. Engaging the insured comes with its challenges, particularly in more complex topics such as health care procurement. To overcome these hindrances, two solutions were signalled: first, moving towards a professionalization of the council of insurees; second, strengthening communication channels with the insured, with clearer messages that can better inform their decision-making.

Data governance

Representatives of health care insurers signalled limited access to intelligence that is fit for purpose and fit for use towards supporting their role as a value-based purchaser of care. Most of the data available to health care insurers are claims data; patient-reported outcome (PROMs) and experience (PREMs) measures are still very limited. Regarding the latter, one hindering aspect is that of health care insurers collecting or getting access to these data, which relates with the limited trust of care providers and citizens on the potential uses of these data by health care insurers. For example, care providers are reluctant on the potential benefits of sharing these data, anchoring their concerns in the

context of data protection legislation. Data available for health care insurers are currently used for three key purposes: 1) regional profiling of communities; 2) procuring and purchasing care; 3) measuring performance towards supporting quality assurance and monitoring initiatives. Although health care insurers are limited in conducting individual-level profiling because of privacy laws, most health care insurers stated that through collaborations with regional partners (e.g., municipal health services—GGD), they have been able to link data at community-level. This supports health care insurers in better understanding the profile and needs of communities and the use of intelligence in supporting value-based health care procurement and purchasing.

Financial mechanisms

The approaches for procuring and purchasing care are evolving with the increasing presence of health care insurers in regions. If a health care insurer has sufficient market share in a region, this could lead to a representation model alike (i.e., where a leading health care insurer negotiates on behalf of other health care insurers), facilitating opportunities for shared learning. Conversely, a limited market share in a region could have implications on the willingness of a health care insurer in investing in that region. Representatives of health care insurers advocated for the alignment of financial and incentive mechanisms across actors to steer change towards creating value and strengthening the health (care) system's sustainability. For example, nudging value creation via providers could be achieved via a multi-year or volume-free contract. Health care insurers signalled, however, that a pooled budget could be the instrument with the greatest effect on steering change. A pooled budget would strengthen trust among actors and spur investments in prevention and health promotion. In parallel, a financial model should be in place to divide among health care insurers the (financial) benefits of investing on a population's health.

4. Concluding considerations

The breadth to which health care insurers use patient-reported data in their business models varies greatly across countries. Health care insurers are actively using patient-reported data to enhance care quality and value-based health care, predominantly through procurement and purchasing of healthcare; quality assurance, improvement, and reporting; and the engagement of insured people. These aspects were also highlighted in the specific context of the Netherlands, where the rollout of an amendment to the Health Insurance Act sought to strengthen the influence of the insured in health care procurement. Towards supporting health care insurers in engaging citizens, including patients, in the financial decision-making of health insurance funds, we suggest health care insurers:

- The constitution of an advisory board represented by a diversified sample of insurees to steer the strategical direction of health care insurers regarding health care procurement and product development;
- Regularly convene focus groups with citizens on thematic discussions, notably about their needs, expectations, and preferences;
- Foster transparency on performance measures regarding aspects of interest to insurees (e.g., benchmarking of care providers);
- Explore new approaches to health care procurement and purchasing introducing performance measures of importance to health service users in contracting care from providers, such as outcomes and care experiences.

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