February 2015

VALUE BASED PROCUREMENT (VABPRO) - P 12077

Final report: February 2015

Main authors: Eklund Fredrik, Ikävalko Suzan, Krag Marie, Maksimainen Anna & Treschow Alexandra.

Short description:

- Systemized definition of shared outcome and value objectives that integrate service payers', providers' and users' perceptions
- Analytical approach with use of metrics and reimbursement/incentive models as drivers for system level value
- Value based service design and procurement model to help public providers improve the value and outcome of health and social care services.

VABPRO partner organizations

Nordic Healthcare Group (FI, SE): NHG is a leading consultancy firm in Finland specialized especially in planning and developing health and social care services. NHG offices are located in Helsinki, Turku and Stockholm. Together with our customers, we produce customised solutions for improved productivity, effectiveness, quality and customer orientation. Our work varies from the analysis, planning and deployment of new business models and processes to hospital planning and Due Diligence projects.

City of Espoo (FI): the city of Espoo is the second largest city in Finland and is located next to the capital city of Helsinki. The population of Espoo is around 250 000. Hiltunen Nina, firstname.lastname@espoo.fi

City of Jyväskylä (FI): The city of Jyväskylä is located in the lake district of Central Finland. Jyväskylä´s population growth rate is one of the highest in Finland, currently the population is at 132 000. Solankallio-Vahteri Tytti, firstname.lastname@jyvaskyla.fi

City of Landskrona (SE): The City of Landskrona is located in Southern Sweden (the Skåne region) and has some 42 000 inhabitants. The municipality is – among other things – responsible for the provisioning of social care services to the elderly and health care services provided in a home environment or in elderly housing. Klang Vanerklint Eva, eva.klang.vanerklint@landskrona.se

Copenhagen Living Lab (DK): CLL is a leading Danish consultancy firm, operating in the field of user-driven innovation. CLL develops and facilitates complex co-creation processes, where mutual business partners and customer become involved as active players in the development of new solutions. CLL makes use of user-driven innovation as a systematic approach and qualitative scientific method, in creating insight into unmet or unidentified user needs. Krag Marie, mk@copenhagenlivinglab.com

Forum Virium Helsinki (FI): FVH develops new digital services in cooperation with companies, the City of Helsinki, other public sector organizations, and Helsinki residents. The aim is to create better services and new business, plus to open up contacts for international markets. FVH is a part of the City of Helsinki Group. FVH's innovation projects focus on the following themes: Wellbeing, Smart City, New Forms of Media, Environment & Sustainability, Innovative Procurement, Growth Services and Innovation Communities. Ritvos Roope, firstname.lastname@forumvirium.fi

Norrbotten County Council (SE): The county council is responsible for provisioning of all health care in Norrbotten and employs a total of 7 000 persons. Services are provided both in-house and through procurement. Kristian Damlin, firstname.lastname@nll.se

Fact-sheet

Title and project number:

P 12077 Value based procurements in primary and social care (VABPRO-project)

Main authors:

Eklund Fredrik, Nordic Healthcare Group (SE), firstname.lastname@nhg.se
Ikävalko Suzan, Nordic Healthcare Group (FI), firstname.lastname@nhg.fi
Krag Marie, Copenhagen Living Lab (DK), mk@copenhagenlivinglab.com
Maksimainen Anna, Nordic Healthcare Group (FI), firstname.lastname@nhg.fi
Treschow Alexandra, Nordic Healthcare Group (SE), firstname.lastname@nhg.se

Other partners have contributed to their case descriptions.

Key words:

Public procurement, service design, health and social care, value, outcome, user-driven innovation

Abstract:

The VABPRO model is designed to support the design and procurement of innovative solutions in which outcome and value is central. Value based procurement models have the potential to significantly enhance quality of health and social care services beyond the impacts achieved with prevailing practices and reimbursement models.

The VABPRO -project addresses fundamental challenges with governance of social and healthcare services, particularly for groups of individuals and patients with complex needs who often receive care from several different organisations and service providers. In particular, the project addresses user-driven service re-design and procurement as a means of shifting focus towards value and the many challenges related to this.

The main deliverable of the project is a proposed model / manual for Value – based procurement which is generic in structure, but emphasizes case-specific prerequisites for making the model work.

VABPRO –project was funded by Nordic Innovation and carried out between March 2013 and December 2014.

Executive summary

The VABPRO model is designed to support the design and procurement of innovative solutions in which outcome and value is central. The driver for such an approach is the hypothesis that financial incentives aligned with defined quality objectives can improve health and social care. Value based procurement models have the potential to significantly enhance quality of health and social care services beyond the impacts achieved with prevailing practices and reimbursement models.

The VABPRO -project addresses fundamental challenges with governance of social and healthcare services, particularly for groups of individuals and patients with complex needs who often receive care from several different organisations and service providers. In particular, the project addresses user-driven service re-design and procurement as a means of shifting focus towards value.The foundation of the project is formed by a number of case studies representing different settings within social and healthcare in Finland, Sweden and Denmark. The case studies also represent different stages in the service restructuring and procurement process, from feasibility analysis to executed commercial public procurement.

The main challenges and therefore focal points of the project have been turning focus from traditional focus on output in procurement, creating a joint understanding of value and understanding the user-perspective in value creation. Some methodological inspiration has been found outside the Nordics.

The main deliverable of the project is a proposed model / manual for Value – based procurement which is generic in structure, but emphasizes the case-specific prerequisites for making the model work. It can be boiled down to a few critical steps:

- Thoroughly understanding of the service which is subject for procurement and the target group to which it is directed
- Finding the “sweet spot” where patients and customers perception of value is aligned with the commissioner’s desired outcome of the service
- Defining relevant metrics and securing that these metrics can be continuously monitored and evaluated
- Defining incentives for the service providers and implementing a value-based reimbursement model based on relevant metrics and objectives

There are evidently several challenges related to implementation of the model e.g. in terms of organisational governance, need for evidence-based methods, data availability and quality and, simply, putting your money where your mouth is. However, the case studies jointly show that it is not unrealistic and it is in many cases a rewarding and even necessary exercise to take.

Aspirations that support Value based services and procurement include;

1. Embrace Impact Accountability as a common value
2. Establish a common language and data infrastructure
3. Apply best practice guidelines and aim at common/shared standards
4. Evolve – strive for continuous improvement

We believe that the Nordic societies need to be front runners in providing and investing in publicly paid services that really make our citizens feel that they have been helped and cared for in a manner that meets with their needs and create tangible value.

In the end, also the service providers will benefit most for providing the service which is really needed. Understanding the clients and users' needs will help Nordic service providers also to develop services for other markets often very similar to ours. Striving for better (system level) value for money will slowly but surely also hopefully shift the balance towards prevention and empowered citizens - and thus create both savings and better wellbeing for our Nordic societies.

Last but not least we wish to thank Nordic Innovation for supporting collaboration between Nordic countries health and social care players. We feel it has been worthwhile strengthening our ties, learning from each other and working towards a shared Nordic Value.

The report structure

The first part of the VABPRO report describes and defines the starting point of our work as a problem statement. As next step we discuss the concept of value and means how to drive value. Then the VABPRO hypothesis are reflected on the state of the art understanding of the partner organizations in order to locate the main areas of development and support needed to implement VABPRO thinking.

Chapter 6 discusses the concept of demand and user driven innovation (UDI) while chapter 7 reflects UDI and service design in our VABPRO cases. Chapter 8 describes the generic model and main steps for carrying out value based procurements in health and social care. Chapter 9 provides some recommendations. Chapter 10 then continues the discussion to future development and application possibilities.

In the end of the report we have included the descriptions of our VABPRO cases. The cases represent a wide spectrum of health and social care services, where we have tested the VABPRO thinking. Some cases are real life service development or procurement cases – some still hypothetical cases, which have not yet been tested in real life.

Overall, based on the evidence and experience so far, we are confident that the VABPRO model will provide a new starting point for the development of various health and social care services. VABPRO manual with its check list provide one concrete starting point for this development.

Content

Nordic Healthcare Group

1. The initiative from Nordic Innovation

The public sector is by far the largest buyer and consumer of health care products and services in the Nordic region. This creates a major opportunity for demanding new and innovative products and services from the private sector.

But public organizations are not conscious enough of the potential in using procurement and innovation on a strategic level. Cooperation and exchange of knowledge between public procurers is limited, and there is a need for improved dialogue between procurers, suppliers and the users of the services.

The aim of the Nordic program Innovation in the Health Sector through Public Procurement and Regulation is to make a change: To create better public health services through competence building and collaboration, and to develop the supplier industry through closer contact with the public buyers.

The ultimate goal is to make the Nordic region a global frontrunner in the field of innovation procurement in the health sector.

The program is one of the six so called lighthouse projects that the Nordic Ministers of Trade and Industry agreed on for the Nordic cooperation program for innovation and industry policy 2011-2013[1]. Ministry of Trade and Industry in Norway is the owner of the program *Innovation in the Health Sector through Public Procurement and Regulation.* In October 2012, Nordic Innovation together with its partners Tekes, Vinnova, the Danish Business Authority, Innovation Norway and Rannis launched the call The Nordic region as frontrunner in innovation procurement[2].

As a result of this call three cross-Nordic projects were financed and started in spring 2013, namely;

1. Nordic Public-Private Innovation Net (PPI NET)
2. Integrated training program and demand dialog network for Innovative Nordic Health care Procurement (INHP)
3. Value based procurements in primary and social care (VABPRO)

[1] http://www.nordicinnovation.org/projects/lighthouse-projects/nordic-lighthouse-projects/
[2] http://www.nordicinnovation.org/Documents/Calls/CALL_publicprocurement_final.pdf

Value based procurements in primary and social care (VABPRO)

The VABPRO project focuses on primary care (GP-practice and health centre operations) and social care (elderly care services and services for the physically and mentally disabled). VABPRO-project set as its aim to develop a value based procurement model. The aim was also to contribute to a system shift from price-driven procurement to a value based and holistic approach where factors such as patient experience and prevention are integrated.

In a procurement-perspective, the municipalities procure health services or reimburse health costs. A change in the way these services are procured, can lead to win-win-win, where society (tax money), patients and suppliers all can bring their knowledge to the table (co-creation) and also benefit from the better results. In the best possible situation Value based service design and procurement creates (service) system level savings and better overall services based on users real needs.

Participants:

Finland: Nordic Healthcare Group (project manager), City of Jyväskylä, Forum Virium Helsinki, City of Espoo.
Sweden: City of Landskrona, Norrbotten County Council.
Denmark: Copenhagen Living Lab.

Objective:

The main objective is to support and develop procurement that creates overall system level value and has been defined as:

A. Procurement that is user-driven based on real needs
B. Procurement that delivers better quality services and patient satisfaction
C. Procurement that is problem solving in co-creation with the suppliers

Deliverables:

The main deliverables of the project are summarized below:

1. Gather knowledge base of value based procurement in primary care from global experiences and literature
2. Analysis of structural, legislative and analytical characteristics in the countries. Identification of common key success factors for development of value based procurement.
3. Create a training and coaching program to increase value based procurement understanding within participating healthcare organizations
4. Design value based procurement models with the participating healthcare provider organizations
5. Gather experiences from the components 1-4 into a value based procurement manual to distribute value based procurement skills within Nordic healthcare organizations.

2. Problem statement

Health care systems in the Nordic countries are generally good in a global perspective. Commonalities are shared across the Nordic Countries and the health care systems are built on the same principles of universality and equality. Although, generally sound healthcare systems, financing health and social care will be a challenge for our nations in the upcoming years. Moreover, it has become more evident that the way the health systems have been financed until now has resulted in organizations and care processes that are optimized for output and are lacking patient focus. The welfare states have turned the population into passive recipients rather than active co-creators of health care services. The challenges ahead will be to change the focus from output to outcome, include a patient perspective and to drive the needs of care backwards by shifting attention to maintaining and regaining health and independence from productivity.

Focus on the prevention and needs reduction of heavy users

Health care needs and costs are not equally distributed among the populations of the Nordic countries. A small portion of the populations is responsible for the majority of costs in health and social care. Only about 10 % of the population in Sweden give rise to 80 % of total health and social care expenses and the proportions are similar in the other countries. Effective and focused preventive measures and services directed towards these patients can prove to become highly value-creating alternative investments. Thus, innovative new approaches to system level improvements merit a focus on these individuals.

Most health and social care services provided by municipalities and county councils are not part of system of free choice. For these services financing is made through existing resource allocation and there is virtually no connection between quality, performance or outcome, and economy. In systems of free choices, only some kind of purely performance-based reimbursement models are applied without any relation to outcome and value of the service. The conclusion is rather bleak:

Hardly any of today's service providers have clear financial incentives to improve outcome or subjective value of caretakers.

Objectives on increased value need to be aligned with provider incentives. The primary focus of health care professionals is to help their patients, but financial incentives set the frames of the operations. From our experience, provider incentives are primarily achievable through financial mechanisms. As mentioned above, the current performance based reimbursement models applied in health and social care do not offer incentives to providers to reduce needs or overall costs for services. Rather, the incentive is to achieve an increased demand for their services. The objectives of any health or social care service must clearly be aligned with provider incentives, since provider incentives direct the results of the service.

The ultimate challenge is therefore how to create provider incentives that both improve perceived quality of the caretakers and reduce service needs as well as overall social and health care costs for the payers, as illustrated in the figure below.

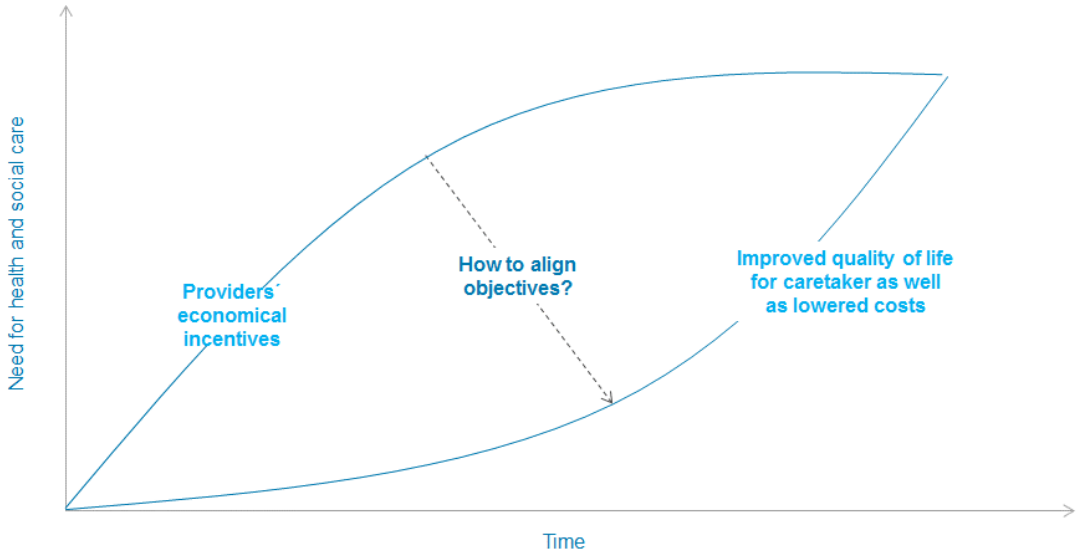


Figure 1. The "Incentive paradox" – A starting point for VABPRO. Source: NHG

3. Orientation to the concept of value

Dimensions of value in health care

The value concept in healthcare is a concept that all stakeholders instinctively can agree on, that is to aim improving outcomes and do it as efficiently as possible. The Harvard economist Michael Porter defines value in health care as "health outcomes per dollar spent" and this definition has become broadly adopted.

In reality value definition is difficult and needs to be defined and agreed on for every situation. What matters for one patient might not matter as much to another. Identifying what most patients can agree on matters for a given service could still be outside the scope of what the provider would define as an outcome of the service provided. Beside, a payer´s perspective could be to include costs for the patient over a meaningful episode of care, of which a provider´s service may only make up a part. Then the accountability for the overall cost and final outcome of a care episode particular would be shared over organizational silos. Provider accountability without influence and control will not be a driver for development, innovation and improvement. Thus, the services included in a care episode need to be organizationally linked.

In summary, defining outcomes and which costs to include are essential to assess whether value is improving, but here lies the difficulty in implementing value in the current Nordic healthcare systems.

From output to outcome

Traditionally health organizations have focus on outputs but outcome data are increasingly being applied as objective measures of quality and performance. Output could be in terms of health services (e.g., visits, drugs, admissions) and health outcomes could be preventable deaths, functional status, blood pressure level. Output are in more direct control by the provider than outcome and ultimately, value. Without the external factor influence that impacts outcome and value, output more clearly represent provider performance which makes it attractive for management and steering. Measures to improve efficiency can be effective, but lack the perspective of relevance and improvements are made as sub-optimizations in silos. For instance, efficiency measures could evaluate the relative cost of a hospital stay for a condition without considering whether the admission was preventable or appropriate.

Outcome is not fully a result of the provider´s performance; it is the result of co-creation with the user or patient. The fundamental co-creation characteristics makes in instantly more complex than output and it includes the user or patient into the parameter in addition to other external factors.

Output is rarely fully aligned with outcome and value. An illustrative example of outcome/value complexity is the outcome/value of smoking cessation from a stop-smoking program. To what extent can the provider actually affect outcome vs. the patient him- or herself? In the case of smoking-

cessation, the patient´s role in achieving the outcome, for instance with personal motivation is easy to identify. Can the degree of causality be quantified? It is likely challenging to answer to which degree the patient´s role and the provider´s role is responsible to the outcome. Smoking cessation is an apparent outcome in the case of stop-smoking programs, but as mentioned above already identifying outcome and value for a health care service can be a challenge.

User-driven-innovation as tool to define value as perceived by the users of the service

User driven innovation is a valuable approach to unfold and specify value as perceived by the users of the service, unravelling the value factors relating to e.g. patient engagement, resilience, patient motivation etc. To produce strong and operational user or patient focused concepts it is important to ask what is important to the people in question - in relation to the situation and context of a service. When systematically asking oneself questions in this direction, concerning for instance the specific challenges and motivations of the service receiver, it is possible to identify value concepts in accordance with the needs of the target group.

An important cornerstone in user driven innovation is the qualitative, explorative methodology, or "innovative ethnography", which allows for in depth exploration and understanding of specific problems and needs. Innovative ethnography basically applies a systematic methodology to look for important expressions and matters related to the experience of quality for the service receiver. The outcome of this process is the definition of explicit criteria that can be used as measures for perceived value in an innovation and evaluation process. Innovative ethnography, and the user driven innovation approach, thus allows us to understand and unfold the service experience. By clarifying the value definition from a service receiver's perspective, we can look for, or develop, the right service solution.

VABPRO – in pursuit of tangible value in today´s Nordic social and healthcare

Although outcome and value are concepts that are discussed in health care policy, procurement in the Nordic countries today almost exclusively focus on resources, production and output. Below is a schematic presentation of the production process of health and social care services. The VABPRO ambition is to harness value in health and social care services and stimulate innovativeness through value based procurement. The aim is to provide commissioners with directions to how to pursue value by focusing on the more advanced steps in the process of service production within the context of procurement (figure below).

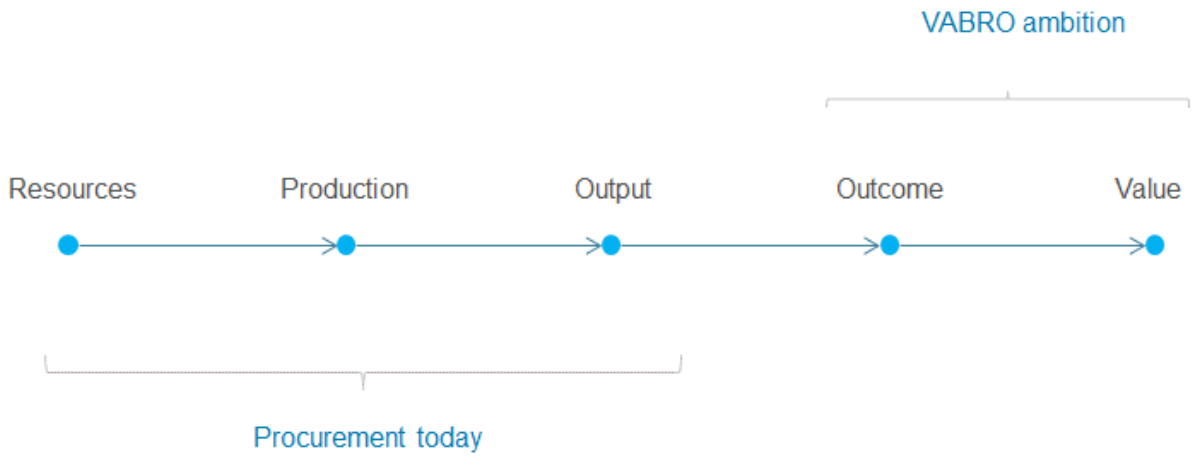


Figure 2. Dominating procurement principles and the VABPRO ambition. Source: NHG

VABPRO seeks to promote value overlapping with outcome by an innovative procurement process design taking into account both the commissioner perspective as well as the user/patient perspective. A foundation for this is obtained through identification of outcome and value metrics that are agreed to be overlapping.

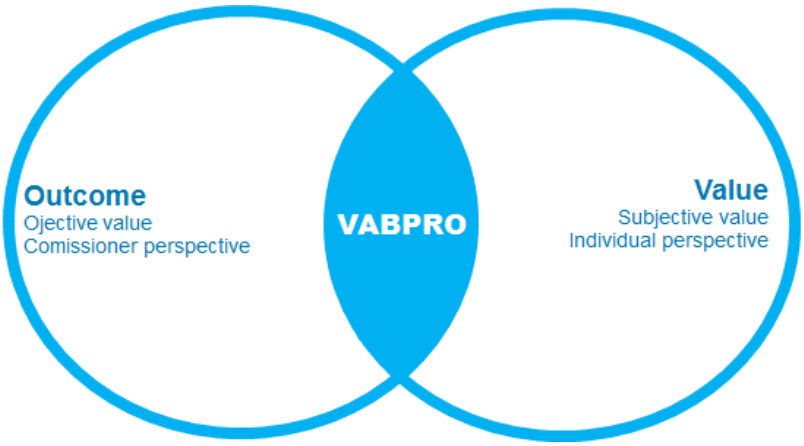


Figure 3. VABPRO – perspective on value (illustration). Source: NHG

In the identification of values overlapping with outcome, a dialogue with users/patients is often required on their needs and requirements to reach a thorough understanding of their perception of value, e.g. with user driven innovation methodology.

The framed outcomes/values will then be used in a process of developing provider incentives. The first step in this process is the identification of outcome/value metrics that can be used by the procurer. These metrics must be highly objective and linked to provider performance in order to be relevant. Established

and validated instruments and analytical models are preferable and require less time to put in place. Regardless if the metrics are new or established, it is important that from all perspectives (commissioner, provider and user/patient) they are appropriate and trustworthy.

The next step is to link incentives to the metrics chosen. This is done with an anticipated value enhancing behaviour of the provider in mind. The incentive can be both positive (bonus) or negative (penalty). A risk/benefit assessment from the provider perspective is important. Finally a reimbursement model is constructed that encompasses the value-promoting incentive to promote a higher quality service. Tangible value created with the service can only be ensured and made evident with proper monitoring and evaluation metrics and frequency.

Aim of value based service design and procurement is a win-win-win situation

Value based innovation should thus lead to a "win-win-win" situation for the payer, user and provider of the services (service system level cost/benefit, user value, business case) with following gains:

Win. 1: Cost-effective and high quality public services
Win. 2: Sustainable Service and Business models and new Business
Win. 3: Better user needs adopted services, incl. user engagement & empowerment and service adaptability

This VABPRO process approach fully supports this aim while each step taken adds to the value generating outcome. This situation can be seen in the following illustration, where the first modules contains the user-driven design of the new service, the second module includes the economic rational and parameters that drive a cost-efficient way of providing the services and the third module represents the outcome – i.e. a situation where all three (payer, user and provider) actors value objectives are fulfilled.

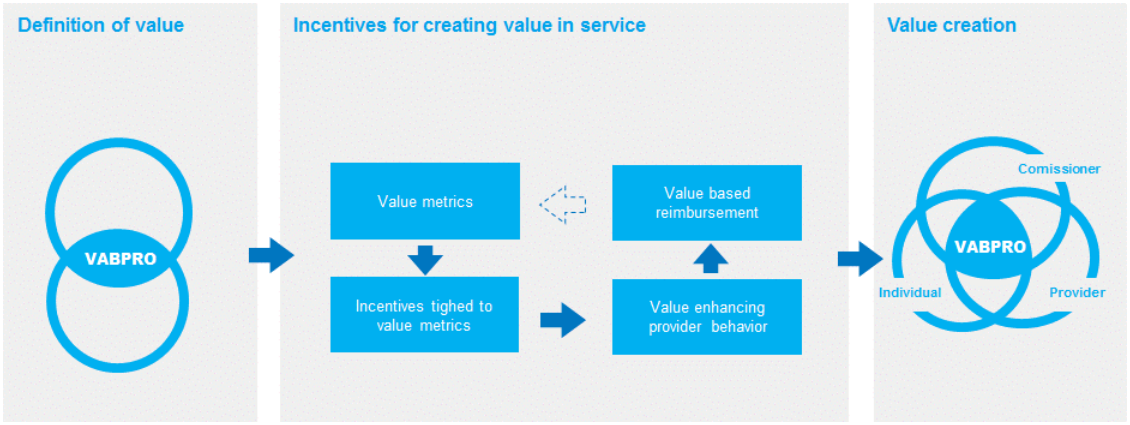


Figure 4. VABPRO – from value definition to value creation. Source: NHG

4. VABPRO organizations preconditions, perceptions and skills

NHG Finland made a study in 2014 which revealed that 70% of Finnish of public health and social care organizations say their operation are organized and produced in a user-centric manner.

Also the VABPRO project started with a similar short study in 2013. The aim was to create an understanding of the existing situation in the public organizations involved in the project and to provide the State of Art platform to develop the VABPRO-model. The results of the questionnaire showed that participating public organization were fairly confident and familiar with the key issues around value based service design and procurement. However, in line with the above mentioned NHG Finland client inquiry, also VABPRO work revealed that the reality is somewhat different and challenging than the perceived situation expressed in the questionnaire answers.

Knowledge building and support is needed on many levels and in many areas of innovative and value based procurement. Much more than what was the outcome of the questionnaire, which covered among others the following issues:

Degree of social and healthcare integration in services **- can we move ahead with these issues in VABPRO**	**Starting point: Strategic framework and competences:**

• Services are poorly joined up and in silos
  ○ Organizational and budgetary alignment
  ○ ability and willingness to share objectives and funding/budgets
• Services are not designed around the customers / users
• Overlaps and gaps in provision, poor sequencing of interventions etc.
• Services focus more on cure – and not care
  ○ Resources should be moved towards early or preventive intervention
• (Co-)commissioning of complex cross-cutting outcomes (with touch points in primary care, social care, etc. services)
• Service transformation by providers across service boundaries
	• The partners have carried out some activities around innovative and/or value based procurements, however, the organization's internal capabilities, competencies and knowledge for conducting innovative procurements are estimated as average
	• The capacity for carrying out UDI & In-house competencies for applying UDI methodology were estimated either as high or as moderate
	• All procurement cases are part of public services renewal-, industrial policy-, or procurement strategies
	  ○ However, the degree of commitment from management is not in the level it should be
	• In all organizations role of patient empowerment and prevention is included in organization's strategies and made the priority in operations
	• Partners are familiar with the use of bonus/sanctions models or other types of performance based measuring, metrics and incentivizing models, but they have not yet been utilized in practice.

• Payment for multiple outcomes when achieved	○ Services are often productized and strictly defined by price. • Hands on experience of pre-procurement co-creation and specifications setting, aiming at an open Innovation challenge (i.e. functional / outcome / value based specifications) is still scarce ○ Focus is still heavily on the public procurers role in planning the procurements alone ○ cooperation with other public procurers nationally and/or internationally needs a boost

Identified support needed to develop VABPRO cases

Based on the VABPRO questionnaire and discussions with the VABPRO project participants the following areas were identified as important for successful case development in this project – and organization also clearly needed support in these areas:

- **Analytical tools and information** (e.g., service use and needs analysis, metrics, bonus/sanctions models) and **implementation support**
- **Service design**, i.e. – how and when to apply user-driven innovation (UDI) methodologies and tools and engage the users of the services in the co-creation and procurement process

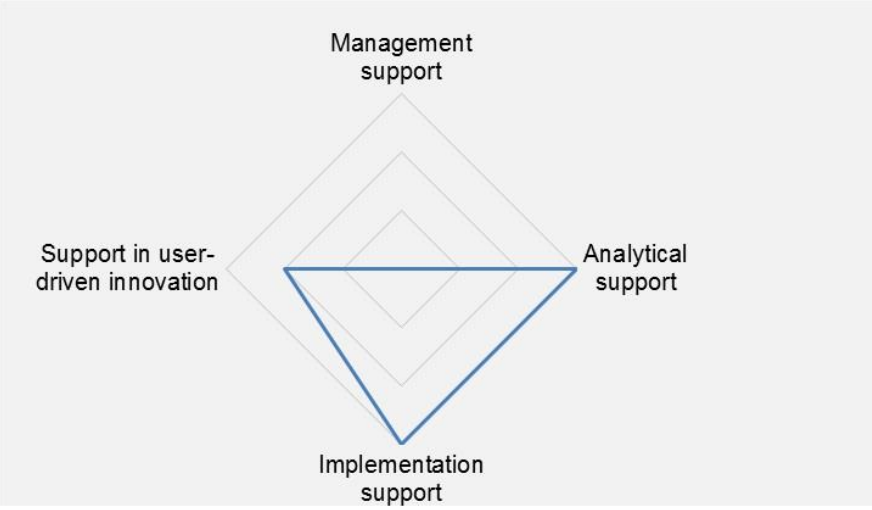


Figure 5. Expectations for VABPRO. Source: NHG

5. Methodological inspirations/distinctions behind VABPRO

Paradigm change, public procurement practises

The health care systems in the Nordic countries are facing great challenges. Health and social care needs are increasing and resources are limited. What are the implications for external service providers in health and social care in a world of scarce resources? Payers in the health care systems can utilize the procurement process to drive innovation, develop new solutions and ultimately secure improved "health outcomes per dollar spent", to quote Michael Porter. The health care systems in the Nordic countries are not averse to this approach, but they are challenged by how to achieve it in practise. Some inspirational cases for VABPRO are presented below.

UK: Reablement

Reablement is a service that has been adopted nationwide in the UK as well as in Australia for the last decade. Reablement services are targeting different users in different ways in different places, but there are a few distinct definitions:

- Support for people with poor physical or mental health or a disability to help them live as independently as possible by learning or relearning the skills necessary for daily living.
- An approach or a philosophy within homecare services – one which helps people do things for themselves, rather than having things done for them.
- A temporary service offered for a limited period of time

Reablement is generally designed to help people learn or relearn the skills necessary for daily living which may have been lost through deterioration in health and/or from increased support needs. A focus on regaining physical ability is central, as is active reassessment throughout the reablement episode.

Studies have shown that reablement improves outcomes, particularly in terms of restoring people's ability to perform usual activities and improving their perceived quality of life. Reablement has also been found to achieve cost savings through reducing or removing the need for ongoing support from traditional home care and other related services. However, there is currently little research on or evidence to suggest that it reduces primary care or hospital care costs, although indications point to that it can be achieved.

USA. Accountable care organizations (ACO)

The affordable Care act is a health care law from 2010 that includes provisions for the implementation of ACOs. An ACO has a payment and care delivery model that tie provider reimbursement to quality metrics and reductions in total care costs. So far, three pilot programs have been initiated. There are three main characteristics of an accountable care organization:

- The organization is led by health care providers and has a strong element of primary care. Healthcare providers in the organization are jointly responsible for the total health care cost and quality of care for a well-defined population.
- The reimbursement model is linked to quality improvements and cost reductions for the defined population. If cost savings are achieved (compared to predicted costs) the ACO may receive a financial bonus.
- The organization makes use of reliable and progressively more sophisticated quality measurements to ensure that the savings are achieved by better coordination of care and prevention. The financial bonuses are linked to the fulfilment of the quality measurements.

There are some evidence suggesting that ACOs reduce costs, especially for patients with high and complex care need. Also, results from pilot studies suggest that clinical quality is improved by ACOs.

6. Demand and user driven innovation – a tool to create Value

A general introduction to User driven innovation (UDI) / Service design with focus on social and health/primary care services

Why to use UDI / Service design when designing health/primary care services

Delivering a service always means some degree of involvement of the "service receiver" – e.g. the patient or care receiver of a care or health service. Thinking of a specific care service like medication of a hospitalized patient, this becomes clear. The service provider (the care giving nurse at the hospital) would not be able to operate and deliver the service (giving medicine to the patient) without the patient receiving the medicine. The same chain of reasoning can be applied to more tangible service products - e.g. a pill dispenser for home medication. The immediate interactions between the provider and the service receiver are less apparent when the solution at stake is a tangible product, rather than a service. However products as well as services have no relevance unless they enable the user - or service receiver - to perform the job in a meaningful way.

Unfortunately it is often the case - for both service and product deliveries - that the needs and immediate value experiences of the user or service receiver are not inherent to the providers design and operation practice.[3] As stated earlier in this report, this can - partly - be explained as a gap between the focus on output on the one side and on outcome/value on the other side; as different objectives at stake, when developing or optimizing services within social and health care. These two kinds of focus are not necessarily conflicting; rather they represent different perspectives and definitions of value.

When we experience that existing organisations and care processes are lacking a patient focus; that service operations are run and new product and service solutions are designed and implemented to optimize for economic output (reduced public spending, more cost-effective operation systems, etc.), the question to be asked is how to orchestrate the optimisation and design of services in a way that emphasises the experienced value of the service taker in terms of experienced quality of care and perhaps even optimized life quality in general. In other words, how do we optimise for the desired outcomes of the care receiver or patient, by incentivising design and implementation of services that optimise the experienced quality of life of the care receiver, reflecting a holistic health and care ecology?

User driven innovation (UDI) offers an approach and a range of tools that have proven successful to bridge the gap between a provider's and user's (service receiver's) perspective. Whether the goal is a

[3] Marc Stickdorn & Jakob Schneider (2011:36): This is service design Thinking., BIS Publishers, Amsterdam

complete redesign of a new care service or it is to identify points of optimisation of an existing service, UDI offers a mind-set to slip into the shoes of the service receiver; to explore and grasp the specific needs and motivations of the (potential) end user related to a particular context of use, and to apply this in the development or optimization process.[4]

User and people-centred value creation

To do user driven innovation is basically about taking a needs or a problem oriented approach. A qualitative explorative methodology, and tools such as explorative interview, participant observation, customer journey mapping, etc., is applied to allow for in depth exploration and understanding of the specific problem and needs, that a given service solution aims to meet. In order to define and develop the right service solution for a specific target group, we need to be able to identify and comprehend the needs and motivations relating to the service subject – which often includes a thorough understanding of the life context of the service taker; of daily practices and experienced challenges relating to his or her health and care situation.

When applying this explorative approach to the process of designing new service solutions, it makes sense to speak of people driven innovation, rather than user driven innovation. We aim to approach our target group as people, with needs and motivations that are ascribed to their particular way of life, and not necessarily to their position as users of a given service or product.

Just like a Business Model Canvas[5], or similar business developing tools, can be applied to help unfold all relevant aspects and areas concerning the production and delivery of a product service system (output focus), a People value Canvas can be applied, supporting the service designers and developers in doing people-driven innovation; i.e. support making people the focal point of the innovation process.

The People Value Canvas is not a method but a framework for interpreting requirements for successful value creation. It focuses on factors that promote and search for possibilities in every solution to path the way for people-centred, or empathic, value propositions to emerge and increase.[6] By this we mean value propositions that are built upon deep and sincere understanding of the needs and desires that drive and motivate the people targeted for the solution/innovation in focus.

---

[4] Marc Stickdorn & Jakob Schneider, (2011:37): This is service design thinking., BIS Publishers, Amsterdam

[5] See *Business Model Generation – A Handbook for visionaries, Game changers, and challenges (written by Alan Smith, Alexander Osterwalder, Yves Peigner & time Clark)*

[6] Mie Bjerre, Thomas Hammer-Jakobsen, Dick van Dijk, Jesper Lund, Sabine Wildevuur & Anne Äyväri (2013:137): Connect, Design for an empathic society, BIS Publishers, Amsterdam

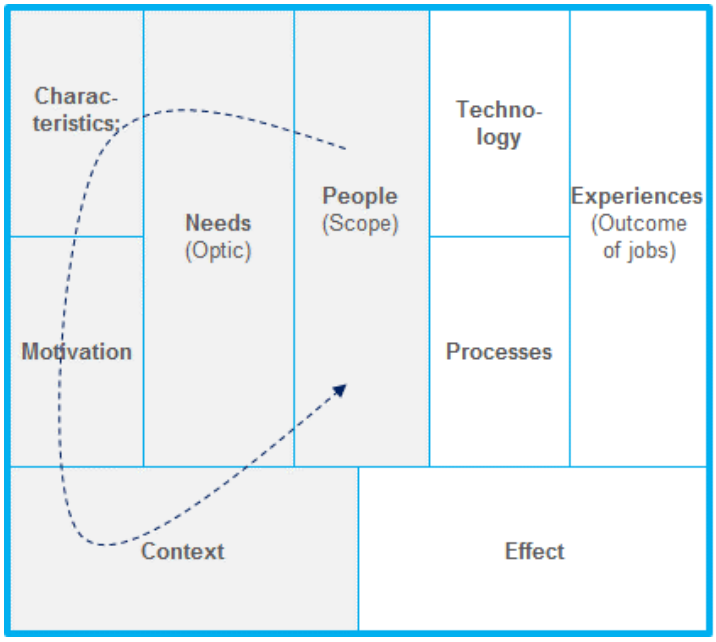


Figure 6. *People Value canvas©:* People take centre stage in the people value canvas. The canvas paths the way for an empathic value propositions to emerge: The squares of the canvas are filled in, and revised, in an ongoing iterative innovation process; looking into needs, characteristics and motivation relating to context and experiences, technology and processes relating to effect.[7]

The strength of the people value canvas is its insistence on asking new kinds of questions about what in a service provider's offering is important to people. A thorough presentation of the methodologies and palette of tools for implementing a people driven innovation process is out of the scope of this report. The crucial point here is to sketch out the significance and consequences in terms of the value optic offered by the people driven approach.

When encouraging, in the innovation process, the identification of people-specific needs, follows the definition of differing - needs-related - values specific to the target group. People (or user) driven service development, and innovative procurement of health and care services, thus means targeting and defining value as the desired outcomes of the service taker. But how do we define - and work with – value as a differing, needs- and context-specific, concept?

Generally put, value depends on what is valued. We may speak of economic, social, ethical, moral, ecological, or political value. However, this multitude of aspects or types of value should not discourage us from thinking systematically about value creation and key dimensions to which this array can be reduced. The aim of people driven innovation is to prove that social value and meaningful differentiation can be produced as systematically as economic value. This combined systematic - or strategic - and people-driven focus is what characterises the user driven innovation process.

[7] Bjerre, Hammer-Jakobsen, van Dijk, Lund, Wildevuur & Äyväri (2013:137)

A model of value based procurement – for implementing a value based innovative procurement process in social and health care services - thus encompasses a systematic, people-centric way to identify or synthesize operational value metrics.

How to use UDI in a way that creates measurable added value

In chapter 11 (Appendix) case descriptions exemplify how the user driven methodology and tools have been implemented in practice to generate outcome-focused value metrics in concrete procurement processes within social and health care.

When planning and managing a value based procurement process, which (as opposed to a regular procurement process) builds on an innovative methodology, it is important to pay note that a larger work load than usual is required before the actual preparation of the tender. New kinds of tasks are required in the early stages of the process. This means that, apart from an increased work load, there is a need for different kinds of expertise and resources, than what is usually required in a procurement project. (This new expertise could include anthropologists/ethnographers, researchers, service designers and innovation consultants, besides practitioners/professionals and experts within specific social/health care domains). At the same time there is a strong need throughout the entire process for setting up and maintaining a close, cross-disciplinary collaboration between the different expertise and stakeholder groups involved (public/private level, political/strategic level and financial expertise).

The value based procurement can be approached in different ways, and the extent and activities at the different stages prioritised differently, according to the scope, scale and available resources of the project. (The resource factors include for instance staffing/composition of the project team, process and time frame, access to existing knowledge and research, etc.) Regardless of the scope, however, the general idea in the value based procurement process is to keep a combined focus on effect (defined as people/user centric outcome) and a systematic, iterative approach to the (innovative) process of defining the desired effect.

Effects are defined based on the consultation of real experienced needs. At a general level effects are specified throughout the (value based, innovative) procurement process, moving from a more abstract level of effect understanding to a concrete specification of the task that the service solution will have to meet: In the first stage of the project, during prioritisation, the desired effect will outlined based on strategic considerations. At the following operational stage ethnographic research and analysis is typically applied to identify the most important needs insights relating to the users (target group) and situational context in question. At the succeeding and final stages of the process (dialogue and tender) the identified (desired) effects are thus implemented and qualified through dialogue with supplier and evaluation of possible solutions/proposals. Hence effects are “consolidated” through an iterative process of defining the effects and unfolding of the problems and opportunities relating to the service task.

This iterative, effect-driven approach ensures that the focus on effect is rooted in an in-depth and systematic problem-understanding process, and that the aspired solution - including the impact measures of a given tender - builds on a thorough understanding of the user needs and context.

To allow for a systematic assessment of service solutions – proposed by suppliers - it is important to translate the desired effects into "operational" search criteria or/and actual value metrics, that can be evaluated. Depending on the activities and methods implemented the results of the analysis can be a listing of user specific functional requirements, description of user segments/profiles, directing the dialogue and subsequent evaluation of service solutions.

7. UDI / Service design in each VABPRO case

As described above the user driven innovative procurement process can be approached in different ways according to prioritization, scale and scope of the project. In the cases described below various methodologies and analytical tools has been used to apply a people/patient centred and value based approach; this includes quantitative data gathering and analysis, cross-organisation audits, qualitative needs assessment and innovative ethnography, direct user involvement, together with by cost analysis and economic assessment.

The different cases are representative of differing process focuses. They are as such not "complete" cases – below follows some suggestions as to added activities that could added or considered in similar cases.

In the Norrbotten case the problem centred approach could be further embraced by implementing a qualitative needs oriented approach (innovative ethnography) in the coming specification of value metrics and evaluation criteria for new service, treatment and intervention solutions. The definition of needs specific profiles (segments within the target groups) with related insights and conceptual tracks would allow for differentiating service concepts, hence guide the (market) screening of existing solutions (that meet the unmet needs of the service receivers) or/and help identify relevant areas of innovation, where the design of new services is required.

Similar steps could be implemented in the cases of Forum Virium Helsinki and Jyväskylä, where the available (qualitative) needs analysis and value assessment (from the service receivers' perspective) can be used to define specific people-centred value metrics to guide the "packaging" of service concepts or evaluation of services in ways that meet the demand for "innovative height" in terms of new design and new private/public payment models.

In the case of Landskrona City an early stage qualitative needs assessment would allow for differentiating assessment of the needs of the care receiving elderlies, with focus on specific challenges and motivations relating e.g. to different courses of illness or treatment. Metrics derived from qualitative needs assessment would serve to guide the service evaluation, next to organisation and cost driven metrics.

In Espoo and Aalborg, the qualitative needs exploration has led to the definition of people-centred value metrics: In Espoo the people/user-centric value metrics has also been one of the key drivers for designing the value based reimbursement model. Espoo has in their reimbursement model included bonuses-sanctions that are dependant of how well the independency of an individual autistic person develops as a result of supportive housing services and of the permanency of the care personnel. Similar reimbursement or bonus/sanctioning models could be developed in the case of Aalborg, promoting and maintaining the focus on people who receive care for personal lifting and moving in their home.

As stated earlier, however, the appropriate process, methods and tools to implement a user driven innovative approach varies from case to case. The approach should be introduced with consideration for available resources, expertise, existing knowledge, prioritisation and the given possibilities concerning scope and scale. There is as such not “one and only” recipe of how to conduct a user driven (value based) innovative procurement process. The crucial aspect of applying a systematic needs and problem oriented approach should be considered separately for each case.

8. Developing a model for Value Based Procurement in Health and Social care

The main objective of the project reported here is to develop a procurement model that creates overall system level value. To accomplish this, there are three fundamental criteria that need to be met:

- Procurement that is user driven and based on real needs
- Procurement that delivers better quality services and patient satisfaction
- Procurement that is problem solving in co-creating with the suppliers

Designing the model has been an iterative process throughout the project based on the case studies and their starting point and discussions, seminars and exchange of ideas between the project parties. The starting point for identifying the relevant components of the model has been returning to some basic prerequisites for procurement identified by the project participants:

- What is the service subject for procurement and who is the service directed to?
- What is the value of the service obtained by the customer/patient (the individual)?
- What is the outcome of the service sought by the payer and commissioner of the service (e.g. the municipality)?
- Can relevant metrics of outcome and value be defined and monitored?
- Can reimbursement be based partly or entirely on the outcome and value captured by the metrics?
- Can the procurement be based on the reimbursement model and are the metrics identified sufficient for monitoring quality and outcome for the service?

Definition of target group and service

Defining the target group and service go hand-in-hand when targeting a model for value based procurement. The starting point for defining the target group is that they should have a common perception of value of the service, which in turn requires a relevant segmentation of clients/patients. Segmentation is, of course, subject to social and healthcare laws and regulations, which may limit the degree to which segmentation can be done. The scope and content of the service, in turn, should be based on what resources, competences and methodologies are required for achieving an objective. This may also be limited by laws and regulations as well as structural factors, since all competences and resources may not be available within the same organisation.

We have aimed for an analytically driven understanding of characteristics as a means of identifying the target group and relevant services. Addressing a complex and difficult to define problem, an analytically

driven understanding of the problem and identification of the target group for the service helps bring the process forward.

Target groups are often predefined and rarely questioned which may inhibit service development and value creation. The Norrbotten – case serves as a good example of extensive quantitative analysis can be used for client/patient segmentation. The use prevalence (and joint prevalence) of alcohol and drug abuse combined with somatic and mental illness was analysed for adult individuals in the municipality and the figure below illustrate the analysis logic. The analysis enables identification of groups which all have slightly different perceptions of value of a service all captured by different value metrics. However, different groups may display similar perceptions of quality and need for similar services (in terms of organisation, resources and competences) and these groups can, in turn, be considered segments.

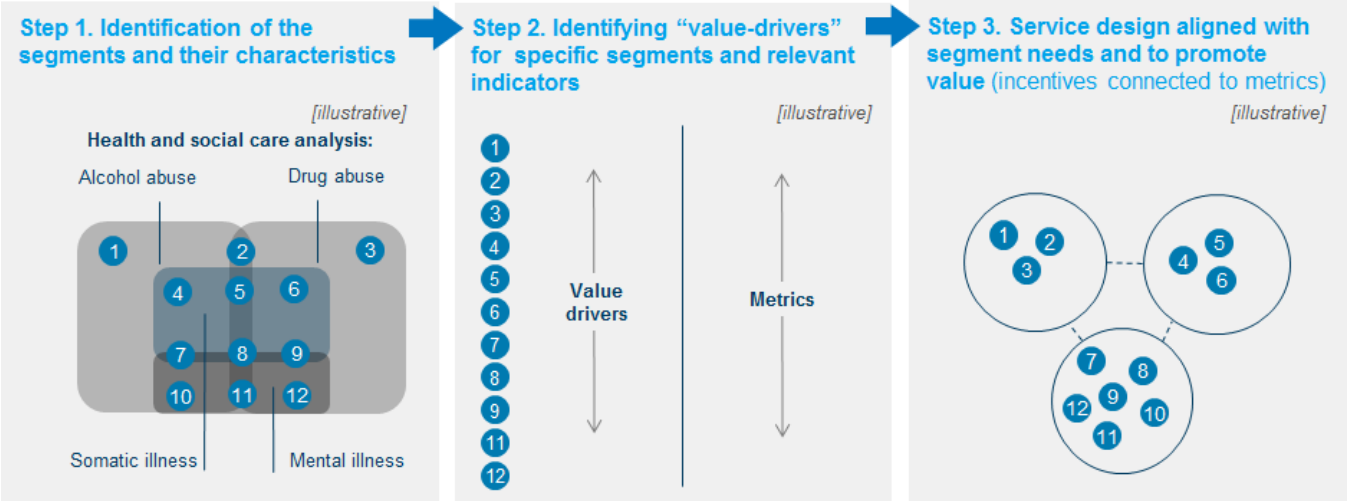


Figure 7. Analytical approach to segmenting client needs. Source: NHG

Value and outcome

As has been discussed earlier, output is fully a measure of provider performance while outcome is the result of a co-creation with the user/patient. Moreover, there are fundamental differences between outcome and value that have had to be accounted for in the project, e.g.:

- Outcome is" controllable" to a higher extent. Value is perceived by the client and is therefore subject to subjective valuation
- Outcome refers to" objective" quality, while Value reflects"subjective" quality as perceived by the individual. However, defining objective quality is not straightforward.
- To what extent can providers be reimbursed for achieving outcome (e.g. evidence based medicine) without generating perceived value by the client or patient?

- Documentation and monitoring of Outcome and Value are inherently different

A critical key to success identified in the project is that potential conflicts between outcome and value must be eliminated. These are present when the perception of value is not aligned with objectives of the payer and commissioner, e.g. when public funds do not suffice to produce a certain service. On the other hand, services may not be optimally designed and produced to support value creation.

In each of the cases we've been able to identify a "joint interface" between outcome and value. In most cases, this happens when service design enables more efficient use of resources while increasing perceived value. For example this is achieved in parts within the Espoo case by introducing a value-dependent part of reimbursement. In the Landskrona case it is shown that an increased level of function and independence among the elderly creates value for both the individuals and his/her next-to-kin and decreases the municipalities' costs for the clients over time.

Metrics and monitoring

The importance of quantitative analysis and metrics cannot be emphasized enough in this report. The case studies have clearly indicated that, even if a joint definition of value and outcome can be found, that defining metrics that can be monitored over time is very challenging. In most cases we have not been able to find ready metrics and monitoring structures in the cases, indicating the development potential within this area. For example, in Landskrona a web service was launched in order to enable monitoring of the clients development of function. This in turn, is critical for monitoring whether the objective and value is achieved.

Reimbursement and procurement model

The importance of metrics and monitoring becomes increasingly evident when designing reimbursement models. If this cannot be done, the prerequisites for creating incentives for outcome and value creation are lacking. Definition of the service, the target group and an outcome and value – oriented reimbursement model create the foundation for value-based procurement.

Case contributions to the model

The cases represent overlapping and complementary characteristics. They span across the social and health care sector as well as across the Nordic countries.

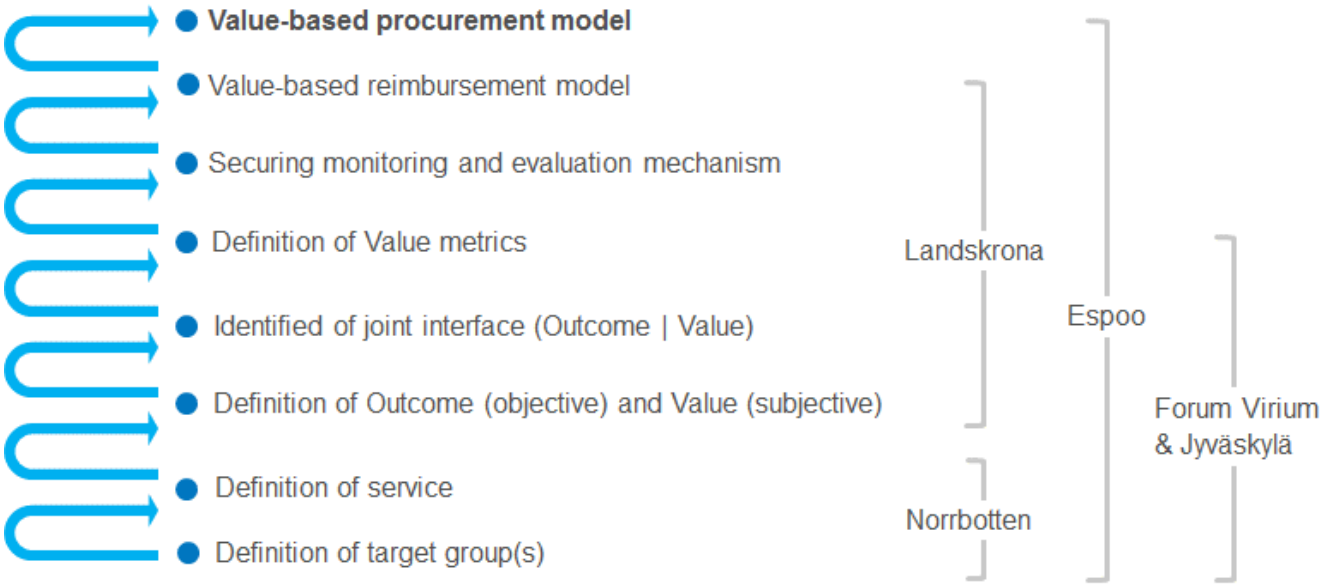


Figure 8. The VABPRO – model and case contributions. Source: NHG

9. Recommendations for conducting Value based procurement

In order to be able to conduct successfully a value based procurement exercise the procuring organization there are a number of relevant issues/parameters that need to be considered/tackled. These issues are shown in the illustration below followed by discussion and recommendations on how to approach these and what to keep in mind.

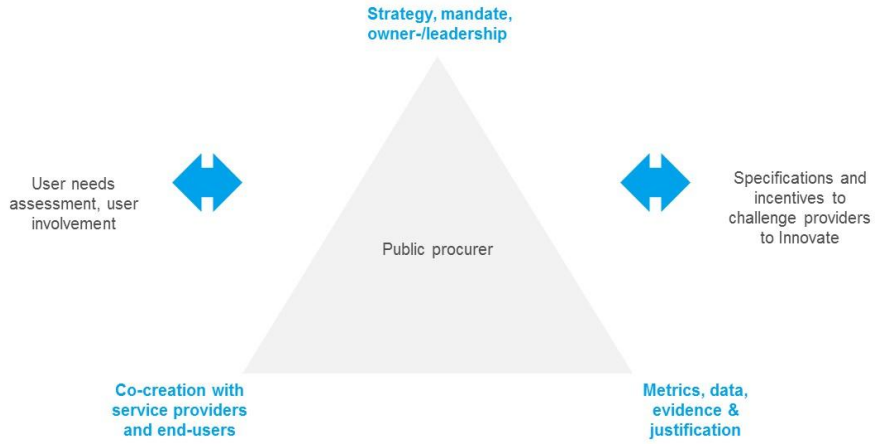


Figure 9. Key parameters of value based procurement – and how to approach them. Source: NHG

Define your Strategy and secure an adequate Mandate and Organizational structure that supports system change

The success of the operative instruments often depends on the success of strategic instruments; incl. organizations general strategies and service area specific strategies. Innovative or value based procurement is actually linked more to the strategy and its implementation rather than about procurement as such.

Clear leadership, mandates, dedicated budgets and targets are also needed. This is even more important if the aim is to invest in new areas and approaches such as preventive measures that can be seen as alternative investments – if compared to the existing situation within the services.

If the above factors are clear and in place then the organization is more likely to mobilize and make use of the new and innovative operative instrument – and more likely also to succeed in its operations and gain from continuous learning.

For any Social and Healthcare providing organization it is therefore important to have a "Smart procurement" strategy integrated into the overall Health and Social care service strategy. The Smart procurement strategy needs some clear cut implementation targets as well as dedicated budgets to ensure that these alternative investments actually take place and are secured with adequate resources.

Organizational boundaries can create great challenges when one is trying to redesign and incentivize health- and social care services in a new and more value creating manner – possibly aiming at completely new service concepts. It is of paramount importance that these challenges can be solved in situations where a user-centric and analytically driven approach is to be implemented.

Handling organisational boundaries and breaking of silos can mean dealing with issues such as causality and power, cost/profit-sharing – but also potential legal and other system level barriers.

Define real needs and co-create with suppliers and service users

Value based services can only be crated if there is thorough understanding of the real needs of those using the services – and also understanding how these can be best fullfilled. This implies a systemic shift in the sense that public services provided can no longer be defined by the public authorities alone. Expectations are clearly also growing that tax financed public services should create measurable effects and value. To succeed with this the public providers need to start working more closely with the users / citizens and in the case of procurement situation also with the supply side.

The supply side needs to be included in the whole procurement process in a result driven manner – i.e. from the service definition to implementation phase. The buyer and provider need to share a common vision and objectives for the service production in order to create optimal conditions for continuous improvements. Incentives for both parties need to be aligned and lead to same direction and towards a common also by the service user shared goal.

The objective should be to construct a thorough understanding of the clients/user's needs, of the problems in the service delivery and of the current service contents. This should also include open feedback and collection of new ideas. Key aims should include:

1. Service users are included in designing of the new services as well as in the evaluation (value creation) of those once these are taken into use.
2. The new service concepts and working methods are based on user empowerment and inclusion.

Data, metrics, evidence and justification

It is far too common that public organizations are lacking a proper understanding and analysis of their current cost structures and service use and resources allocation. Availability of necessary data and data processing tools & capabilities are crucial if the organization wishes to understand what the current service use is and how that is divided among users – i.e. where the resources/money is going and how it is spent. This possibility to establish the baseline gives the opportunity to compare the existing situation with the one where service and resources are designed to support better outcomes and value. Existing data and analysis of it also makes it easier / more feasible to establish correct evaluation methods based

on analytical evidence /metrics. In cases where this is not possible other means and ways of capturing value creation must be established.

Specification and incentives that challenge the providers to innovate and secure continuity

Providers should be challenged in a manner that drives renewal/innovation but still keeps their business thriving financially. A challenge is to understand how to define the specifications and reimbursement model in a manner that is justified, transparent, measurable and satisfactory both to the procurer and the supplier. Ethical questions may also rise in certain services related to service quality and legal provisions.

To secure continuous improvement and a satisfactory working relationship procurer and supplier also need to agree on a systematic way to evaluate progress and agree on eventual adjustments to the service agreements.

Transfer the Needs and defined new value based specification properly into tender documentation

Thorough work is needed in order to really turn the focus in the procurement to:

- **Value creation (**prerequisites, opportunities and risks).
- **Feasibility of capturing value** (prerequisites, opportunities and risks, the do:s and the don´t:s).
- **Realization of value benefits**, important issue in innovative procurement -> cost burden can rarely become higher therefore the aim of an innovative procurement should be a positive or at least a neutral impact on the total costs of services.

10. Value based service design and procurement – future development and application possibilities

Value based approaches are implementable in most social and healthcare services

Value base approach can be further developed and used in a wide variety of services spanning across all social and healthcare services. As has been shown in the previous chapters in this report Value based approach can be used as a tool in different phase of the development and procurement process.

It can be seen as an instrument to redesign services in a user-centric manner, to procure cost-efficient services and also to support alternative investments in services with strong focus on prevention.

Value investments can be seen as an alternative way to use public spending. Publicly paid services are in this case no longer seen as rigid output defined by the public authorities themselves only but as alternative investments (compared to the previous ways of providing and producing the services).

In order to work with the alternative investments approach and procure intelligently it is crucial to understand the state of art situation, i.e. to understand the prevailing use of services, their costs and quality indicators. Evaluation and metrics guarantee that alternative investments can be justified and there is evidence on their effects.

Examples of generic services where VABPRO methodology/process model could deliver better ROI (other than the VABPRO-project cases) include Child welfare, mental healthcare, chronic disease care (multimorbidity), family services.

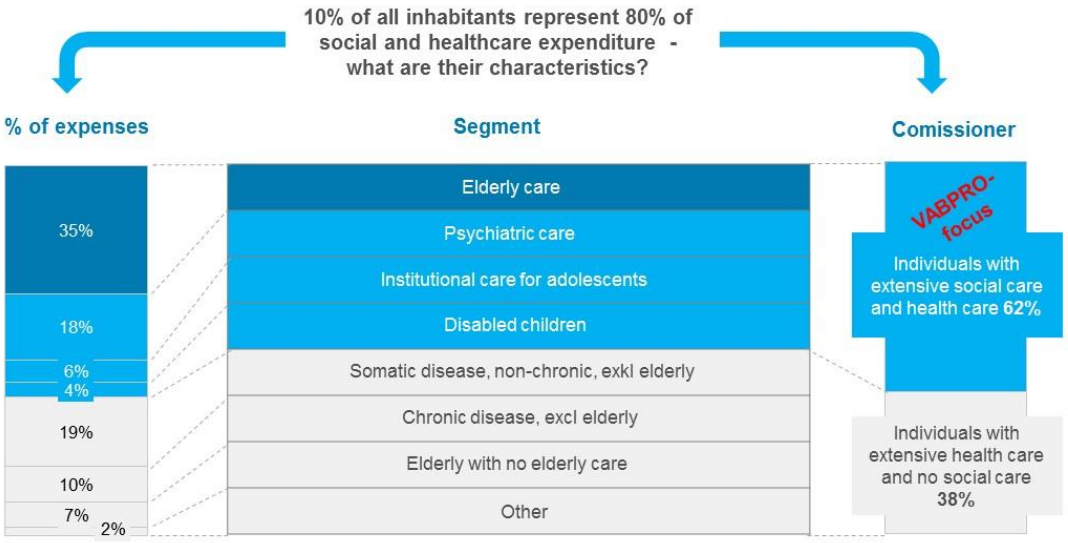


Figure 10. A small portion of the population represents the majority of costs in social and health care. Source: NHG

VABPRO approach could support the user-centric development of new ICT / technologies based services and drive their deployment

Scaling up integrated and person centred care with innovative uses of ICT / eHealth can become easier if approached with above described Value based procurement or alternative investment approach. Here, as in the non- ICT based services, it should be a question about challenge driven innovation.

A market push of existing solutions can therefore rarely be the answer. When designing the new services a value based and demand driven procurement approach has a better possibility to secure that the new solution is actually integrated into the existing or modified care concept and continuum.

The value and demand driven development and procurement approach supports the definition of sustainable eHealth services through;

- Balanced system level cost-benefit analysis where total cost of care can rarely become higher
- Tackling more easily interlinked challenges for the different care providing organizations

The crossing of three innovation areas in Value based eHealth services include:

- **Change in the public care or service delivery pattern and content** - i.e. often organizational or/and service concept innovation = redesign of the services for the target group in question.
- ICT/technology based: **Managing growing demand and shrinking budgets** with the support of new technology and patient involvement / empowerment.
- **User–driven** (care personnel & end –users). Users as designers of services and as subjects in the care delivery process itself. Patient involvement/empowerment as integral part.

A value proposition to people with chronic conditions in eHealth area could for example include elements such as;

- New personal health technology (eHealth/mHealth) as a channel
- Perception of the patient as a resource person, patient empowerment
- Better quality of life and user satisfaction – handling rising expectations and costs
- New payment models that reward provider performance and enhance coordination of care and sharing of data /patient information

The Nordic Innovation Challenge competition "The Nordic Independent Living Challenge" [8]is another example where the use case and service can in the end be defined in a completely new manner. Value based approach could create opportunities to approach analytically the impact objectives and related appropriate metrics for the desired services. This is turn can support the deployment of these.

[8] http://www.nordicinnovation.org/fi/meidan-tapahtumia/registration-deadline-for-the-nordic-independent-living-challenge/

From consumer eHealth markets to integrated service markets in Nordic countries.

The Nordics could jointly;

- Provide a platform for cross-border Nordic innovative service design and value based procurement undertakings
- Offer an interesting possibility to create a joint Nordic test market for eHealth services that actually integrate with the publicly provided health and care services.
- Make use of the digitalized Nordic systems and connected data sources.
- Showcase new integrated patients-centered value propositions with incentive and reimbursement models that drive continuous improvement and benefits for all parties.

The InMente- project; an example of ICT-based service with multiple value objectives

The InMente innovation project has aimed to develop a new ICT service, that can help people with mild to moderate dementia – primarily over 65 years – to manage their everyday life (in their own home) for as long as possible

The development of a product-service solution for people with dementia has been fostered by a public private collaboration between 8 partners (including private software developers, designers, service providers, an interest organization, innovation consultant & ethnographic researchers, an educational institution and two local municipalities

The aim and driver in the project has been to create value on three equally important bottom lines: 1) enhance the quality of life for people with dementia and their relatives, 2) commercial growth, 3) reduce public spending.

The preventive achievements of the InMente solution represent a potential of a 15 months **postponement of the need for home care**.

If the solution reach a target of 5.500 users, and has the intended effect of just 1 hour of postponed home care per week (estimated to 500 DKK), then the **total public savings** accounts for 165 mil. DKK.

Figure 11. Effect (estimated). Source: CCL

Radical Innovation and Disruptive Care/Business Model cases in Healthcare

How to move forward towards value based (public) procurement has been explored, developed and even implemented in some of the best healthcare organization in the world. In order to succeed with this it is crucial to understand that healthcare systems, organization and public procurement must always have the "real need" and a holistic approach as a starting point.

Larger total value chain solutions and system transforming service design / procurement projects may have bigger implications for the future. These should in fact probably be the area of focus for future disruptive and value based public procurement. Hospitals represent only a fraction of the healthcare, actually less than 25 %. Therefore there is a clear need to look at system level transformation and new types of service and business models. These models are likely to support the shift from inpatient to outpatient care allowing patients to become subject instead of pure object in their care. The models will also aim at breaking traditional organizational silos in public services.

System level Value creation and the opportunities it can create for different actors (including the public payers, patients, the suppliers/companies and investors) has been studied and made visible also in the Nordic PPI Net-project report: Value based procurement manual – a road map to radical innovation[9].

[9] This report that connects with VABPRO approach can be found here: http://inspirecampus.eu/wp-content/uploads/2014/12/Value-based-procurement-manual_Nordic-PPI-report_201401102.pdf

11. Appendix: VABPRO case descriptions

CASE: Value based approach to prevention and treatment of alcohol and drug abuse in the Norrbotten region on Sweden

Case: Introducing a patient centred and value based approach for healthcare and social care prevention and treatment of alcohol and drug abuse or addiction.

Case owner: Norrbotten County Concil (NCC) and Municipality of Luleå (MoL).

The NCC/MoL VABPRO case started with the awareness that healthcare and social care interventions for individuals in need of care from both the municipality and the county council would benefit form a better cooperation and coordination of care. Individuals with alcohol and/or drug problems are subject to care form both municipalities and county councils. Thus a care delivery is dependent on producers from different organizations and cultures to coordinate and cooperate.

The VABPRO methodology was identified as an interesting approach for this group through its ability to take a patient centred and holistic needs based approach on the interventions.

To begin with, an audit of the municipalities within the county council as well as the county council showed an unacceptably large variations in access to alcohol and drug abuse treatment in Norrbotten. As a result of the audit, a joint effort was initiated to close the gaps and sign an agreement between these parties on the financing, responsibilities and overall structure of health and social care within the field of alcohol and drug abuse prevention and treatment to improve the situation for this group. The VABPRO case consisted of the work of providing the analysis as the foundation for and to guide in the process to form an agreement between the county council and the municipalities that eventually, on October 10 2014 was signed.

The overall objective in the agreement for the target group care is equal access to high quality treatment for alcohol and drug abuse or addiction in the Norrbotten region. The outcomes to be achieved are:

1. Increased access to evidence based care and support
2. Clearly defined and more efficient roles and responsibilities for municipalities and county council
3. Decreased differences in quality of care and treatment results

This work is part of a large scale reorganization of the healthcare and social care structure in Norrbotten that takes place over a long period of time. Within the timeframe of the VABPRO project only on the first stages of the VABPRO methodology were processed.

1. **Definition of the service and target group**

The general aim in the Norrbotten region is that the interventions that will be developed in Norrbotten should be patient centred and based on the knowledge of the needs of the target groups.

To identify the care consumption and the flaws and shortcomings of the care provided individuals with alcohol and/or drug problems, a quantitative analysis was performed. The quantitative analysis identified young adults with drug abuse problems and mental illness as a particular group within the broader target group that had a suboptimal care structure and consumption. The analysis showed that psychiatric/mental comorbidity for young people with drug or alcohol related problems is very frequent. Thus, a joint and team-based approach dealing with both medical problems is required in a service designed for this target group. This approach is also supported by evidence and guidelines.

Another important intervention that needed re-evaluation was inpatient hospital care. An analysis of the patient flow shows that there is a high need for improved continuity. Inpatient hospital interventions were frequently performed with no follow up or too long time to follow up which gave rise to aggravated care needs further on. Further analyses indicated that regular outpatient follow up visits following a hospital admission would improve the outcome and decrease the overall health and social care consumption for the target group.

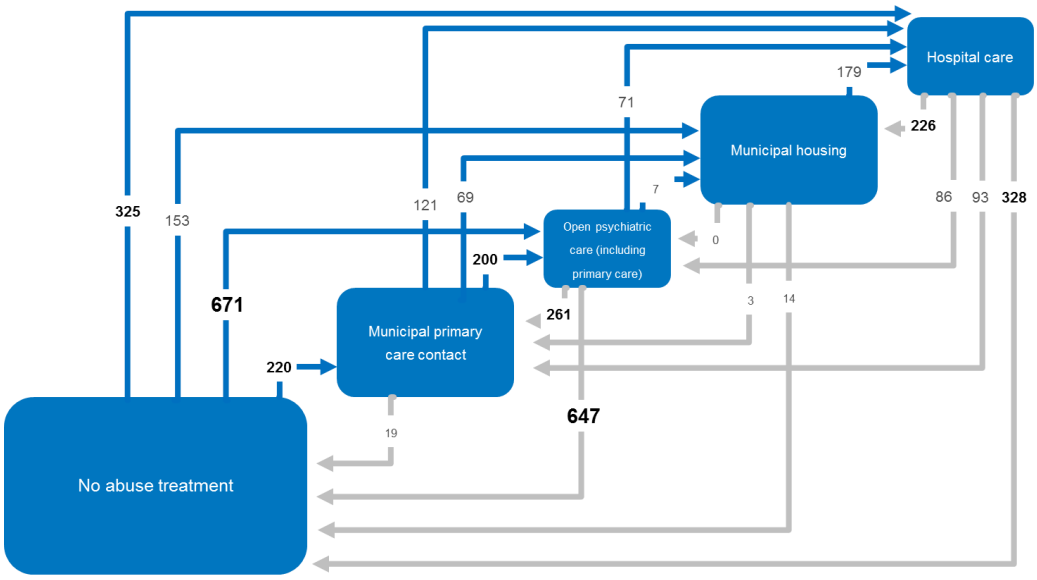


Figure 12. Patient flow analysis, example

To make these changes possible a new centre for treatment of abuse and addiction is being formed in Norrbotten with three main missions:

1. Provide special competence for hospital inpatient treatment of dopy individuals in need of medical surveillance and abstinence treatment

2. Provide special competence support to municipalities and primary care units to their care of individuals with alcohol and/or drug problems
3. Provide assessment of the needs of the target group. This includes an assessment of the needs of individuals post drug or alcohol related hospital admissions as well as a better understanding of how to provide coordinated and simultaneous interventions.

The centre must have the necessary competence to handle these issues and support the community and the organizations that are responsible for the interventions with training and sharing of best practices.

A framework has been developed within the VABPRO project to assess these challenges in line with the VABPRO methodology and taking the new national guidelines in consideration. This will now be deployed by the centre.

2. Definition of outcome, value and measurability

The analyses for this case suggest that interlinked interventions would be successful for this target group. The outcome that is desired is obviously that the individuals that are subject for the interventions are helped to get rid of their alcohol and/or drug problem. Regular follow up contacts and tests could be used to measure the outcome.

Initially, the metrics used will measure to what extent desired processes are achieved and if individuals have equal access to treatment and that high quality services such as follow up visits and team-based interventions are offered. These measures are aligned with the overall objectives in the agreement that makes up the foundation of the coming development of the services.

3. Outcome, value metrics, monitoring and evaluation

The metrics to be used in the services will be assessed in later stages of the process. The quantitative analysis performed provides information on the needs and care consumption of the population in Norrbotten. The analyses also suggest some metrics that can be used to follow up the success of interventions in the target groups. Since the design of the services and interventions are in an early stage a choice of outcomes and metrics has not yet been made.

4. Reimbursement structure and logic

The reimbursement structure and logic will follow the policy of all reimbursements in Norrbotten County Council. Thus, it is likely that the services will be reimbursed with a mix of budgetary allocation and performance fees with an outcome or value based reimbursement part constituting up to one per cent of the total reimbursement.

CASE: Increase independence and functionality of elderly with a reablement service in Landskrona City in Sweden

Case: Introducing a multi competence team with the mission to increase functionality and independence of elderly in need of social care services

Case owner: The Landskrona City municipality in Sweden

The Landskrona VABPRO case In Landskrona, elderly with social care needs aggravated by a hospital admission were identified as a user group who´s needs had to be addressed from both a quality and cost perspective. A large and increasing need for temporary housing of their elderly population was as a serious problem for the municipality. Moreover, the health and social care needs of the caretakers were not attended to in the most value-creating way in the temporary housing bed. The caretakers had likely rehabilitation and habilitation potential that was not adequately addressed.

1. **Definition of the service and target group**

The primary target group was elderly who, following a hospital admission, are discharged to temporary housing before returning to home care. A service in the individual´s own home was designed to replace temporary housing and named Mottagningsteamet. It is provided by a multidisciplinary team consisting of home care and home rehabilitation professionals.

There is no specified length of the service, but maximum length of stay is three weeks. It is provided on individual basis based on needs. Following an episode with Mottagningsteam, “ordinary” elderly care services are resumed (e.g. home care within a free choice system).

2. **Definition of outcome, value and measurability**

The desired outcomes of the service were a reduction of short term housing beds and a reduction of the overall need for health and social care provided by the municipality for the caretaker. Another outcome was not having patients ready for discharge remaining in hospital.

Subjective value from the caretaker´s perspective was embodied in the outcome measures chosen. Additional value measures were increasing level of functional independence and perceived safety of the caretaker as well as increased trust of his or her relatives towards the care provided by the municipality

The hospital was not involved in the project and county council data on hospital admissions and bed days would have been valuable.

Outcome/value	Parameter	Measurement
Increased independence defined by reduced care needs	Cost for caretakers overall need for municipality provided health and social care (home care, home health care, temporary housing, nursing home)	Total cost for care in a 7 month period including 3 months following the intervention. Comparing the cost for the population with Mottagningsteam and/or temporary housing during the pilot period to a historical comparative control group with only temporary housing.
Speedy discharge from hospital	Cost for caretaker ready for discharge remaining in hospital	Comparing costs (penalties to the county council) for patients ready for discharge during pilot period to costs during a historical equivalent period.
Increased independence in daily activities defined by increased cognitive and/or motoric functionality	Caretakers level of functional independence	Measurement with adapted FIM instrument. The same measurement performed at the start, at the end and three months following an episode with the Mottagningsteam. No control comparison possible.
Increased perceived safety by the caretaker	Caretakers perceived safety in the current situation	Measurement of level using a visual analogue scale. Comparing measurement before and after a caretaker´s episode with Mottagningsteamet. No control comparison possible.
Increased trust by caretaker´s relatives	Relatives trust regarding the care provided the caretaker in the current situation	Measurement of level using a visual analogue scale. Measurement before and after a caretaker´s episode with Mottagningsteamet. No control comparison possible.

3. Outcome, value metrics, monitoring and evaluation

The outcomes were made measurable using municipality activity data. In order to identify if outcomes were reached or not, data from an historical comparison group of individuals was included in the analysis of the data.

Functional independence was measured using an adapted functional independence measure (FIM) instrument. Perceived safety and trust was measured with a visual analogue scale.

Enabling technologies for collection, monitoring and evaluation are critical. The technology chosen had its limitations. The reported data format was not in the format desired and additional manual calculations were needed to obtain the key performance indicators desired.

Evaluation parameters

Parameter	Measurement
Cost for care with Mottagningsteam	Comparing costs for a caretaker´s episode with the Mottagningsteam to an episode at a temporary housing.
Number of temporary housing beds available	Analyze the development of temporary housing beds during a relevant time period including the pilot period and some time before.
Number of temporary housing bed days	Analyze the development of temporary housing bed days during a relevant time period including the pilot period and some time before.

4. Reimbursement structure and logic

Daily reviews ensure that only value-creating activities are offered caretakers. Evaluation is used to obtain an understanding how the service is performing and determining whether the resources in the service are required and being well used and that the right target groups are included. The evaluation will also be the primary way to demonstrate outcome and economic viability.

The evaluation of the effectiveness of Mottagningsteam for different target groups is of importance in order to ensure that the included target group's benefit from the service provided. With increasing experience from target groups selected, inclusion and exclusion criteria can be specified. With appropriate data collection, monitoring and evaluation, the activities needed for a particular target group profile during an episode with Mottagningsteamet can to some extent become predictable. This allows for efficient planning and organization of resources.

Mottagningsteam is a separate service distinct from home care and health home care in Landskrona. The evaluation of the service showed that it can improve individuals´ independent living.

Mottagningsteam create recognized opportunities and structures for outcomes-based compensation models for the benefit of the individual, the municipality and the county council. An optimization of the capacity for independent living is the outcome and value that should be ensured in a reimbursement model for the Mottagningsteam service.

CASE: A digital service provided 40-year-old men to reduce CVD risk factors, Forum Virium Helsinki, City of Helsinki in Finland

Case: Behaviour change through digitally facilitated, awareness and engagement in activities affecting cardiovascular disease (CVD) risk factors in 40-year old men in Helsinki.

Case owner: Forum Virium Helsinki (FVH) is a public-private innovation platform delivering new digital service innovations in collaboration between the companies, public sector and the citizens. FVH is owned by the City of Helsinki and it collaborates with the city's social services and health care department in developing future oriented services and solutions, as well as with companies and research units developing innovations in this topic.

The FVH VABPRO case is a digital service concept aiming at improving the engagement of and commitment to behaviour change in various lifestyle choices. The objective is to lower the risk for CVD (as well as other lifestyle diseases) in the target group of 40-year old men in Helsinki. The service is based on personalized healthcare and wellbeing innovations by local companies and research organisations that already exist on the market. These services have, however, not been packaged and taken into use as a complete service and certainly not yet as an integral part of the public primary care services.

This VABPRO case offers an opportunity to bring why certain existing public services do not attain their objectives into discussion. It also offers a generic possibility to show how new innovative digital services can be created and be taken into use as well as monitored, as well as their impact and value creation aspects.

From the local authority perspective it is not obvious who should be the procurer and payer of this kind of service; the VABPRO analysis aim is to identify and conceptualize the service in a manner that makes it possible to create evidence based value. These value based services can in turn create opportunities to various stakeholders (public service departments, private companies, end-users and others).

1. **Definition of the service and target group**

The target group is 40-year old men in Helsinki, for which a "Kundit Kondikseen" ("Getting Guys in Shape") health promotion intervention already exists within the Citys social and healthcare services. Kundit Kondikseen service consists of a health consultation session at a health station and a related basic metabolic panel and cholesterol levels blood test. It is promoted to and provided for all 40-year old men in Helsinki.

According to studies about healthcare personnel's experiences about the Kundit Kondikseen service, the main development ideas concerned issues on how the share of target group men participating in the health examinations could be increased. The share of men currently taking part in the service was estimated to be 25 % - 30 % of the target group. Also, according to the analyses of this study, there have been service availability and accessibility limitations.

A particular subset of the target group are men with existing condition for high CVD risk or pre-diabetes, some are already on preventive medication (e.g. statins, metformin). There are issues with adherence to this medication and commitment to preventive lifestyle changes in this subgroup. This target group is of high importance while it is a high risk group of CVD. there is great potential to lower their health care costs, prolong their healthy life years and improve their life quality.

FVH's VABPRO project case is a digital service concept aiming at improving the commitment to behaviour change in various lifestyle choices, in order to lower the risk for CVD (as well as other lifestyle diseases). It is based on innovations by regional companies and research organisations that already exist in the market, but are not packaged for such use.

The service aims to increase awareness of and engagement in reducing personal risk for CVD. The digital mobile service contains a genetic risk screening test (as developed by for example FIMM) and aggregated lifestyle information and data from mobile apps that track the exercise and movement (as developed by for example Moves or HeiaHeia). The service is provisioned through Taltioni [10]mobile health data aggregation platform as well as health check-up of the Kundit Kondikseen [11]service by the city of Helsinki.

Also, other, optional, value added services for the target group would be packaged into the digital service. These would include services such as additional genetic risk screening tests and mobile lifestyle coaching applications. These would be provided with a cost by for-profit organisations linked to the service concept for those users who wish to pay for the added value services.

The value proposition in this VABPRO case is that increased personalized and "technologically validated" risk awareness, delivered through digital means that are attractive to the target group of 40-year-old men, would allow for and lead to more engagement and real life commitment to the lifestyle changes necessary to reduce the risk for CVD.

2. Definition of outcome, value and measurability

There are social, health and economic outcomes identified for this service.

[10] http://taltioni.fi/en/
[11] http://www.hel.fi/hki/sote/fi/Viraston+esittely/Hankkeet/Kundit+kondikseen

From the end-user/customer perspective, the expected outcome is a more positive development of health status and better experience of the health services offered. Both the actual lifestyle changes as well as the experience of personal control in health issues drives the development of both.

Subjective values identified:

- Patient self-empowerment, possibility, ability and motivation to be part of the personal service delivery
- Personalized services that are perceived as valuable and usable.
- Peer support and sharing of experiences and effects of the used services –> i.e. community building
- Increased feeling of health and well-being / improved quality of life

From the public service (service payer) perspective, the expected outcome is a lowered burden on the health care costs of the target group on a long term perspective, strengthened preventive services (primary and secondary prevention), and less remittals to specialist care services.

From the healthcare personnel perspective, the expected outcome is a better work satisfaction that is attained through the better impact of the work.

From the service delivery perspective (public or service provider), the expected outcome is the enhanced ability to respond to end-user quality demands in the digital domain as well as new business opportunities that arise from the packaging of value added services to a service concept.

From the service delivery perspective (public or service provider), the expected outcome is the enhanced ability to respond to end-user quality demands in the digital domain as well as new business opportunities that arise from the packaging of value added services to a service concept.

3. Outcome, value metrics, monitoring and evaluation

User-driven innovation approach in concept design and value definition

The service concept was developed with an iterative WIBGI-method with a small group of the end-users of the target group. The service proposition/feature back log for the WIBGI included a large amount of digital/mobile innovations related to personalized wellbeing. The main insight from this user involvement was that a single easy-to-use channel for the service discovery and service provisioning is a key success factor. The existing Kundit kondikseen service was not found very attractive by most of the users due to various reasons (personal attitudes towards health; lack of modern features; difficulty of use).

User-driven innovation supplier engagement approach in procurement situation

The end-user and supplier involvement in the procurement situation should ensure that:

- The packaging of the innovations to the service concept is engaging for the target group. Several assessed innovations in personalized healthcare were seen as difficult to use or targeted to some

very specific (different) target groups, like extreme sports. This should be validated by using an end-user panel or test group in the pre-procurement phase.

- The business logic of the service concept should be adopted according to the target group. For example, some end-users would be willing to pay for additional services within the service concept. However, while this target group includes the subgroup men with existing condition for high CVD (often with chronic conditions and multiple problems), it could be worthwhile providing these new services free of charge or event through a "prescription" of digital service for this particular subgroup.
- As the service concept includes public, private and research stakeholders, the actual business logic/case of the service concept should be developed with the target groups prior to the procurement.
- The Business case could evolve over time when first experiences have been gathered and analysed. The procurement specifications and contract terms should allow for continuous improvement and possibly include incentive and reimbursement models that drive this improvement.

Outcome and value metrics

Outcome/value	Parameter	Measurement
1. **Positive development of health status, defined by decreased future health service need**	• Total cost of health care of the user • Experienced and measured health status in the target group	• Number of health care visits within a follow-up period. • Levels of / less remittals to specialist care • Amount of sick-leave days due to health issues • Number of new diagnoses for CVD, Diabetes
2. **Increased satisfaction with the health services for the user**	• Customer satisfaction level • Increased use of Kundit Kondikseen service	• Increased number of men using Kundit Kondikseen service as of % of target group annually • Customer satisfaction metrics as compared to earlier intervention for the same target group, and a comparison group
3. **New business opportunities for value added services**	• Number of value added services in the service concept • Amount of revenue generated for the service delivery	• Number of for-profit organisations providing value added services in the concept • Number of totally new innovations/SMEs providing the added value services • Amount of revenue generated through the service delivery
4. **Ability of the service providers to respond to the user quality and service demands of the new digital domain**	• User experience	• Evaluation through involvement of a target group user panel

Monitoring and evaluation

Outcome and value could be monitored and evaluated by benchmarking with the Kundit kondikseen service and target group. This could be done by the City Helsinki primary care services together with selected professional from the research sector. The method can be a traditional research setting comparing two different groups of service users; one that only uses Kundit kondikseen services and other that uses the new services.

It is crucial to ensure the availability of data for evaluation, while it is not always possible to retrieve the data from electronic health records that easily. Parameters could be the ones described above or further developed according to the selected target group. Data should be available from the start as well as from the mid-term and final review. Both qualitative and quantitative metrics should be used for evaluation. Ii should be acceptable that outcomes and analysis of this type of first study will be indicative. However, they might provide surprising and interesting evidence that can be used to develop the service further – also in generic terms and for other service areas alike.

The focus of future evaluation is:

- adherence to the new services, use of the offered key services that affect health status through life style changes
- whether regular standard service use and cost burden are offset by the gains achieved using the new preventive services
    - Depends on the data and evaluation tools/methods available for this user group
    - After taken into use the new services, knowledge and experience will incrementally increase and enable setting of thresholds and targets for outcome.
    - In a procurement situation tender specifications and contact obligations should ensure continuous improvement.

4. Reimbursement structure and logic

The drivers behind the business/reimbursement logic are:

- Considering procuring impact, a holistic intervention with a defined amount of lifestyle changes within the target group should be the actual procurement target.
- On the digital domain, there are no traditions on which parts of the services are provided by the public sector and which by the private sector. For example in mobile public transport applications the delivery of the end-user services is done in a public-private collaboration with basic features typically free-of-charge for the users and advanced features requiring payments.

- In the target group, there is willingness to pay for this kind of service, if the service quality is what is expected from a modern digital service and the payment logistics are familiar (for example through AppStore and similar channels).
- The public sector provides the basic Kundit Kondikseen service at minimal fee (14,70 € standard service fee year 2014) for the target group. This fee does not cover the service provisioning costs. It is not feasible, or very difficult, to increase the service production costs.
- The user experiences of the health and wellbeing services are usually low in the target group. There are huge business opportunities in delivering the services in a compelling way for the target group.
- The VABPRO service concept aim is to bring about lifestyle changes that in turn can be measures and evaluated in terms of value they create (cost savings, adherence to service etc); not clinical practices of the Kundit Kondikseen service. The assessment of total cost benefits requires a long-term evaluation. However, it is possible to do short term evaluations in the area of life style changes and the impacts that these can create in terms of better health status (prevention) and future cost savings.
- This could be an example service that Helsinki primary care prescribes to a selected and defined risk group.

The next stage of the service planning would focus on co-planning the business ecosystem logic with the key stakeholders.

Revenue Streams

Today mobile app business models are often based on a cloud-based "free-to-play" model: a basic service with key core features is free (or very cheap) for the end-users, and added value options within the service will create most of the revenue for the service provider.

Companies that develop and provide the new digital services could generate revenues by means of risk-benefit sharing with the procuring authorities: providers could benefit from the app sales and maintenance according to the savings in the healthcare system.

In fact the new Service could be ”prescribed” to patients by public or private healthcare providers and also possibly be paid by the public healthcare providers if there is evidence that this could create system level savings and better healthcare outcomes. Potentially the fact that the Service gets prescribed by the healthcare providers could secure a better patient adherence to the usage of the app.

The ongoing ”APOTTI” client and patient data system procurement process taking currently place in Helsinki can open up opportunities for innovative services. The new system will bring social care, primary care and specialist care services under one data system. It will be used by several hospitals and municipalities in the Greater Helsinki Region.

It might offer opportunities for companies to develop new innovative User-Driven eHealth /mHealth services in collaboration with the public and research sectors, using the integrated data and the Patient data system to this end. Innovative procurement processes could then be used to acquire these innovations. Alternatively, these new eHealth services could be prescribed by the public sector services – and this is more likely to happen if there is evidence that these services actually create system level value as describe earlier in this case description and in the generic VABPRO material.

CASE: Enhance emotional skills of women of 20 years of age, Jyväskylä city in Finland

Case: Behaviour change through empowering group activities together with horses. Target group: young females willing to enhance their emotional skills. The group is called Hevosvoimaneidot. This model combines with two different group activity methods developed in Finland: Voimaneidot and Kokemuksellinen tunnetaitovalmennus EASEL ®.

Case owner: City of Jyväskylä, Finland

The Jyväskylä VABPRO -project case is a service concept aiming at improving the ability to enhance the target group's emotional skills and have new abilities to express their feelings in various situations. The target group is young females around 20 years of age with long term mental problems and difficulties in communication and self-expression. The service is based on personalized well-being innovations by a local company pre-existing on the market. The service has been packaged but not taken into use as complete a service, in particular not as an integral part of the public primary care services.

The VABPRO case also offers an opportunity to compare and elicit discussion on why certain existing public services do not meet the objectives. In addition, it also offers an opportunity to demonstrate how new innovative services can be created and taken into use as well as monitored, regarding the impact and value creation aspects.

From the city organisation perspective it is not obvious who should be the procurer and payer of this kind of service; the aim of the VABPRO analysis is to identify and conceptualize the service in a manner which makes it possible to create evidence based value. These value based services can, in turn, create opportunities to various stakeholders (public service departments, private companies, end-users and/among others).

1. **Definition of the service**

The service increases awareness of one's own behaviour and self-esteem. It provides new ways to express one's emotions.

- Strengthens one's skills to evaluate feelings, emotions, strengths and weaknesses
- Improves self-control and empowerment
- Gives strength to overcome obstacles and solve problems
- Increases empathy and social skills in everyday situations
- Increases interaction skills and how to create better and long lasting relationships
- Creates more responsible behavior
- Gives new experiences of joy and happiness

Helps revising the past to new positive experiences

2. **Definition of the target group**

The target group is young female adults about 20 years of age situated in Jyväskylä. The group is call-ed HEVOSVOIMANEIDOT. Their health promotion intervention already exists within the social and healthcare services. Hevosvoimaneidot service consists of 10 group meetings. The group leader is a psychologist and they meet at the healthcare center or at the stables.

3. **Definition of outcome and outcome measurability**

From the end-user/customer perspective, the expected outcome is a more positive development of mental and social situations and improved self-esteem.

From the public service (service payer) perspective, the expected outcome is a lowered burden on the social and health care costs of the target group, strengthened preventive services (primary and secondary prevention), and less remittals to specialist care services.

From the healthcare personnel perspective, the expected outcome is better work satisfaction, which is attained through increased work impact

From the service delivery perspective (public or service provider), the expected outcome is the enhanced ability to respond to end-user quality demands, as well as new business opportunities that arise from the packaging of value added services to a service concept.

4. **Definition of value and value measurability**

Subjective values:

- Patient self-empowerment, opportunity, ability and motivation to be part of the personal service delivery
- Personalized services that are perceived as valuable and usable.
- Peer support and sharing of experiences and effects of the used services –> i.e. community building
- Increased feeling of well-being / improved quality of life and experienced happiness

User-driven innovation approach in concept design and value definition

The service concept gives a new perspective on diverse approaches to psychological services related to personalized wellbeing in a specific target group. Methods used are consultation, group conversation and educating the social and health care personnel.

The idea is to build a specific approach to match individual needs. The country side surroundings and animals like horses help to adjust. The new surroundings help to challenge the old behaviour and create

new insights. This helps the customers to process their ways to perform in everyday situations and support changing behaviour, especially in social and emotional situations.

User-driven innovation supplier engagement approach in procurement situation

The end-user and supplier involvement in the procurement situation should ensure that:

- As the service concept includes public, private and research stakeholders, the actual business logic/case of the service concept should be developed with the target groups in mind, prior to the procurement.
- The Business case could evolve over time when first experiences have been gathered and analyzed. The procurement specifications and contract terms should allow for continuous improvement and possibly include incentive and reimbursement models that drive this improvement.

5. Outcome and value metrics

Outcome/value	Parameter	Measurement
1. Positive development of subjective well-being defined by decreased future need of mental, social and health care service	• Total cost and amount of different mental, social and health care of the user • Experienced and measured health status in the target group	• Number of care visits within a follow-up period. • Levels of / less remittals to specialist care
2. Increased satisfaction with the health services for the user	• Customer satisfaction level	• Customer satisfaction metrics as compared to earlier intervention for the same target group, and a comparison group
3. New business opportunities for value added services	• Number of value added in the service concept • Amount of revenue generated for the service delivery	• Number of for-profit organisations providing value added services in the concept - Amount of revenue generated through the service delivery
5. Ability of the service providers to respond to quality and service demands	• User experience	• Evaluation through involvement of a target group

6. Monitoring and evaluation

The outcome and value could be monitored and evaluated by benchmarking with the Hevosvoimaneidot service and target group. This could be done by the city of Jyväskylä together with selected professionals from the research sector. The method could be qualitative research comparing two different service groups: one using traditional services and the other using the new services.

Parameters could be the ones given here, or further developed according to the selected specific target group. Data should be available from the start, as well as from the mid-term and final review. Both qualitative and quantitative methods can be used for evaluation. It should be acceptable that the results of a pioneer experimental study such as this could be indicative. However, the study might provide surprising and interesting results that can be used to develop the service further.

The evaluation focuses on:

- adherence to the new services, use of the offered key services that affect the status of well-being through life style changes
- whether regular standard service use and cost burden are offset by the gains achieved using the new preventive services
    - Depends on the data and evaluation tools/methods available for this user group
    - In a procurement situation tender specifications and contact obligations should be written in a manner that allows for continuous improvement.

6.1 Evaluation parameters

- Collection and evaluation of key data through the offered services by the users' improved well-being, check-ups every 6 months
- Number of health care visits within a follow-up period
- Levels of remittals to specialist care

7. Reimbursement structure and logic

The drivers behind the business or reimbursement logic are:

- Considering procuring impact, a holistic intervention with a defined amount of lifestyle changes within the target group should be the actual procurement target.
- There are huge business opportunities in delivering the services in a compelling way for the target group.
- The VABPRO service concept aim is to create lifestyle changes that in turn can be measured and evaluated in terms of the value they create (cost savings, adherence to service etc.) The assessment of total cost benefits requires a long-term evaluation
- The fundamental question of which part of the public sector is cost responsible for the lifestyle changes of the citizens? Improving the overall experienced well-being of the target group could be seen as a responsibility and result of various departments of the city.

8. Reimbursement models - Revenue Streams

The new service could be ”prescribed” to patients by public or private healthcare providers and also possibly be paid by the public healthcare providers if there is evidence that this could create system level savings and better mental, social and healthcare outcomes.

CASE: Housing service for persons on the Autism spectrum, City of Espoo

Case: The target is to maintain better quality in services and to get more benefits to the end-user by utilising service design and by strengthening end-user´s and producer´s participation in service design and procurement processes. Pilot case is the procurement process for housing services for the autistic people. The procurement considers housing services for 12 autistic persons who live in housing unit in Espoo. The housing unit is located in one of the community centers (Leppävaara) in Espoo.

Case owner: City of Espoo, social and healthcare department and procurement management unit

In Espoo VABPRO -project case the main objective is to develop such procurement practices in housing services that create cost-efficient results and more benefits to the end-user. This is thought to be achieved by identifying the end-user's essential needs and modifying them into service packages and practices that ensure the flexibility needed in producing housing services.

In pilot case the target was to seek the best service design practices and methods for planning the content of housing services for the autistic people in the procurement process. And in addition to strengthen the customers' participation and to improve dialogue practices with service providers.

The main actors are City of Espoo, unit for services for disabled people in social and healthcare department, procurement management unit, unit for procurement services, service providers, customers and their relatives, Aalto University, Kolmas Persoona (service designer), KPMQ (legal adviser), Sofie - web-based analysis-service (Social Impact Assessment).

To organize housing services for disabled people is one of the statutory duties for public sector. There are some established practices to provide them. Even though there are legislative and national recommendations of how to provide housing services and which the minimum standards for the service are, there still seem to be some dissatisfaction toward the housing services among the end-users and their relatives. Also there seems to be a lot of immaterial factors when describing the quality and are usually forgotten from contracts. At the same time the costs of housing services have risen rapidly.

This project has a starting point in Espoo strategy. Strategy stresses that the services, whether they were health or social services should be more efficient and create more benefit to the end-user. Procurement policy is to organize and supply public services more effectively and productive. In procurements the productivity target is 2,5 % in a year. It is obvious that more innovative ways are needed in procurement processes.

The annual costs of this kind of (24/7) housing services are 45 000- 75 000 euros per year per a client. The annual costs of this housing unit for 12 autistic people were 1 million euros. In this pilot case the target was to reduce costs 5 %.

In project one target is to innovate methods and best practices in service design that are can be bring in to use with other customer groups e.g. mental health and drug rehabilitation.

The key challenges in current way of procuring or buying services is that the minimum standards and minimum quality in certain factors are usually well defined. They are usually the factors that are defined in legislative or national recommendations. What are lacking are outcomes or benefits defined in individual level and the mechanism how to measure it.

In the pilot case clients and relatives and providers were taken with to redefining process. In workshops all actors (clients, relatives, municipalities and service providers) defined in their point of view which is the most important factors to be taken into consideration when defining housing service.

Challenges occurred how to create the best practices to communicate with autistic people to find out the information needed. Here the relatives had a significant input, but the validity of client´s owns opinions to be noticed remain unsure.

The other target group was service providers who were also taken into defining process. In pilot case workshops were held to providers during the market dialogue. Providers were asked that how they would develop the housing service for autistic people and how they see the possibilities to bring out the benefits more clearly into contracts. Discussions went quite well although participants were each other's competitions. The market dialog had three-steps: first workshop, second individual interviews and third the possibility to comment the procurement documents on the net.

Procurement actors get more information provider`s insights that could be used in re-definition.

1. **Definition of the target group**

The client group comprises clients on the autism spectrum, mainly persons with autism or autism and learning disabilities in ages 20-35 years. Clients mainly study, work or attend daytime activities, with the exception of clients undergoing a supported practice housing period, who may also be at the housing unit during the day.

2. **Definition of the service**

To organize housing services for disabled people is one of the statutory duties for public sector. There are some established practices to provide these services. The minimum standards and minimum quality in producing housing service are usually well defined. They are usually the factors that are defined in legislative or national recommendations.

Housing services include assistance and support that autistic person needs in his everyday life inside the home and partly outside. The assistance and support may be need in individual hygiene, clothing, cooking and eating, cleaning and doing laundry etc. as well as leisure time activities. Individual differences occur in the intensive of assistance and support.

In pilot case the clients already live in their homes (in the housing unit). The procurement process focuses on housing services that are used by the target group. Almost everyone needs 24/7 housing services, some clients need only part-time assistance.

There have sometimes occurred problems in situations when the need for support or care changes during the time caused by changings in individual performance and health. They may have led to the situations where client needs to move to a new home or institution to get the care he needs.

3. Definition of value/ outcome and measurability

From the end-user's perspective, the values are

- Customer can more intensive participate and give their input when defining and designing services.
- Being part of service-defining process will motivate and increase positive effects of customer's welfare and improved self-esteem and independency.

From the public sector's perspective, the values are

- To increase the satisfaction of customers and the effectiveness of housing service in customer's wellbeing.
- Reduce the long-time costs in housing services, when the provider has better capacity to modify the housing services to the customer's chancing needs.

From the service delivery perspective (public or service provider), the expected outcome is the enhanced ability to respond to end-user quality demands.

The main outcome in the pilot case is to have a contract that ensures the end-users' benefits and has the incentive system that ensure that the provider has interest to increase the level of function and independence in clients everyday living. The other outcome is to have a mechanism (practices, measurable quality metrics) in contract that ensures the ongoing evaluation and modification of service.

The table below shows the pilot case's bonus-sanction system in contract. The aim is that bonus-sanction system ensures the quality of housing services and supports the independency of the autistic person.

Outcome/value	Parameter	Measurement
Client satisfaction	Result of the client satisfaction survey conducted according to the 360 development procedure. Change % from comparative figure (the comparative figure for 2014 received X, can be changed by control group) Buyer reports 1 times/year	Incentive (x €) if the positive change is over % of the comparative figure Sanction (x €) if the negative change is over % of the comparative figure
Development	Implementation of individual service for Clients. A change initiated or approved by a Client towards	Incentive €/month of a Client's verified service need reduction approved by the Client.

that strengthens Client independence	more independent service content number/hour/day compared to service used before by the Client. For example, changing the Client's individual service need from the strongly supported service category to supported service. Service Provider reports 6 month period	For example: 2 x (monthly rate of previous content according to the service ecosystem – monthly rate of current service content) x 6 months = Z €
Client involvement	Implementing activities that are organized on the Clients' initiative The number of client initiatives must be > X in order to be taken into account. Events organized based on an initiative must have involved at least > X% of the residents. For example, organizing social gatherings. Service Provider reports 12 month period	
Number of complaints	Creating a comparison figure to which the number of written of complaints is compared. Sanction-free buffer value	Sanction (x €) if under a certain limit value, over % of the comparative figure Incentive (€x) if the positive change is % of previous comparison.

4. Monitoring and evaluation

The outcomes and values of the pilot case will be monitored and evaluated. The social and economic effects and individual experiences will be evaluated by the Sofie analysis programme. The evaluation period will be 1 year.

During the contract period the contract will be monitored and evaluated every 6 months by contract's executive team.

5. Outcomes, analysis and conclusion for future practices

The main outcome is the contract concerning housing services for autistic customers.

In the project has been done a manual for the executive managers who lead the service design and procurement processes. In the manual there are examples how to participate customers in the design process and examples of how to communicate with people who has difficulties in communication.

Methods are applicable in planning new services or to other client groups.

CASE: Procurement of personal lifting and moving systems for private homes, City of Aalborg in Denmark

Case: To achieve a procurement based on operational needs, to meet the potential in keeping the citizens receiving help to be physically able of lifting/moving for as long as possible in their own home

Case owner: City of Aalborg, Denmark (Department of elder and handicap care) and Copenhagen Living lag, a private innovation and consulting company

The Aalborg VABPRO case "Innovative personal lifting and moving" is an innovative procurement (pilot) project funded by the Danish Business Authority, and has been carried out from January 2013 to June 2014. The objective of the project has been to provide a foundation for entering into agreements on innovative assistive technology for lifting/moving within home care in the City of Aalborg. This foundation has been provided through a scrutiny process, divided into two phases:

1. Identification of needs and market screening
2. If no solutions exist to support the identified needs, a procurement based on operational needs will be conducted.

Phase 1 of the project has recently been completed, and will be described below. Phase 2 has not yet been initiated.

Background:

Personal lifting and moving of citizens is a job typically performed by home care employees several times a day. The majority of the employees in home care perform an estimated 2-6 lifts of citizens on an average work day. The personal lifting is often time consuming, as most municipalities have a policy, that two employees are required in order to perform the lift – this also applies to the municipality of Aalborg.

To some extent the lifts are also a physical strain. Citizens who receive help for personal care are categorised by functional capacity: a) Highly self-reliant: Moderate limitations, b) Have difficulties: Severe limitations, C) Not capable: Total limitations.

Until now the consideration of working environment has been the driver of procurement and use of lifts. A former project (by the Danish foundation for Welfare Technology) has aimed to reduce the time consumption of care assistants by reducing the staffing from 2 to 1 when doing personal lifts.

Focus has only to a limited extend been on the citizens' opportunities of achieving a higher degree of experienced freedom and self-reliance by using other lifting systems in private homes.

Especially the job of getting out of bed and into the bathroom/toilet is decisive to the citizen's experience of personal freedom. The project has focused on citizens in all categories. In the "heavy" categories the expectation is better working procedures and working conditions. In the "easy" categories the expectation is that citizens to an even higher degree will become self-reliant.

Thus the possibilities of improvement in the domain of personal lifting and moving lie within released time/hours for employees, improved working environment in the lifting situations and enhanced personal freedom of the citizens. It has been critical to the assessment of efficiency measures for the municipality to be able to reduce the staffing from 2 to 1. However, the objective of this project has to an equally extent been to identify solutions, that make citizens with moderate to severe limitations partly self-reliant (e.g. assisted by partner/spouse). This type of solution will enhance the personal freedom of the citizens.

Definition of the target group

The primary target group of the project is citizens in the city of Aalborg, who receive help for personal care and citizens who have just received assistive technology/tools, but manage on their own, for instance with help from their spouse. Furthermore relatives and personal assistant are involved, including coordinating home trainers, therapists, lifting instructors and social and social and health care assistants.

Definition of the service

Approach

The service solution for personal lifting and moving in private homes is to be defined through a process in two phases:

Ethnographic study: In phase 1 an ethnographic needs study has been conducted to identify and specify needs for support for getting out of bed and into the bathroom at a specification level that allows for a systematic screening of the market and formulation of the demand. The ethnographic study consists of observations and interviews with citizens in the city of Aalborg receiving home care for lifting in their home; 18 people within the age of 32-90 years and with differing lift systems (floor and/or standing lift). Semi structured conversions has been conducted with 5 relatives and 11 assistants, besides groups interviews with professionals, concerning care and lift practice and home/interior arrangement.

The needs analysis includes a mapping and description of insights (clustering of varying needs) relating to existing lifting practice and identification of profiles (citizens segments) with the opportunity of achieving partial self-reliance.

Market screening and evaluation: On the basis of the needs analysis a mapping of the market and a dialogue with potential suppliers has been conducted to clarify whether adequate solutions exist that will

meet the identified needs: The market screening and evaluation is based on stated objectives that has been formulated for home care lifts (with a needs overview and listing of the search criteria), and dialogue has been facilitated with a number of suppliers to clarify the needs for further development of existing solutions – as well as the interest in developing/delivering from their part.

The conclusion of phase 1 is based on an assessment of the identified solutions in relation to:

- Operational (functional) requirements, based on the needs study and profiles
- Economic baseline of the existing costs of the municipality

Source: CLL

Results – Definition and listing of requirements for a personal lifting service

Based on the ethnographic research and analysis 4 profiles has been elaborated and described to identify specific citizens segments, who have the possibility of becoming partly self-reliant (see figure). The profiles are archetypes, each composed of insights from several citizens in the ethnographic study. Each profile is described according to the level of emotional challenges concerning their acceptance of help in the daily living and according to their ability to act on their situation. The four profiles serve as a point of reference in the evaluation process.

Relating to the four profiles 8 themes (insights) has been identified that specify the experienced needs concerning the situations of lifting/moving and the character of the need for help for people with varying degrees of reduced mobility. Each theme reflects specific functional or emotional demands, and is broken down into specific functional requirements to direct the market screening as search criteria. Under each theme a list of functional requirements (functional or emotional) has been listed (see figure below).

Functional requirements	Emotional requirements
Participation • Maximise the possibility of participation and self-reliance, adapted to the individual functional ability and situation • Maximise the possibility of going to the bathroom yourself	Autonomy • Maximise the feeling of autonomy – beeing to decide timing, frequency, destination and by whom and how • Maximise the possibility of making yourself independent of help

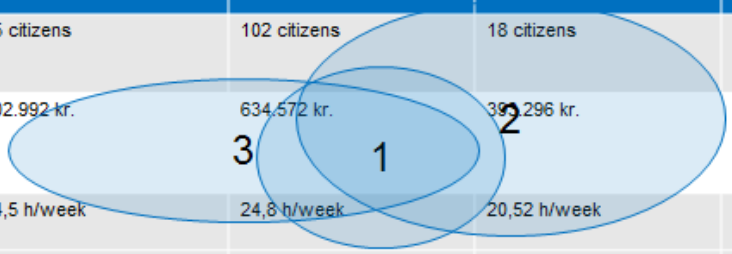
• Maximise the possibility of using all available resources – keeping the body going and supporting potential rehabilitation	
Bodily adaption • Maximise the adaption to the body and its natural movement pattern – to get up • Maximise comfort in the meeting between assistive technology and the body – avoid the feeling bumping against • Maximise the possibility of 'landing right' and siting up well	Safety/footing • Minimise anxiety of falling/beeing dropt • Minimise the feeling of being helpless/at someone else's mercy • Maximise the experience of assurance that the technology will work • Maximise the feeling og footing/'ground connection'
Control • Maximise the possibility of taking control and setting the pace • Maximise the possibility of being able to control safety and precautions	Privacy • Minimise indecent/exposing and unacceptable situations • Maximise the experience of privacy in intimate situations
Discretion • Maximise the adjustment of help/support to the interior of the home (stairs, floors/carpets, doorsteps, ceiling, space) • Maximise the possibility of preserve the homely atmosphere and interior design • Maximise discretion concerning someone being helped	Dignity • Maximise the feeling of having a normal life • Maximise the feeling of being an equal person despite the need for assistance for movement • Minimise the feeling of being an object that needs moving/handling

Source: CLL

As part of phase 1 the municipality's financial costs relating to lifting and moving in private homes has been mapped out, to provide an economic baseline and reference for assessing and estimating the possibilities of improvement in terms of economic outcome (see figure).

The total number of citizens within the target group (158 citizens in the city of Aalborg) has been assessed according to functional ability – classifying whether the citizen is able to lie, sit up, stand or walk. This allows for a closer assessment of resources spent and economic potentials relating to specific service solutions.

	Operational level			
	Can lay	Can sit	Can stand	Can walk
Number of citizens out of 158 citizens in the municipality of Aalborg	25 citizens	102 citizens	18 citizens	13 citizens
Average of total anual costs pr. citizen Home care, cleaning (dressing, medicin, food etc.)	902.992 kr.	634.572 kr.	399.296 kr.	23.244 kr.
Average of total home care hours pr. week.	34,5 h/week	24,8 h/week	20,52 h/week	15,25 h/week
Average of number of liftings pr. day	4,9 l./day	3,3 l./day	3,0 l./day	2,8 l./day
Average of minutes spend on liftings pr. week	129 min./week	95 in./week	77 in./week	40 in./week
Anual cost for the actual lifting time	45.928 kr.	33.823 kr.	27.414 kr.	14.241 kr.
Types af aids distributed in percent	33% - loft lift 60% - floor lift 7% - standing lift	14% - loft lift 63% - floor lift 23% - standing lift	0% - loft lift 68% - floor lift 32% - standing lift	0% - loft lift 77% - floor lift 23% - standing lift
Average of total expences on aids pr. citizen	15.566 kr.	14.051 kr.	13.298 kr.	12.626 kr.



Source: CLL

Conclusions – preparation of phase 2 (tender)

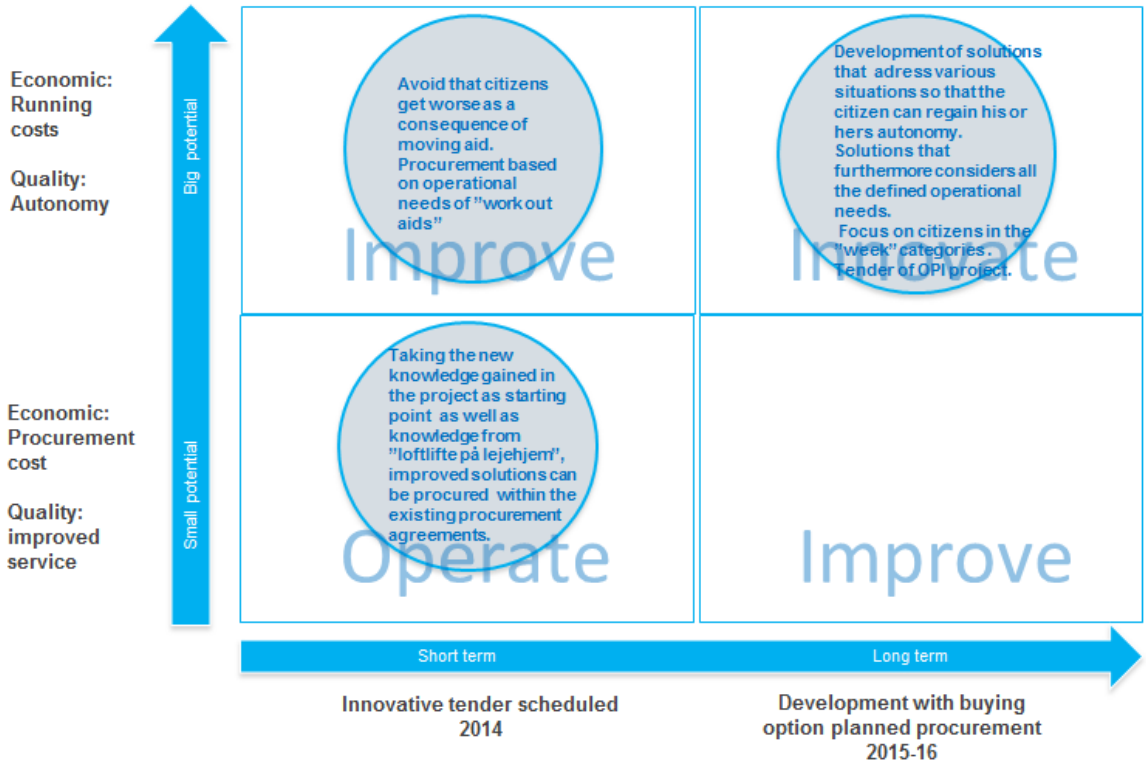
Based on the above mentioned search criteria (profiles, functional requirements and economic baseline) and an assessment of identified possible solutions for a personal lifting service, 3 different possibilities for a tender has been identified (se figure, circles 1-3), supporting different strategies from a procurer and innovation perspective:

1) Transverse solutions, offering the citizen autonomy and reducing operational costs (procurement of improving/better solutions, based on the new knowledge gathered in the project, within the existing procurement contract)

2) Avoid that the citizen gets worse as a consequence of help for lifting/moving (procurement of training technology)

3) Reducing the constraints related to lifting and supporting the citizen in maintaining his home, allowing the citizen to regain autonomy (concerted planning/demand for solutions, considering all the defined functional requirements, with focus on citizens in the weak categories - OPI tender)

The three possibilities (tender strategies) can be described as *operation procurement, improving procurement and an actual innovation project (OPI) with procurement in view*. Each strategy places itself differently in terms of economic and qualitative potential (innovation height) and in terms of time required to realise the procurement (see figure).



Source: CLL

The conclusion of phase 1 in the project is that all of the three above mentioned tender possibilities are worth pursuing. Based on a strategic and financial assessment - regarding the realisation of each possibility - the project has decided on to parallel tracks for a possible continuation (phase 2) of the "Innovative lifting and moving" project:

Track 1: Procurement of training technology (avoid that the citizen gets worse as a consequence of help for lifting/moving)

Track 2: Development collaboration with private supplier (OPI tender, to further develop lifting technologies that reduce the constraints related to lifting and allow the citizen to regain autonomy)

Definition of outcome / value and measurability

Track 1

The objective of track 1 is through a procurement based on operational needs, to meet the potential in keeping the citizens receiving help for lifting/moving physically able for as long as possible. Specifically the focus is on citizens within the category "able to stand" and on keeping the citizens on this level of functional ability for as long as possible and thereby postpone or completely prevent impairment of the functional abilities. In case their functional level of ability is worsened to a degree

that places them in the category “able to sit up”, this implies a significant increase in the care related costs.

The aim of a procurement based on operational needs is to ensure a training effect of the applied technologies for target group, making sure that the daily moving contribute to the citizens maintaining their physique as much as possible, thereby maintaining autonomy and self-reliance.

Track 2

The objective of track 2 is to meet the potential in making the citizens within the category “able to sit up” more self-reliant and give them back their autonomy. This will result in more experience safety and life quality. At the same time there is a substantial potential cost reduction, in reducing care resources by enabling citizens to handle more jobs/procedures on their own.

Track 2 requires development collaboration between the municipality and private supplier. One supplier has shown interest in developing their lifting system.

Market screening and evaluation of service solutions

The 4 citizen profiles, the 8 themes and functional requirements and the economic baseline have served as search criteria and a frame work in the dialogue with potential suppliers. Subsequently each proposal (supplier and/or service solution) has been evaluated according to the perceived value and economic outcome.

VABPRO Manual

CHECKLIST FOR VALUE BASED SERVICE DESIGN AND PROCUREMENT

The aim with this checklist is to support new undertakings of Value based service re-design and procurements. It hopefully also provides an analytical and structured approach to any type of value based investment that aims to create system level societal impact.

It contains a list of issues that have been relevant for the VABPRO-project and the development of the Value based procurement process. It is not an exhaustive list, but aims to provide a basic structure and set of issues any organization should reflect upon when approaching social and healthcare services provisioning in a new and more holistic way.

Organizational issues

- Health and social care providers have clear and internally shared understanding of their organizations strategic objectives
- Health and social care providers have defined service area specific challenges and objectives for change
- Organizational silos and boundaries are identified and decisions taken to which extent redesign of the services is possible in this (VABPRO) context
- Adequate resources for development and evaluation work can be found in the organization
- Impact accountability is a shared value
- Cost-benefit analysis can be done and stretched over a longer period of time.
- Measuring does cost -> work in an area where this pays off and the pay back can be made visible creating thus evidence on the value of chosen alternative investments.

Definition of target group and service, use of data

- Do understand your current service use, cost structure and allocation of resources in a given area. If possible analyse the current service use using available data in selected social and health care areas. If data is not available try to quantify and describe current service and resource use in another manner.
- Identification and segmentation of the service users. Based on the current service use analysis identify the service user groups that you wish to target. Based on the analysis create eventually new user segments you wish to target.
- Needs assessment and Re-design of the service, (re-allocation of resources). Based on the service use analysis and new segmentation re-design the services in a user-centric manner – eventually with clear focus on primary or secondary prevention.

Co-creation with the users

- Design the new value based services also together with the end-users (patients, families etc)
- Choose an appropriate method for co-creation depending of the service and target group
- Ensure that the users are part of the continuous development and evaluation of the services
- Create effective and easily implementable ways of collaboration and inclusion.
- Create an atmosphere and working model that ensures trust, empowerment and inclusion.

Market dialogue with the suppliers

- Engage with the market (suppliers) in the pre-procurement phase already in order to understand what is feasible and what is not
- The buyer and provider need to share a common vision and objectives for the service production in order to create optimal conditions for continuous improvements.
- Incentives for both parties need to be aligned and lead to same direction and towards a common also by the service user shared goal.
- Make sure that value objectives, metrics and evaluation methods are transparent, fair and easily implementable also in reality.

The Value creation process, use of data

Setting the general and service areas specific objectives:

- The new service concepts and working methods should be based on user empowerment and inclusion.
- The provider (payer) organization should have common shared objectives, which are not hindered by silos. These objectives should be taken into consideration if needed also in the system level resource allocation.
- Make sure that defined value objectives are clearly communicated to the service supplier and do not infringe with any legal requirement on the service quality in question.
- Work preferably with areas where you can get valid data (service use, financial figures etc)

Setting the metrics and evaluation parameters, transferring the specifications into proper tender documentation

- The role of quantitative analysis and metrics is very important – using a combination of quantitative and qualitative analysis and metrics are often the best way to create understanding in the area in question.
- Accept that causality is not always easily or scientifically definable and that you might need to "learn by doing"

- Define clear and understandable metrics that can be monitored over time.
- Be prepared to change/adopt the metrics and evaluation model in collaboration with the service provider if needed during the contract period. Include appropriate contract clauses into the tender documentation.
- Transfer the Needs and defined new value based specifications properly into tender documentation

Creating incentives and reimbursement models

- The importance of metrics and monitoring becomes increasingly evident when designing reimbursement models. If this cannot be done, the prerequisites for creating incentives for outcome and value creation are lacking.
- Incentives and reimbursement models should be constructed carefully and be service area specific. They should also be monitored and changed if they do not actually drive better outcomes or if other difficulties arise in using the model.
- Cost burden of publicly paid services can rarely become higher therefore the aim of an innovative procurement should be a positive or at least a neutral impact on the total costs of services -> design you reimbursement model in a way that the system level costs are sustainable and that re-allocation of resources remains possible over time.
- Secure your own organizations financial and other resources when changing the way you work and collaborate with end-users and suppliers - > if savings occur, consider using some that into improving your own organization capabilities to interact with the suppliers and users of the services.

Securing continuous improvement and sustainability

- Understand and secure fare and sustainable business margins in order to make it possible for the supplier to develop its services and stay competitive on the market.
- Aim at long term collaboration with the supply side, creating incentives for the suppliers to satisfy also your mid to long term service needs
- Find an appropriate balance between direct financial compensations for value creation (bonus-sanction models) and other ways of rewarding the supplier, e.g. buying more services from the same supplier.
- Create a structured and trust based collaborative development model with the supply side that allows for continuous improvement and adjustable contracts based new learnings.