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Leading Through Complexity: Systems Thinking for Sustainable Health Systems

Aligning incentives, data and collaboration to create sustainable health outcomes

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"When we don't see systems, we fall out of the possibility of partnership with one another; we don't understand one another; we make up stories about one another; we have our myths and prejudices about one another…and our systems - organizations, families, task forces, faith groups – squander much of their potential."
Barry Oshry, Seeing Systems: Unlocking the Mysteries of Organizational Life

Executive Summary

Private health insurers are facing unprecedented challenges in sustaining their funding models due to shifting demographics, rising healthcare costs and the availability of personalised treatments. The growing reliance on high-cost treatments such as innovative cancer therapies, alongside the complex health demands of an ageing global population, is putting significant strain on the viability of existing payment structures. Without fundamental reform, the imbalance between healthcare costs and insurance contributions threatens the sustainability of healthcare systems that have some reliance on private health insurance.

A key challenge is the misalignment of incentives within current fee-for-service models. While insurers focus on managing financial risk and cost control, healthcare providers are incentivised to increase service volumes. This is compounded by the barriers a fragmented system places upon the pooling of data that could positively impact health outcomes. Addressing these two challenges head on could help tackle inefficiencies in care, unnecessary costs and limited coordination between different stakeholders. The paper presents an approach based on Systems Thinking as a viable alternative, requiring a shift towards funding models that reconsider the relationship between payers, providers and patients, ensuring that incentives and resources are aligned towards achieving better long-term health outcomes, while removing systemic restrictions to change and innovation which can help drive their achievement.

Despite its advantages, barriers prevent the widespread adoption of a systems-based approach. These include power imbalances between stakeholders, resistance to change, short-term financial planning cycles and a lack of meaningful evaluation metrics. Healthcare organisations must address these structural challenges by pursuing collaboration, promoting transparency and aligning incentives with patient health outcomes. A paradigm shift is necessary to overcome the fragmentation of the current healthcare system.

Coordination across insurers, providers, patient groups and other stakeholders is essential to drive meaningful change. Real world examples of successful implementation of key elements of a systems-based approaches are provided in several case studies summarised within this paper:

1. Healthier SG, Singapore's population health approach.
2. Martini Klinik, reducing life altering complications as a result of prostate surgery.
3. Building a value-based framework for chronic conditions: Psoriatic Arthritis (Phase 1).
4. Achmea's True Age Test in collaboration with employers

Finally, the paper concludes with a proposed framework for transition towards a systems-based approach to healthcare with cues for further research and actions for members.

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Introduction

"The problem with private health insurance is that…we've got to a point where the old model of health insurance, which involves being a good bill payer at the end of our customer's journey, is unsustainable."
Nick Astwick, CEO Southern Cross

Private health insurers face significant challenges in their mission to support existing members and attract new ones. Two of the most pressing are:

- balancing the costs of innovative cancer care and other personalised treatments (see iFHP's white paper 'Horizons in Cancer Care: Payer Perspectives & Strategies for the Future' (2) for a full discussion);
- managing the imbalance between healthcare costs and health fund contributions for an ageing global population (see iFHP's white paper 'Health Insurance Redefined: Managing the Global Ageing Challenge' (3) for a full discussion).

Traditional funding models cannot keep up with advances in medical science or the prevalence of chronic illness. It is increasingly challenging for private health insurers to balance the books and we risk members becoming dissatisfied with their health coverage and health care. We anticipate that serious financial pressures and gaps in care coverage will be exposed in the richer, industrialised countries within the next 10 years. Projections indicate that by 2034, healthcare costs for individuals over 65 could rise by 16% in high-income countries, while costs for those over 85 could increase by as much as 44% (3).

Insurers (and other stakeholders in the health system) are aware there is significant wastage and avoidable spending in healthcare. An important question, then, is what systemic challenges are private health insurers facing in their efforts to secure better value care for their members?

Misalignment of incentives in existing payment models

Private health insurers are typically motivated to manage risk and costs, as this is the primary way they remain financially viable. Private clinics or clinicians are usually motivated to sell health services. The more procedures they sell, the more financially viable the practice. The goals of payers and providers are in direct conflict, leading them to operate in silos. In instances where healthcare facilities are increasingly coming under ownership of private equity firms we can expect the emphasis to shift even further in this direction.

This means private health insurers have a limited set of tools at their disposal to navigate healthcare funding challenges. Under existing fee for service payment models the main incentives insurers can use to influence the rest of the system are reducing or withdrawing funds. It is too blunt an instrument to support better value for members over the course of an episode of complex, specialty care (let alone across the course of their lives).

As a result, many providers (and patients) perceive insurers as holding all the power, because they make the decisions about payment. This creates misunderstandings and conflict, eroding trust and collaboration. Insurers frequently become gatekeepers in the clinical pathway, decreasing the autonomy and accountability of clinicians for the care they're providing. Ultimately, this decreases the value of the healthcare members receive and increases the risk and costs insurers are expected to bear.

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Challenges in gathering meaningful data across a fragmented system

Data is the cornerstone of how insurers forecast and manage risk. With more means of capturing, gathering and analysing data than ever before, we have the promise of being able to provide vastly better services and better experiences for health plan members. The obvious opportunity is improving operational efficiency and making cost savings. The biggest win is becoming partners in improving health across the lifespan, improving member retention, value of care and ultimately, cohort health. As explored in iFHP's paper on AI ('The Opportunity for Artificial Intelligence in Health Insurance') (4), translating this aim into reality is challenging.

The rewards of stronger data analytics and use of AI for insurers (and their members) include:

- improved risk forecasting and pricing models
- real-time delivery of underwriting and claims management
- highly personalised services, for example a 'health concierge' type service for better preventative care

Yet, it is not feasible for private insurers alone to gather all the necessary data. Member health data is collected in different ways, at different points in a healthcare system and for different purposes. This is another example of actors across a healthcare system operating in silos and missing the opportunity to collaborate. We are a long way off having a data infrastructure that allows payers, providers, administrators, data registries and patients to easily bring their data together.

Another barrier is data privacy concerns and a lack of trust around how sensitive health data will be used by the different stakeholders. When they are each concerned with different purposes and outcomes, providers or patients may be reticent about sharing data and reluctant to collaborate on improving data infrastructure.

Key Takeaways:

- Fee-for-Service models do not provide sufficient levers or incentives for insurers to positively influence healthcare funding.
- Conflict between insurers, providers and patients creates silos, incentivises self-interested approaches and creates barriers to collaboration.
- A wealth of data is available (or potentially available) to significantly improve health, but fragmented systems lack the infrastructure and willingness to pool data.

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What is systems thinking and how can it address healthcare funding challenges?

"Creating systems change involves not only changes in thinking, but also in behaviours and ways of being for individuals and organisations."
Anna Birney, CEO, School of Systems Change

Defining Systems Thinking

Our starting point for a definition of a systems thinking:

- Making sense of the world by paying attention to the relationships between parts and how they influence each other, rather than segregating them.

Systems thinking recognises that all systems are made up of interconnected parts whose interactions determine overall outcomes. A key feature of this school of thought is the identification of feedback loops, which show how changes in one part of the system create ripple effects throughout. It acknowledges emergent behaviour, where the collective interactions within a system lead to outcomes that are not always predictable from the behaviour of individual components.

In healthcare reform, this perspective helps examine how the behaviours of different actors in the healthcare system collectively shape patient outcomes. Rather than addressing individual problems in isolation, systems thinking identifies the broader patterns and structures influencing the system and, therefore, its outcomes. A key aspect of this is recognising barriers such as fragmented care and misaligned incentives, which hinder the effectiveness of healthcare delivery. When actors in the system work in silos without seamless coordination, patients experience gaps in care, leading to poor health outcomes and higher costs.

Driving impact from systems thinking through a systems-based approach

A systems-based approach translates the insights gained through systems thinking into practical change. It puts systems thinking into practice by recognising that:

- Change doesn't happen in a vacuum—it requires understanding how different elements interact.
- Addressing root causes is more effective than treating symptoms of a problem.
- Sustainable change comes from modifying structures, processes and mindsets across the system.

Sonia Roschnik of the International Hospital Federation (IHF) explains: "A systems approach means identifying those things that are likely to lead to unintended consequences while highlighting the real levers for change." In complex systems like healthcare, we need to go beyond the silos of payer, provider, patient (and others) to avoid simply pushing the problem into a different stakeholder's domain.

Anna Birney, CEO of the School for Systems Change counsels against the more common term 'systems thinking' and instead using 'systems practices'. Systems change is more of a shared, continuous improvement practice that needs input from multiple system stakeholders rather than a command and conquer approach where one entity directs the others. It is a continuous practice rather than a fixed plan with a specific end point.

It represents a paradigm shift which may seem daunting for an industry like insurance that is highly analytical, highly regulated and risk averse.

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However, it is this positively disruptive nature of a systems-based approach that both

- presents some challenging barriers to its adoption, and;
- gives the potential to address the most pressing challenges for private healthcare.

Pilots have shown the potential for systems-based approaches, like value-based care and population health, to provide better value care and reduce overall expenditure (5). Examples of successful value-based health care projects demonstrate the value of aligning all stakeholders around a shared outcome of providing the best care for the patient and engaging all partners in pooling data so they can design payment models to support this, delivering benefits for all parts of the system. For a more detailed discussion of value-based healthcare from an insurer's perspective, see iFHP's White Paper: Unravelling Value-Based Health Care (6).

Three Part model for a Systems-based Approach

"Private health systems are fragmented, individualised and self-incentive driven. They are not systems in the sense of all parts working intentionally in an integrated way to produce the system's ideal."
Nick Astwick, CEO of Southern Cross.

CEO of Southern Cross, Nick Astwick, shares three things that are non-negotiable for sustainable systems change. These are based on evidence from successful transitions to value-based care.

1. Outcomes – align the leadership of all parts of the system around shared outcomes.
2. Incentives – design the incentives needed to produce the desired outcome(s).
3. Trust – let elements of the system innovate without micromanaging.

Outcomes

We need to start at the end: what outcomes are desired? We also need to determine how we will measure progress towards the outcomes.

Aligning on outcomes requires elements of the system to prioritise what they have in common. In private health, the obvious answer is the people requiring healthcare, the customers. insurers, providers, pharmaceutical companies (and others) all aim to provide a service to their members and patients with each group holding vital data and expertise that could contribute to collectively providing better value care and experiences for members and patients. To define shared outcomes, stakeholders must pool their data and identify the existing, but unintended, consequences of operating in silos. Examples may include delayed diagnosis, avoidable complications, non-compliance with treatment programmes and poor co-ordination of care.

Where these reduce the overall value of care provided, the opportunity exists to improve operational efficiencies and coordination to save costs, improve patient/member experience and care pathways or reduce risk. This provides a data-driven starting point for agreeing shared outcomes.

Incentives

Designing incentives must take into account the relationships between different parts of the system, or it won't support the desired outcomes. Value-based models (as an example of a systems-based approach) seek to put the patient and their care at the centre (aligning around shared outcomes) and changing the way payment is managed (shifting the incentives).

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Harold Miller, CEO of the Center for Healthcare Quality and Payment Reform explains how fee for service payment models (and even some value-based payment models) may impose barriers to achieving the outcomes desired by payers, providers and patients (7). One element of value-based care could be to identify 'avoidable spending' and reduce it. Avoidable spending here means services that are expensive to provide and either unnecessary or even harmful for patients. To reduce avoidable spending it's often necessary to rely on services like transportation, nursing, community health workers and communication between physicians to co-ordinate care. These are high-value services that can reduce avoidable spending, but the cost to deliver them is generally not adequately supported by fee-for service payments. For example, delays in responding quickly to complications during cancer treatment can result in emergency department visits or hospitalisations that could have been avoided. Oncology clinics are paid for office visits and to administer cancer treatments. They are not paid for employing nurses or community health workers to proactively contact patients to manage symptoms. As a result, oncology clinics that do invest in better co-ordination of care will lose money and potentially become financially unsustainable.

Trust

When a system encourages behaviours and processes that are creating undesirable effects this tells us there is a problem in either alignment around a shared outcome or the relevance of incentives, or both. In other words, it's a problem with the system itself, not a failure of an individual part. This also means scapegoating or trying to micromanage one part of the system does not lead to sustainable improvement. It erodes trust between system stakeholders and pushes them back to prioritising their individual outcomes, to the detriment of the overall system.

As a result, when there is a high degree of micromanagement, unintended consequences tend to be more intractable and become programmed into the system. On the other hand, we can witness much greater innovation and better results when relevant experts are empowered to decide how to better manage their operations to contribute to a shared outcome.

The Tight-Loose-Tight (TLT) model is a useful tool in this context and has been used successfully in value-based care applications.

- Tight: Outcomes and expectations must be clearly defined at the start.
- Loose: Flexibility in implementation, where different elements of the system are trusted to use expertise to find the optimal pathway.
- Tight: Clear accountability & evaluation on progress towards outcomes.

Supporting the development of new payment models that support flexibility (or trust) for clinicians to direct care, while also giving incentives to increase value for the patient (as opposed to an individual health service or transaction) is a good example of this.

Key takeaways:

- System stakeholders need to pool their data and uncover the unintended consequences of operating in silos, in order to identify shared outcomes.
- Use data and shared expertise to define measures of progress and identify incentives that take into account all relevant parts of the healthcare system. And look at how current incentives create barriers to desired outcomes.
- Trust in this context means aligning around shared outcomes, while giving individual parts of the healthcare system more freedom to create positive change.

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What are the Barriers to adopting a systems-based approach?

Adopting a systems-based approach creates disruption, which means there will always be barriers to negotiate.

The main barriers in health systems are:

- Existing power dynamics
- Lack of meaningful evaluation
- Short term business planning

Power dynamics

> *"Power is rarely named. We talk about the different layers of our systems as if they are equal and have equal influence, but this isn't the case." Bridgette Collado, Change/Transformation advisor at a major US health system*

Power exists in different forms and in different places in a system and a systems-based approach requires us to pay attention to it. In most current private healthcare contexts, private health insurers hold power around payment. One of the criticisms of a fee for service payment model is that in some contexts it incentivises providers to increase volume of treatments, rather than provide excellent care or improve health. A lot of power rests in what is paid for and when it is paid for by insurers and power dynamics will often be a factor in the unintended consequences created in our systems.

Useful questions about power in health systems are:

1. *How do we define value and who gets a say in how we define it?*

What patients, clinicians and insurers believe is 'good' value care may differ. Even between different patients, a 'good' outcome from treatment or for their health will be different. Agreeing shared outcomes for the system is an important and potentially lengthy process. The bigger the system, the more challenging this will be.

2. *How much power does a clinician have to follow evidence-based care pathways and make clinical decisions that promote better health outcomes for patients?*

At iFHP's 2024 Value Based Healthcare Study Tour, Lili Brillstein and Harold Miller reminded the group that clinicians have a wealth of insight into how and why healthcare for their patients isn't just delivering the best health outcomes at the lowest cost. With a systems-based approach, this can be unlocked to create benefits for the whole system. However, this only works when all insight holders have sufficient influence within the system and are empowered with both more freedom to follow evidence based care pathways and clearer accountability for the resulting outcomes.

3. *Where is there influence that can be harnessed to support behavioural, process and regulatory change needed by the system to move towards the shared outcomes?*

'Population health' initiatives often involve encouraging patients to make changes to their lifestyle to improve their health. Increasing the uptake of early diagnosis tests or implementing an exercise regime involves changing behaviours that happen outside the clinic. Who or what will truly influence the behaviour change needed to meet the agreed outcomes? It could be community groups, employers or government communication campaigns to name a few.

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The most relevant layers of influence are likely to come to light as the project progresses, reinforcing the need for systems-based change to be responsive to what emerges (following a Tight-Loose-Tight model) rather than following a pre-determined set of rules.

Meaningful Evaluation

The shared outcomes that insurers, providers and patients are all motivated to align around are often difficult to evaluate. With the example of diabetes as a chronic disease, a blood test alone cannot measure whether patients' health outcomes are improving as a result of the care they're receiving.

Blood tests for HbA1c are relatively easy to carry out if patients are engaged enough to attend the clinic. A standard measurement for diabetes management is to record HbA1c using blood tests. A simplistic 'good' outcome is Hb1Ac levels below a certain threshold. The real outcomes story is much more complex, as it depends on the patient's lifestyle, social determinants of health, co-morbidities (including mental health) and more. ICHOM's Patient Centred Outcomes for Diabetes is more meaningful and also includes 13 different elements, which will require a number of different processes to measure (8). Evaluation using this framework would be more meaningful, but only if it actually happens.

Bridgette Collado, whose work involves liaising with both insurers and clinicians on behaviour change programmes warns, "We tend not to spend enough time at the start of a programme to understand what will happen downstream. Evaluation frequently isn't properly budgeted of resourced. When we do get to measurement, insufficient lack of preparation leads to a lack of clarity and we get pushback on the process of measurement." Evaluation frequently falls by the wayside as a result of:

- lack of budget for evaluation work, meaning it is likely to be deprioritised.
- lack of interoperability between data systems and out of date data architecture.
- lack of clarity on what metrics are needed and why, leading to pushback or incomplete data collection;
- lack of time investment at the start to align on outcomes, the problems likely to be encountered in reaching them and in designing practical metrics & evaluation processes.

Short-term business planning

Complex systems are slow to change, therefore a systems-based approach needs a long-term commitment.

In most commercial environments, business planning cycles are now shorter than ever, with one- or three-year planning now standard and a strategy spanning a maximum of five years. As a result of rapid change during the COVID-19 pandemic, even planning three years ahead has become a projection into great uncertainty. Short term financial targets can lead to an overemphasis on cost reduction presenting a challenge to executives who might otherwise champion longer-term initiatives.

As Harold Miller, President of CHQPR explains, "Health funders taking a short term perspective on cost reduction can cause damage. For example, failing to pay adequately for high-value services can lead to increased spending on avoidable services and reducing payments to smaller providers can force them out of business, thereby reducing access to care for patients and reducing choices of providers for both patients and payers. Instead of savings, the result is often worse outcomes and higher overall spending in the future."

Even if an insurer is willing and able to prioritise a long-term approach, the pressure to jump into solutions without the necessary preparation around outcomes or establishing a meaningful and viable programme of evaluation is immense. This either sabotages a true systems-based approach, leading to poor results and frustration or makes it unattractive from the beginning.

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The need for a new paradigm: how do we co-ordinate for Systems change?

Unacknowledged power dynamics, a lack of meaningful evaluation and short-term business planning all incentivise a way of thinking, behaving and relating to other parts of the system that prioritises top down management and operating in silos. In doing so, we obscure our view of the wider system and incentivise our people to pay attention only to their individual part in it.

For health organisations to take a systems-based approach they need both a set of steps to follow (a plan for the desired change) and for key influential individuals to develop the skill of stepping outside their habitual perspective (or 'zooming out' as Anna Birney & Marion Birnstill describe it).

Therefore, a day to day, moment by moment barrier to a systems-based approach is a lack of encouragement or empowerment of individuals to step out of their entrenched, habitual positions in the system. For health insurers, this means stepping out of a habitual refrain that they need cost-savings (and therefore reduced risk) as an immediate outcome of collaboration. Or to put it another way, letting go of expectations that providers will align with the insurer's primary concerns. (The reverse will be true for providers.) Without it trust cannot be developed and it is impossible to identify, much less align around, shared outcomes.

Time Out of Time is a methodology developed for giving system actors time to step out of their entrenched positions and building their skill of perspective taking. Developed by Barry Oshry in his work on The Power Lab, Time Out of Time (or TOOT) is a facilitated meeting space for stakeholders to step outside whatever they're busy doing and witness the bigger system patterns (9) (9a). This brings stakeholders back into partnership with each other and away from squandering the system's potential. It makes it possible to co-ordinate diverse stakeholders so they can work on defining shared outcomes, designing appropriate incentives and building or maintaining trust.

The paradigm shift required to work with systems is a change in how we as individuals, teams and organisations perceive ourselves and others in the system, which then creates a substantial shift in how stakeholders co-ordinate and collaborate. A top-down approach may side-step it and inadvertently reinforce those barriers noted in the previous section.

Paradigm shift is difficult to convey in theoretical terms, so this paper will examine four case studies to gain insights that are as meaningful as possible. Each demonstrates a systems-based approach in a healthcare context and the best practice that can be taken from each.

Key takeaways:

- Unacknowledged power dynamics can block other stakeholders from contributing their full expertise towards better outcomes for all.
- Meaningful evaluation is complex and frequently under resourced. This leads to challenges in managing accountability down the line and demonstrating progress towards outcomes.
- Short-term business planning can lead to an over-emphasis on immediate cost-reduction which may inadvertently lead to worse outcomes and higher costs over the longer-term.
- Systems practice can be best supported by a paradigm shift in how we co-ordinate and collaborate: to work towards shared outcomes stakeholders need to learn to step out of their habitual, entrenched positions and take a systems view.

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Case Studies: Real-world examples of systems based approaches in health

How, then, do we 'do' systems thinking or adopt a systems-based approach and overcome the barriers to doing so? Because a systems-based approach challenges the existing paradigm of top-down management and compartmentalisation of functions it is not impossible to offer a prescription. Exactly what happens in fruitful systems change depends on how the system innovates towards its shared outcomes.

This paper will present four case studies of systems-based approaches in health:

1. Healthier SG, Singapore's population health approach.
2. Martini Klinik, reducing life altering complications as a result of prostate surgery.
3. Building a value based framework for chronic conditions: Psoriatic Arthritis (Phase 1).
4. Achmea's True Age Test in collaboration with employers.

1. Healthier SG, Singapore's population health approach

Singapore's healthcare transformation programme, Healthier SG, aims to mitigate the burden of an ageing population and increasing chronic disease by enrolling older residents into a long-term relationship with one clinic or family doctor (10).

The system: In its white paper outlining its approach, Singapore's Ministry of Health (MOH) names residents, family doctors, community partners, regional health managers as stakeholders. 'Enablers' include IT infrastructure, people development and financing policy. Community partners like Sport Singapore are involved to support residents with making day-to-day health and lifestyle choices.

The desired outcomes: The overarching aim is to increase preventative healthcare and decrease unnecessary curative healthcare.

Data and evaluation: Metrics for the multi-year programme are divided into short term (1-3 years), medium term (3-10 years) and long term (>10 years), for example:

- Screening rates for chronic diseases (short term)
- Avoidable emergency department attendance rate (mid term)
- Disease prevalence for identified chronic illnesses (long term)

To facilitate data gathering for evaluation, all family doctors who join the primary care network are required to use a clinic management system that supports updates to the National Electronic Health Register (NEHR). Training and one-off grants are available to support IT adoption.

Incentives: The programme is introducing 'capitation', whereby family doctors receive an annual service fee for each patient enrolled. The fee will reflect the different risk profiles of different population segments and works alongside existing fee-for-service payments for other medical services. Residents also have access to enhanced benefits and subsidies if they commit to visiting just one family doctor or clinic.

Co-ordination: The Ministry of Health in Singapore has the task of bringing stakeholders back to their shared outcomes with a long-term commitment (exemplified in 10 year evaluation goals).

Results: None published as yet for Healthier SG; however, Singapore had already achieved higher life expectancy with lower healthcare expenditure as a percentage of GDP compared to other developed countries (10).

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This example involves empowering physicians to make decisions about what care is most appropriate for the patient, within the overall outcome of improving medical outcomes. It's an ambitious transformation programme that takes a 'wide-angle' view, going beyond the traditional health system. This has informed the incentives needed to change the behaviours of patients and clinicians.

By designing a shift away from episodic care, doctors (or clinics) are supported to develop a longitudinal view of a resident's health, build trust and offer effective preventative care.

The data requirements are far reaching. Extensive consultation with all stakeholders was critical to understand each group's role in the system and align on outcomes. Evaluation will be supported by the NEHR, making it possible to securely gather and share patient data for tracking short and long-term progress.

Key elements of a systems-based approach:

- The primary lever for change is to incentivise long-term relationships between family doctors and residents, dismantling existing silos that lead to episodic care.
- Existing power dynamics have been challenged by inclusion of community partners alongside patients and family doctors, to enable healthcare to become part of a patient's everyday life, rather than a one-off transaction at a clinic.
- Implementation of a shared data infrastructure is prioritised for f meaningful evaluation: Clinicians are incentivised and supported via training to upgrade their existing Clinic Management System to integrate with The National Electronic Health Register (NEHR).
- Long-term planning has been prioritised by the Ministry of Health with short, mid and long term outcome indicators.

2. Martini Klinik – reducing the life altering complications of prostate surgery

"If I were a patient with a severe disease, I would like to find a specialized clinic with high-volume physicians and surgeons who can provide me accurate information about outcomes I could expect from the treatment they provide" — Hartwig Huland, M.D., Professor, Co-Founder and Medical Director, Martini Klinik. (11)

The system: The Martini Klinik (a private clinic and a wholly owned subsidiary of the University Hospital Hamburg) and the clinic's patients.

The desired outcomes: For patients to experience fewer life-altering complications as a result of surgical treatment for prostate cancer (12).

Data and evaluation: 'Life-altering complications' are measured in terms that matter to both patients and clinicians:

- one year full continence
- one year severe erectile dysfunction
- one year severe urinary incontinence.

A pillar of success for Martini-Klinik has been comprehensive outcomes measurement and the data gathering to support it, from the clinic's inception. Patients complete a benchmarking survey before surgery and post-operative evaluation continues throughout a patient's lifetime.

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Incentives: As well as a base salary, faculty are awarded a bonus based on number or surgeries, quality metrics and research productivity. The bonuses are pooled and distributed equally.

Co-ordination: This is an example of a provider-led systems initiative. Such initiatives tend to coalesce around developing protocols for care-delivery and demonstrating improved patient outcomes, as in this case study. The relationship with payers is not explored within the literature.

Results: In terms of outcomes, Martini-Klinik shows dramatically fewer life-altering complications compared to the averages in Germany. Patient satisfaction scores are also routinely high.

The Martini-Klinik combines highly specialised outcomes with far-reaching evaluation. Outcomes include dramatically fewer life-altering complications compared to the averages across Germany (see reference 11 for data from 2012).

70-80% of patients opt in to post-operative evaluation and around 70% are still sharing data five years after surgery, which is an impressive adherence rate (12). This is likely to be influenced by the care patients receive, with a faculty member describing their goal to provide counselling for each patient as one would counsel one's own parents (12).

Going hand in hand with well-defined outcomes are the incentives. Incentives for patients are clear: their risk of complications is lower at Martini-Klinik compared to other clinical providers. For staff, bonuses are pooled and distributed equally meaning all staff benefit from improved quality for patients. Staff also benefit from a higher volume of surgeries performed, which is likely to lead to increased expertise, therefore better outcomes and financial sustainability for the clinic.

Our learning from the Martini-Klinik is that orientating a private health system towards medical outcomes for patients leads to better clinical outcomes, better efficiency, higher patient satisfaction and financial sustainability.

Key elements of a systems-based approach:

- Evaluation has been designed into Martini-Klinik's operating model from the start by identifying appropriate metrics and committing resource to gathering the necessary data.
- The distribution of staff bonuses encourages collaboration and shared success, improving both clinical outcomes and the clinic's financial viability.
- Putting the patient at the centre with outcomes they care about (fewer life altering complications) has both shifted the power dynamic between clinician and patient, while also engaging patients in meaningful evaluation.
- Problems arising from power dynamics between payers and providers are addressed by a provider-led approach that starts with designing appropriate care pathways.
- The shared medical & patient satisfaction outcomes, combined with continuous evaluation, leads to better clinical results, higher efficiency and financial sustainability.

3. Building a value based framework for chronic conditions: Psoriatic Arthritis (Phase 1)

BCollaborative's Lili Brillstein shares how previously adversarial stakeholders including payers, pharma and providers developed a shared framework and a new payment model to support value-based care (13 & 14)

The system: Care First (health plan); UCB (pharmaceutical), Specialty-care physicians from relevant disciplines; CrossBridge (analytics company) and BCollaborative (architect of value based care models).

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The desired outcomes: optimise quality and cost of care while enhancing patient experience and outcomes. Achieving this with chronic conditions means the model must also support patients to follow through with their care over the long-term.

Data and evaluation: 20 representatives met to pool clinical and claims data, identifying variations in care and costs of care. Evaluation metrics were identified relating to health outcomes (such as in patient-hospitalisation rate, ER visit rate and RAPID3 PRO) rather than whether clinicians followed specific guidelines. To support robust evaluation, an independent analytics company (CrossBridge) was engaged.

Incentives: All stakeholders (including the payer) agreed to upholding no-risk for providers as an interim measure. That is, providers receive bonus payments for achieving patient outcome targets without risk of decreased payments if outcomes aren't met. This was agreed as an intermediate measure, with a move to providers taking a share of the risk within a few years (14).

Co-ordination: An architect of value-based care models was engaged (BCollaborative). This supported a forum-led initiative that prompted high levels of collaboration among previously distrustful stakeholders.

Results: The published results to date document the first two years of a multi-year project, which has built a culture of shared decision making, identified quality metrics and shared outcomes and agreed a new payment model. The pilot had not yet started at the time of publishing.

This example documents collaboration between historically adversarial partners with very different healthcare roles. Many other documented systems approaches focus on the system of one organisation (like Kaiser Permanente) or organisations within the same context (e.g. providers), whereas this approach presents another level of challenge.

It took a year of facilitated meetings to align on outcomes for this specialty care programme. It was crucial to develop trust before the group could have productive discussions and arrive at truly shared outcomes and evaluation metrics.

A neutral advisor and facilitator (BCollaborative) was instrumental in championing the system and bringing participants back to ‘we’ thinking instead of ‘us vs them’. (Note: This is a similar process to 'Time Out of Time', mentioned above.) The facilitator also provided advice and expertise on building the value-based care model.

External expertise was also sought from an independent analytics company, which presented tools for ingesting claims data, configuring clinical algorithms defined by the team and reporting.

Key elements of a systems-based approach:

- Existing power dynamics can block discussions around shared outcomes. The project demonstrates how this can be remedied through data sharing, collaborative discussion and giving enough time to build trust.
- Commissioning an independent analytics company provided valuable expertise for data ingestion, clinical algorithm building and reporting to support meaningful evaluation.
- The project demonstrates that to build relationships and move away from micromanaging stakeholders, we must move from distrust and defensiveness to understanding and valuing the expertise contributed by each.
- The payment model created incentivised better outcomes for patients without penalising providers, thus further cementing trust.

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4. Zilveren Kruis, Achmea: True Age Test in collaboration with employers

Jeroen Kemperman, Senior Manager Strategy, Business development & Sustainability at Zilveren Kruis, Achmea explains an innovative approach to engaging employers in preventative healthcare.

The system: Achmea (private health insurer and market leader in executing the health system in the Netherlands), health providers and employers.

The desired outcomes: improve preventative healthcare and mental wellbeing to increase the health-span (or healthy life expectancy) of employees.

Data and evaluation: Data on health and wellbeing is collected and bundled at the individual, team and organisation level, to demonstrate the return on investment for a corporate health plan. At the individual level, Achmea uses it's 'True Age Test' (which combines a set of determinants for an individual with a benchmark algorithm based upon data from the Lifelines multigenerational cohort study). For employers, the number of employees able to work more productively for longer is an important metric.

Incentives: Achmea has implemented a straightforward payment model where employers pay a fixed fee to join the programme and a fee for each employee who actively participates. The main incentive for employees is access to personalised health advice.

Co-ordination: This is a payer-led initiative. Change is led by the development of innovative services, designed to develop partnership among system stakeholders. This corporate insurance product goes beyond sick-care and champions overall employee wellbeing to support more productive workplaces and healthier people.

Results: In testing with Achmea personnel, more than 5,500 of 13,000 employees took the test and 20% were then accessing tips and advice to improve their True Age.

In this example the health system is expanded to create benefits an insurer, a provider or an employer couldn't create alone. This benefits employees by giving better insight on how take care of their health. It benefits the employer by reducing sickness-leave and, ultimately, improving employee engagement and making the company a more attractive place to work.

How are the different stakeholders persuaded to come to the table and work together towards shared outcomes? Achmea's approach is to make a diagnosis at the organisation level, then suggest a programme that is aligned with what the company wants to achieve (be it attracting talented people, improving productivity or retaining older for example). The final part of the business case is to show how the impact will be measured. Typically, it is larger corporate organisations that are ready to invest, where their motivations go beyond purely health concerns and include improving recruitment, particularly among young people.

An important consideration for systems change is investment. Projected cost-savings can be very motivating, but they don't remove upfront investment. Jeroen's advice is to be creative about finding investment with partners such as employers, or risk leaving the longer-term efficiencies and cost-savings on the table.

Key elements of a systems-based approach:

- Gathering data to understand motivations of other stakeholders then leading with products that meet them. In this case, employers want a more productive workforce and the insurance product delivers it by improving employee wellbeing and engagement.
- Identifying what each stakeholder needs and delivering on that opens the door for discussions about new collaboration models.

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- An evidence-based approach (using baseline measurements and the True Age Test) makes a strong case to stakeholders for the potential return on investment.
- The evidence-based approach, based on benchmarking and wellbeing data supports meaningful evaluation by defining potential outcomes and presenting ways to measure progress.

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Framework for Implementing a Systems-Based Approach

This paper proposes a five-part framework for private health insurers to consider when working with other stakeholders to implement a systems-based approach.

1. Data
2. Outcomes
3. Payment Models
4. Metrics & Evaluation
5. Leadership & Coordination

Underpinning this framework (figure 1) are the broad aims of creating better value care for patients/members, creating a better patient experience and make progress towards a more financially sustainable healthcare system.

However, it's important to reiterate: these aims are not simply an aspiration for after an insurer's key revenue and business continuity goals have been achieved. Evidence from the presented case studies, along with other systems-based pilots, highlights significant potential to enhance customer satisfaction, improve risk management for insurers and generate savings in healthcare costs.

Therefore, the goals of a systems-based approach are integral for insurers (and other health stakeholders) in meeting business KPIs as economic pressures and uncertainty increase. In short, systems-based approaches offer a way to unlock sustainable business models in times of rapid change.

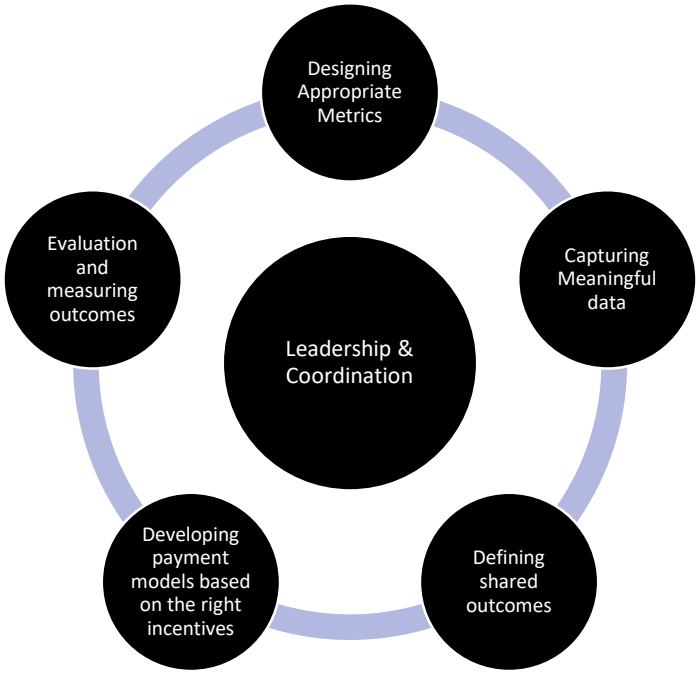

Figure 1: Framework for Implementing a Systems Based Approach © iFHP 2025

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Data

A systems-based approach enables better value care, using data-driven evaluation to support innovation in healthcare. This is achieved through data integration and collaboration.

Systems based approaches use explicit models that can be calibrated to data and repeated by others. A collective process of gathering, analysing and evaluating runs through a systems-based approach and supports all parts of this framework. This, in turn, creates capacity to respond to what emerges across the system, leading to continuous improvement towards shared outcomes.

The golden thread in health contexts will be providing value for patients. Insurers, providers, pharmaceutical companies (and others) all engage with patients at different points in their health journey.

To provide the best service to members and patients, we need to bring the disparate sources of data together to understand what isn't working. Data is also crucial for identifying and delivering preventative healthcare, a key way to improve value for members while managing costs. This responsiveness and data-driven evaluation gives system actors the freedom to innovate, within agreed parameters (the loose part of Tight-Loose-Tight).

The Martini-Klinik approaches the data problem by defining its own outcome measures and maintaining its own data registry of prostate cancer surgery outcomes. This is possible because care is offered in one speciality, prostate cancer care, and the clinic itself holds the means to gather the data needed or holds the primary relationship with other parties who provide data (the patients). For private health insurers, the picture will always be more complex as they are dependent on other parts of the system to gain a holistic view of their members' health journeys.

The barriers to maximising the use and sharing of data in a systems-based approach overlap with those faced by insurers in the adoption of AI:

- data in legacy systems is not well labelled or updated frequently enough
- siloed legacy systems do not have a clear data flow, so cannot pool or share data
- concerns about privacy and sharing personal data.

Private health insurers can start by reviewing claims and member data for evidence of potential areas of avoidable spending or simply to build a picture of the data gaps that are preventing a clear view. Findings can then be used to identify potential ways to engage with other healthcare stakeholders. It's worth reiterating that without clinical data, it is not possible to make system-wide judgements and insurers must be wary of straying into blaming and finger-pointing. The aim must be to present a case for further investigation, together.

Actions for Private Health Insurers to consider – Data Gap Analysis

- Audit available sources of data and identify data gaps
- Identify influential data holders/data gatherers within the system with whom to collaborate
- Review data infrastructure: can data be easily categorised, processed and shared with other stakeholders to support learning?

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Outcomes

Aligning shared outcomes in fragmented systems requires stepping out of entrenched points of view, including diverse expertise and building trust through data sharing and facilitation

In a fragmented system, different elements are usually motivated by different results. They are dependent on each other to achieve their aims, but the way they achieve them (and in some cases, what each element is truly driven to achieve) are in conflict. It is particularly important to pay attention to power dynamics and ensure the relevant expertise and voices are involved in defining shared outcomes. Payers and providers (and other stakeholders) must be encouraged to 'zoom out' and take a view of the bigger system so we can identify shared outcomes.

What constitutes a meaningful shared outcome will be specific to the system and the entities that comprise it. As Lili Brillstein of BCollaborative explains, by combining claims data with clinical data and the relevant clinical expertise, payers and providers can drill down into where variations in care are happening and what the implications are for costs. This allows stakeholders to identify shared outcomes and start to define appropriate measures to demonstrate progress towards those outcomes. Participants must also be prepared to keep stepping out of their habitual, entrenched point of view and understanding other perspective in the system. Where there is little trust between the stakeholders, a neutral facilitator may also be necessary to maintain the necessary conditions for productive discussion.

Examples of Shared Outcomes

- For the Martini-Klinik, outcomes are around reducing life-altering complications of prostate surgery.
- For the Psoriatic Arthritis case study, outcomes include supporting patients to follow through with their care over the long-term, because the condition is chronic.
- Jeroen Kemperman is enthusiastic about the potential of Achmea's innovative Lifespan Proof Housing project (3) to significantly reduce social care spending in the Netherlands. It brings together a system of elderly population members, providers, social care agencies, payers and government around the shared outcome of reducing healthcare expenditure for the elderly. It offers alternative housing arrangements to reduce the numbers of elderly people in nursing or other care homes, reduce loneliness (thereby improving mental health and reducing distress).

Actions for Insurers to consider – Identify potential influencers in your system and their readiness for change.

- How do payers, providers, patients (and others) each define value?
- Is this dialogue already happening? What would need to change to bring payers and providers (and even patients?) round the same table?
- What forums already exist between stakeholders to help facilitate these discussions?
- Who could act as a facilitator in your healthcare system to support stakeholders to step out of entrenched positions and discuss shared outcomes?

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Payment Models

Insurers can drive system change by redesigning incentives: start from the shared outcomes and, in collaboration with system stakeholders, optimise payment models to support them.

According to Nick Astwick (Southern Cross) insurers are well placed to take a lead on redesigning incentives "Funders try and control the clinical delivery, but they need to stand back. They are far better placed to effect systems change by examining the incentives operating in the system. If funders want a different system outcome, they need to change the incentives."

A McKinsey report from 2011 agrees that payers can lead systems change, making the point that a "payor-sponsored" led change uses different mechanisms and incentives to a "provider-partnership" led change. A payer sponsored approach typically centres on innovative payment models that provide incentives for integration of care, with the aim of improving outcomes for patients and therefore giving better value (15).

The system needs to find ways to incentivise the higher-value services, those that will ultimately improve patient experience and create operational efficiencies. While incentives go beyond finance, the financial elements are the most recognisable part of the system's incentives. An obvious way to influence them, therefore, is by redesigning payment models and insurance products.

Insurers are well placed to start that conversation by sharing 'cost of claims' data and engaging providers in assessing total costs of care, with a view to optimising or redesigning payment models that support the new outcomes.

Actions for Insurers to consider – Review 'cost of claims' data and involve providers in assessing total costs of care

- How might the way payment currently happens be a disincentive for providers (and others) to make changes that improve patient experience and the value of care delivered?
- Are current levers for accountability useful - do they direct stakeholders towards their shared outcomes? Can they be measured appropriately?
- Whose expertise and experience are needed to design incentives that will drive desired behaviours?

Metrics & Evaluation

The paradigm shift into systems practice requires flexibility and accountability: investing time in developing robust evaluation with input from all stakeholders, leads to meaningful outcomes.

This framework proposes an elaboration of the concept of trust in the three part model presented earlier in this paper.

The Tight-Loose-Tight strategy (TLT), also referred to above, makes explicit that the key element of enabling trust is also having robust accountability and meaningful evaluation in place. We only know if outcomes are met if we also design appropriate metrics and find ways to gather relevant evaluation data. This must be done at the outset, as Bridgette Collado notes: 12 months after a project is launched, it is too late to realise we need to report on X if there has been nothing in place to gather X data for the last year.

Measuring outcomes is a challenging endeavour and is part of the needed paradigm shift. Selecting appropriate metrics, defining KPIs and ensuring all the data needed to measure them can be collected and stored must be done collaboratively. Doing this well demands significant preparation and research before an initiative is implemented. Firstly, stakeholders must agree on ways to measure outcomes that are meaningful, which will often involve far more extensive measurement than has been conducted before.

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(For examples, see ICHOM's (International Consortium for Outcomes Measurement) sets of patient-centred outcome measurements for different conditions (7).

Stakeholders must also be fully committed to the metrics and KPIs they are each held accountable to and the system must ensure it has the infrastructure and resources in place to share and manage the data.

Once again, data infrastructure plays a critical role in the success of a systems-based approach.

Actions for Insurers to consider – What data infrastructure is needed to support truly collaborative evaluation practices?

- Once shared outcomes are agreed, how can we measure progress towards them? Who is able to/needs to be accountable for measurement and reporting?
- What expertise, resource and budget is needed for effective evaluation?
- If/when our evaluation shows we aren't progressing towards our outcomes, what does that tell us about the system?

Leadership & Coordination

Effective systems change requires visionary leadership, upskilling key influencers and a flexible, all-inclusive approach to coordination for impact

Christopher Bensch, Strategy and Corporate Services at Swiss insurer CSS, shares the following perspective: "Leadership [is needed for systems change] in the sense of being able to articulate a compelling and engaging vision of the future of healthcare, that brings people in motion (employees, customers and partners)."

As systems-based approaches involve such significant shifts, a coherent and consistent approach to developing the necessary skills will be important. However, it is not necessary for all individuals within a system or even a single organisation to be skilled in systems-based approaches. Upskilling key, influential individuals can be enough and the first place to consider is within the leadership teams of each part of the healthcare system.

There are two main directions for competency development to support systems change:

- Building perspective-taking (the practice of stepping out of entrenched perspectives) into an organisation's leadership team (and, potentially, further).
- Leadership in co-ordinating how an organisation interacts with other parts of the healthcare system.

Ron Lavater, CEO of the International Hospital Federation (IHF), is keen to champion systems change skills in hospital leadership teams "Are systems change skills teachable? Yes, and we need people who are being selected for leadership roles to have skill in systems change as part of their toolkit, in much the same way that all leaders now need communication skills".

In terms of co-ordination, the character of a systems-based approach will be different depending on which stakeholder group(s) is sponsoring the change. The four main sponsorship types within health are:

1. Central or top-down – which is likely only to be possible when led by a government or state-sponsored health organisation
2. Provider led – emphases developing protocols for care delivery and clinical accountability, underpinned by information sharing

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3. Payer led – where insurers take a lead, often by developing innovative products or payment models, again with emphasis on shared data
4. Forum led - with even greater emphasis on collaboration in all phases and will likely benefit from some kind of neutral facilitator who champions the system-view.

Based on insight from contributors and the case studies presented above, it is likely that the most successful and most sustained systems-based change will contain elements of all of the above. To address the barriers created by power dynamics, all parts of the system need to be in active collaboration and this is likely to include patients/members as well. The skill needed by leaders will be in uncovering what perspectives are missing from the collaborative effort and finding ways to bring them in.

Actions for insurers to consider – How do we develop leaders to galvanise systems based approaches that tackle the challenges in healthcare funding?

- Where in your system is there readiness for systems change and who may be willing to champion it?
- How can the space and time be created and protected for perspective taking and seeing the wider system view? And how can individuals foster this skill for themselves?
- What forms of sponsorship could work well in the context of your health system?
- How might leadership training help address gaps in systems change skills?

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Concluding Remarks: Moving Forward with a Systems-Based Approach

The evidence presented in this paper underscores the potential of a systems-based approach to reshape healthcare funding and delivery. By aligning incentives, fostering collaboration and integrating robust data-sharing mechanisms, insurers, providers and other stakeholders can collectively drive better patient outcomes, improve risk management and reduce inefficiencies. The case studies explored demonstrate that meaningful change is possible when all parts of the system work towards shared goals, supported by clear evaluation frameworks and flexible yet accountable leadership.

However, transitioning to a systems-based model requires more than strategic planning—it demands a shift in mindset. Health insurers, as key players in the system, have the opportunity to lead this change by rethinking traditional funding structures, engaging in cross-sector partnerships and championing innovation that prioritises long-term health over short-term cost containment. By embracing this approach, the private healthcare sector can not only enhance financial sustainability but also play a pivotal role in shaping a more effective and equitable healthcare landscape for the future.

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