A bundle of joy? Evaluating bundled payments for maternity care in the Netherlands

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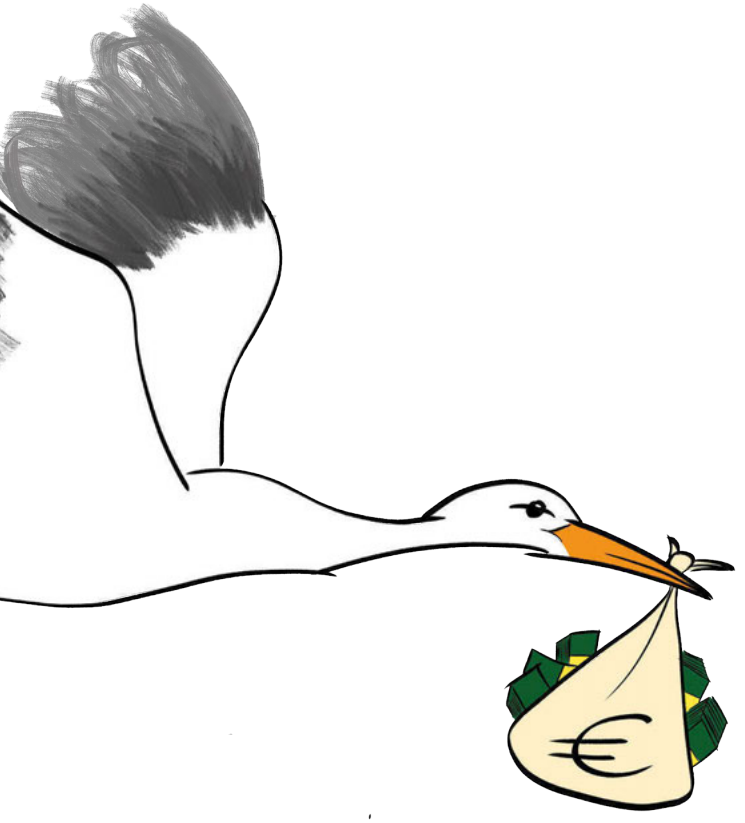

Chapter 6

General discussion

Background and objective of this thesis

In 2017, bundled payments for maternity care were introduced in the Netherlands on an experimental basis. The aim of the bundled payments is to improve coordination and collaboration between maternity care providers and thereby, improve the quality of maternity care and health outcomes of mothers and children.

The main objective of this thesis was to evaluate the bundled payment model for maternity care and to provide relevant insights for payment reform in maternity care. Using an approach with both methodological diversity (quantitative, qualitative and mixed methods) and different perspectives (of payers, providers, professionals, policy makers, experts, and notably, maternity care clients), the studies in this thesis provide answers to the research questions that were posed:

1) how can we apply observational data to evaluate the bundled payment model for maternity care?
2) what is the impact of the bundled payment model for maternity care on health outcomes of mothers and children, maternity care utilization, and maternity care spending?
3) what are the different perspectives of stakeholders on the bundled payment model for maternity care?

This final chapter first summarizes and integrates the main findings of the individual chapters and answers the research questions. Subsequently, reflections on the main findings are provided. The chapter continues with a discussion of methodological considerations and suggestions for future research, followed by implications for policy and practice, and ends with concluding remarks.

Main findings

1) how can we apply observational data to evaluate the bundled payment model for maternity care?

In **Chapter 2**, we addressed the growing availability and importance of routinely collected observational data for evaluations of health policy interventions such as payment reforms. We introduced the Dutch data-infrastructure 'DIAPER' (Data-InfrAstructure for ParEnts and childRen),

which links individual-level maternity claims data, perinatal registry data, and social statistical datasets. We demonstrated how DIAPER was applied to study various research topics related to preconception, pregnancy, maternity care, early childhood and the 'first 1000 days', as examples of the many potential applications of observational data. At the same time, we identified persistent challenges for the use of observational data, including incomplete data sources, variation in data quality, linkage issues, and risks of bias inherent to observational designs (1, 2). Overall, we argued that large-scale observational data-infrastructures such as DIAPER can make a substantial contribution to evaluations of health policy interventions, provided that sufficient attention is given to data completeness, quality assurance, linkage methodology, prevention of bias introduction, and ethical governance.

2) what is the impact of the bundled payment model for maternity care on health outcomes of mothers and children, maternity care utilization, and maternity care spending?

In **Chapter 3**, we studied the effects of the bundled payment model for maternity care on the health outcomes of mothers and children, maternity care utilization and spending during its first two years. This first quantitative evaluation focused on six regions that adopted the bundled payment model in 2017. We applied a quasi-experimental difference-in-differences approach using data from DIAPER (3). The findings showed that bundled payments were associated with an increase in outpatient, midwife-led births and a reduction in in-hospital, obstetrician-led births, along with changes in the use of labor inductions and planned versus emergency cesarean deliveries. Bundled payments were also associated with spending growth reductions. The size and the direction of the associations were heterogenous across integrated maternity care organizations (IMCOs). No changes in health outcomes of mothers and children were found. This chapter has revealed the modest but evident impact of the bundled payment model during its first two years after implementation.

3) what are the different perspectives of stakeholders on the bundled payment model for maternity care?

Based on theoretical notions, there is consensus that APMs have the potential to improve health care quality through increased collaboration (4, 5). This alone would suggest that APMs should be widely implemented. However, adoption of APMs in practice remains low and fee-for-service models prevail. This has also been the case in maternity care in the Netherlands. From the

beginning of the experiment, some providers have been apprehensive of undesired consequences as a result of bundled payment implementation causing them to be reluctant to adopt the payment reform. A deeper understanding of stakeholders' perspectives on payment reform in maternity care is necessary to inform policy makers about the obstacles to implementing APMs and potential ways forward. Therefore, we conducted a Q-methodology study in **Chapter 4** to explore perspectives of stakeholders in maternity care on payment reform (6). We identified three distinct perspectives on payment reform in maternity care. One general perspective, broadly supported within the maternity care sector, focusing mainly on the goal of payment reform being an improvement in health outcomes for mothers and children, and two complementary perspectives, one focusing more on equality among various disciplines as a condition for payment reform and one focusing more on collaboration between disciplines as an intermediate goal of payment reform. This chapter shows there is consensus among stakeholders in maternity care that payment reform is required. However, stakeholders have different views on the purpose and desired design of the payment reform and set different conditions. Working towards payment reform in co-creation with all involved parties may improve the general attitude towards payment reform, may enhance the level of trust among stakeholders, and may contribute to a higher adoption rate in practice.

While evaluations of APMs have become more extensive and increasingly incorporate the views of various stakeholders, the client perspective is often missing. In **Chapter 5**, we take an important first step toward addressing this gap by exploring the themes that are important to maternity care clients and should be included in evaluations of payment reform in maternity care. Findings show that participants prioritized themes focused on the personal care experience over system-level themes. Further research is needed to validate the identified themes in a larger and more diverse group of participants, particularly among people in vulnerable situations. This may provide insight into whether a hierarchy of client preferences exists and whether some clients place greater importance on system-level themes such as quality, accessibility, and affordability. This study highlights the importance of incorporating the client perspective into evaluations of payment reform in maternity care. Rather than directly assessing clients' views on payment reform, which is often complex and not apparent for clients, the focus should be on ensuring that aspects of care valued by clients are not adversely affected by payment reform. While existing evaluations tend to emphasize

system-level outcomes prioritized by other stakeholders, our findings show that clients place greater importance on themes related to their personal care experience. The client perspective therefore provides an essential complement to current evaluation frameworks. Expanding evaluations to include client-relevant themes can lead to more comprehensive assessments of payment reform and support informed policy decisions in maternity care.

Reflection on findings

When considering the results presented in this thesis, several observations stand out. First, the findings suggest that bundled payments in maternity care do have some influence on provider behavior as we observed changes in maternity care utilization and task shifting from obstetricians to community midwifes. Yet, the overall effects of the model, measured during its first two years, are modest. In particular with regard to health outcomes, where no changes have been observed. However, it is questionable whether it is realistic to expect a payment model to have a direct effect on health outcomes. It is much more likely that such effects occur indirectly, through intermediate outcomes such as improved collaboration, coordination, and continuity of care. Therefore, it may be unrealistic to expect measurable changes in health outcomes associated with payment reform after the short follow-up period of two years. Other APM evaluations have also shown that it takes time for effects to fully materialize (7-9). In addition to this, it is possible that only a subgroup of the entire population of pregnant women benefits from the improved collaboration fostered by the bundled payment model. By assessing the effects of the model in the entire population of pregnant women in our analysis, there is a risk that meaningful effects of the bundled payment model for a small subgroup are diluted in the overall analysis and appear to be zero.

Second, it is becoming increasingly evident that nonfinancial features are important to implement alongside a new payment model (10). Signing a bundled payment contract is an important step toward more intensive, structured collaboration between health care providers, but it is only the beginning. Without additional support, real improvements often fail to materialize. IMCO representatives stated that the bundled payment model has provided them with a useful lever to implement changes more quickly and effectively, but that they often still lack sufficient knowledge about which

care processes or interventions are most effective in improving outcomes in their local setting. To overcome this, providers indicated a need for more insight into the characteristics of their population and the specific problems that need to be addressed and more information about the available, effective interventions that can be used to tackle these issues.

Third, it is important to remember that the process of payment reform is time-consuming, resource-intensive, and complex. Establishing and maintaining realistic expectations is essential for staying on course, not only for providers but also for payers and policy makers. It is unrealistic, and perhaps even unfair, to plan to draw definitive conclusions about the success of a payment reform initiative after only a few years. Especially if the necessary support for successful implementation has been (partly) lacking and the focus is on evaluating health improvements rather than intermediate outcomes. Realistic expectations must be established in advance regarding both the effort required to implement payment reform as well as the results that can reasonably be expected, including the timeframes in which they may materialize. In the experiment with bundled payments for maternity care this didn't receive enough attention at the start, which resulted in unrealistic expectations of stakeholders regarding the effort that was needed for implementation and the results it would have. Setting these realistic expectations upfront is essential for a thorough, balanced evaluation of payment reform. As it creates the space and awareness to determine which range of outcomes should be measured, when it makes sense to evaluate specific outcomes, and how long experimentation and evaluation need to continue before drawing definitive conclusions about the success of payment reform and making policy decisions on continuation, termination or scaling based on this. Without the right expectations upfront, there is a risk that experiments will be prematurely dismissed based on incomplete results or unrealistic goals.

Finally, a clear, jointly defined and agreed on goal and definition of success of the experiment with bundled payments for maternity care have been missing as well. As a result, and combined with the previous reflection, it has been difficult to make informed policy decisions about the future of the model. The limited effects after two years combined with the different

interests, expectations, and perspectives of the various stakeholders and the lack of a clear goal and definition of success established beforehand, allows everyone to cherry-pick from the results and create their own narrative. This generates noise and undermines a clear focus on how to move forward. Ideally, all stakeholders should have agreed in advance on the specific goal of introducing the bundled payment model in maternity care (11). At present, there is consensus that some form of payment reform is needed (Chapter 4) and that this reform is expected to improve collaboration and quality of maternity care. However, these ambitions are too general and insufficiently specific. It would have been preferable to develop a matrix beforehand, outlining various possible outcome scenarios and indicating which policy decisions would correspond to each (see Figure 1 for an example of this) (12). While it may not be feasible to achieve full consensus among all stakeholders regarding the goal and definition of success, this approach would at least ensure that expectations are discussed explicitly and clearly articulated from the outset. In addition, there should have been greater clarity from the start about who holds overall responsibility for the experiment and who has the mandate to make key decisions regarding continuation, scaling, or termination. This role may be held by the government, but can also be assigned to other entities such as health insurers or provider networks (13). Clear leadership and vision are essential to give the experiment a real chance of success and, if desired, to scale it up further in the future. Such leadership can also help prevent excessive compromise and ensure that the project does not drift too far from its original plan, design, and objectives. Otherwise, there is a risk of ending up with a diluted version of the original plan. One that satisfies no one, proves only marginally effective, and can easily be dismissed as “ineffective,” even though it no longer reflects the original intent. Once the goal and the definition of success are clear, it is important to develop an appropriate evaluation and policy plan for the entire duration of the experiment. The evaluation plan should specify what will be evaluated, at what times, and using which methods, considering the effects that can reasonably be expected at different stages of implementation. It should also outline when policy decisions will be made, considering a realistic timeframe, which is often longer than what is desired from a governance perspective. Ideally, all of this should be determined before implementing the payment reform.

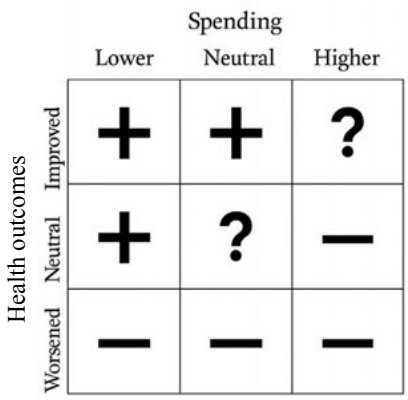

Figure 1. An example of a matrix for policy decisions under different outcome scenarios (adapted from: Toolkit BUZZ2 study (12))

Methodological considerations

There are several methodological considerations regarding the strengths and limitations of the research presented in this thesis and the evaluation of payment reform in general. The combination of multiple methods and approaches and the consideration of nearly all stakeholder perspectives relevant to maternity care (including those of clients) are some of the strengths and unique aspects of the research presented in this thesis. In Chapters 2 and 3, we focused on observational data and quantitative research methods. This provides a broad, factual assessment of the experiment. In Chapters 4 and 5, we used other, more qualitative research methods, looking at the experiment from the perspectives of different stakeholders. Through this, we were able to pay attention to both 'measurable' and 'perceptible' changes resulting from payment reform in maternity care. In addition, we examined what stakeholders and clients consider important regarding payment reform in maternity care (what changes they hope it will bring about, and which aspects they want to preserve). Looking at the existing literature on payment reform in health care, it is quite unique to evaluate a single experiment this comprehensively and from so many different perspectives. Most other evaluations are more one-dimensional, focusing on a single aspect rather than capturing the full complexity of the experiment. Nonetheless, several limitations of the research presented in this thesis must be acknowledged.

First, not all perspectives were fully captured, particularly those of vulnerable or marginalized groups. This limitation is evident in both the qualitative research in Chapter 5, which included few participants from minority or vulnerable groups, and the quantitative research in Chapter 3, which did not examine how the effect of the bundled payment model varied for individuals with different risk or vulnerability profiles. This has implications for the extent to which the results can be interpreted and generalized beyond the study context.

Second, a key limitation is the length of the follow-up period for the quantitative analysis, which raises the question of whether this timeframe is sufficient to expect meaningful effects of the bundled payment model. It remains uncertain whether the limited effects of the bundled payment model observed in Chapter 3 are the result of a short follow-up period, a lack of nonfinancial features supporting effective implementation or the bundled payment model simply not being as effective in practice. This limitation further underscores the importance of extending follow-up periods in future evaluations when assessing quantitative, end-point outcomes such as changes in health, or to evaluate other types of outcomes if results are needed sooner to inform policy decisions in earlier phases of the payment reform.

Third, despite the growing availability and improved quality of observational data as presented in Chapter 2, a limitation continues to be the absence of several relevant data sources. Such as nationwide, standardized measures of regional collaboration in maternity care networks, data on the quality of postpartum care at home, and data collected through maternity care patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs). To address this in the future, it is crucial to identify early on which data are required for a comprehensive evaluation and to ensure that these are collected in a timely and accurate way. If this is not feasible in practice, other outcome measures or research methods should be considered. Moreover, existing observational data should be made more broadly accessible for research, in full compliance with privacy legislation and the FAIR data principles (14). Ultimately, there is a shared desire among stakeholders to gain deeper insight into maternity care processes and outcomes in order to improve them collectively. As long as data sharing or providing access to data is conducted safely, there is no valid reason to withhold existing data from being used for scientific research or to provide maternity care providers with the insight into population characteristics they need to realize improvements.

Future research

The findings in this thesis showed that the bundled payment model for maternity care seemed to exert heterogenous effects across the different IMCOs. As we observed that the same financial incentive (i.e., the bundled payment contract) translated into different changes in clinical practices (e.g., implementation of a shared electronic patient record vs. task shifting from obstetricians to community midwives) and outcomes (e.g., increase vs. decrease in labor inductions). Available literature on payment reform also indicates that context matters (15). Some studies have been conducted to explore the influence of different contextual factors and the mechanisms through which they affect APM implementation, outcomes and effectiveness (16, 17). However, we still only partly understand how exactly context influences the effects of payment reform in maternity care. Further research is needed to identify which contextual factors matter, how they exert their influence, and how this affects changes in clinical practices and outcomes associated with payment reform in maternity care. If we can unravel how this mechanism works, we can take it into account during the design of APMs for maternity care and potentially also use it to better support participating provider networks based on their local context and needs.

In addition, future research is needed to examine how the effect of the bundled payment model may vary across maternity care clients with different risk or vulnerability profiles. It is conceivable that the enhanced collaboration between professionals fostered by the bundled payment model may lead to greater improvements in outcomes for clients with moderate risk, instead of clients with high or low risk. High-risk clients are often already closely monitored, and the potential for improvement among low-risk clients is generally limited. Moreover, both high- and low-risk groups typically remain within either primary (low-risk) or secondary (high-risk) care throughout pregnancy and experience fewer transitions between care levels compared with the moderate-risk group. Since the bundled payment model is aimed at improving collaboration between primary and secondary care and enhancing continuity of care, these potential improvements are less relevant for the low- and high-risk groups, although they are still included in our analysis of the model's effects. In contrast, risks in the moderate-risk group may go unnoticed more frequently, and the potential for improvement may be substantial when collaboration and continuity of care are strengthened. Therefore, the moderate-risk group could potentially benefit most from the

bundled payment model. This hypothesis should be explored to determine whether it holds true and how such insights could inform the further development of payment reform in maternity care. Similarly, the effects of the bundled payment model may vary depending on the degree of vulnerability maternity care clients experience. Improved collaboration and continuity of care may, for example, have a greater impact on clients in a more vulnerable situation. This could be because these clients often have more complex health needs, face a higher risk of care fragmentation, or benefit from closer monitoring and early intervention. Enhanced collaboration and continuity of care help address these challenges by ensuring better coordination, clearer communication, closer monitoring, and more timely interventions, potentially resulting in proportionally greater benefits for clients in a more vulnerable situation. It is important to investigate whether and how the impact of bundled payments differs across levels of vulnerability, to understand the mechanisms behind these effects, and to clarify their implications for maternity care.

Implications for policy and practice

The results of the research presented in this thesis and the reflections on these results yield several implications for policy and practice. I will first discuss several implications relevant for maternity care specifically, followed by implications relevant for those working on payment reform initiatives in health care in general, and end with a reflection on how the transition to APMs relates to the broader transformation of the health care system.

For maternity care specifically, there is a need to collect even more, nationwide observational data to fill gaps in existing data sources. In addition, existing observational data should be made more widely available for academic research and to provide maternity care providers with insight in their population and its needs. Stronger government oversight and coordination are needed to ensure this happens. The current ZonMw program ‘Passende Zorg’ could present an opportunity for financial support in the coming years to ensure important, additional data is collected and existing data is made more widely available (18). Moreover, those tasked with evaluating APMs should become more aware of the existing opportunities to use observational data in their evaluations. DIAPER is a strong example of what becomes possible when routinely collected data are linked and used for such evaluations. There is a need to further increase awareness of these possibilities and to promote

their broader use among researchers. To support this, it is essential that data can be shared and reused safely and responsibly by different research teams in an efficient way.

Another important implication for maternity care is that IMCOs require greater nonfinancial support alongside the payment reform. From the start, they need legal, organizational, and managerial support and practical tools to establish and further develop their organization and governance-structure. Following that, IMCOs also need support to gain insight into their patient populations and the most effective interventions to improve outcomes in their local context. Health insurers and the government should either provide this support or outsource it and ensure that the necessary support is provided. On top of this, influential organizations within maternity care networks (e.g., hospitals) and government structures should facilitate and incentivize payment reform rather than impede it, ensuring the entire system participates in the transformation and works towards the same goal. Achieving this requires sustained momentum and prioritization which can only be imposed top-down.

To summarize, and drawing on the results and reflections in this thesis, I would like to put forward the following considerations for new payment reform initiatives. To begin with, it is crucial to clearly define the goal and definition of success prior to implementation. Based on this, a realistic evaluation and policy plan should be developed to properly inform policy decisions along the line. Although this process is time-consuming and often overlooked, it is a necessary step. The alternative, repeatedly launching experiments and abandoning them after a few years, wastes resources and produces little to no new insights. Careful attention should also be given to the payment reform design and adherence to that design. Co-design with stakeholders is important for developing a robust payment model and building support, but excessive compromise should be avoided. Risk mitigation strategies appear to be important for enhancing APM adoption by reducing the (perceived) financial risks for providers (19). However, these measures should be applied in moderation and, ideally, for a limited duration, as excessive or prolonged mitigation can undermine the fundamental incentives of the APM, which are necessary to drive the intended changes in provider behavior (5).

In addition, successful APM implementation requires a clear strategic vision. It could be argued that it may be more effective if the government implements

proposed payment reform initiatives, such as the bundled payment model in maternity care, through a mandatory, top-down approach. Too much negotiation, voluntariness, and fragmented experimentation may fail to produce the desired effects (e.g., improved collaboration and quality on a national level). Stakeholders operate with a variety of interests, which makes it difficult to reach full transparency and alignment; as a result, progress can become slow and complex. More centralized coordination and direction may therefore be necessary, for example by mandating the adoption of APMs rather than leaving their implementation to providers and payers. For maternity care, this ship may have sailed, but in other health care areas, mandatory implementation from the outset could help accelerate transformation. In general, it is important for the government to reflect on its role at different stages of payment reform and similar transformation processes, to determine when it should take a step back and allow the field to take the lead, and when stronger governmental direction is required (20).

Lastly, the transition towards APMs, in maternity care and beyond, should be understood as part of a much broader, long-term transformation of the Dutch health care system as envisioned in the Integrated Healthcare Agreement (in Dutch: Integraal Zorgakkoord, IZA) and the Additional Care and Welfare Agreement (in Dutch: Aanvullend Zorg- en Welzijnsakkoord, AZWA) (21, 22). The goal is a transformation from health care to health, from volume to value, and from fragmented delivery to integrated, population-level approaches. This transformation is complex, slow, and multifaceted, involving many interdependent elements and significant effort and willingness to change from all actors in the system. This transformation requires changes in how providers work together, how risks are shared between payers and providers, how financial incentives for providers are structured, and how citizens view their own role in health and self-management. For this transformation to succeed, payment models must support the new ways in which we aim to structure the health care system and provide care in the future. Payment models need to be flexible, cross-sectoral, and designed to reward collaboration, prevention, coordination, quality and value creation. Therefore, payment reform is an essential part of the health care transformation. Considering the findings in this thesis, the bundled payment model for maternity care is illustrative of how APMs can promote collaboration and other changes in provider behavior in practice. This confirms the potential of APMs to drive health care transformation. Consequently, the lessons learned in maternity care are also relevant to the broader transformation of the health care system.

Concluding remarks

In summary, the results in this thesis indicate that the use of observational data offers new opportunities for evaluating payment reform. Furthermore, the bundled payment model appears to influence provider behavior in the maternity care context, as evidenced by changes in care utilization and reduced spending growth without observed changes in health outcomes. Stakeholders agree on the importance of payment reform in maternity care, yet they hold different views regarding its goal and design. Clients primarily prioritize their personal care experience with maternity care, which needs to be included in future evaluations of payment reform in maternity care.

It is relevant to further explore the influence of context, as well as client risk and vulnerability profiles, on the effects of the bundled payment model in maternity care. In addition, supporting IMCOs with nonfinancial features alongside payment reform is required to maximize its potential and the collection and use of observational data must be further developed and encouraged within maternity care. For new payment reform initiatives, it is crucial to carefully define the objectives and definition of success in advance, and to align a realistic evaluation plan and policy trajectory, clearly specifying who has the mandate to make policy decisions regarding continuation, scaling, or termination. Payment reform is essential to health care transformation because it supports new ways of organizing care, incentivizes collaboration and value over volume, and helps drive the behavioral and structural changes needed for an integrated, population-focused system. Therefore, it is important to further pursue developments regarding payment reform in health care.

Finally, it is important to remember that payment reform requires time and effort. Maintaining a long-term perspective and staying the course is essential. Strong, visionary leadership, both on the provider-side and the payer-side, plays an important role in this. In maternity care, we have to continue to develop and experiment until the financial incentives of the payment model are fully aligned with the goals and ambitions of integrated maternity care. Achieving this will require moving well beyond the comfort zone of fee-for-service.

A bundle of joy?

In this thesis, I explored whether the bundled payment model for maternity care can be considered ‘a bundle of joy’. Much like caring for a newborn, implementing the bundled payment model in maternity care has proved to be challenging and requires a lot of time, effort, coordination and support. While the full benefits are not yet certain, the bundled payment model shows potential to improve collaboration among health care professionals. With the right support and adjustments, the bundled payment model can still achieve its potential and foster collaboration in maternity care on a larger scale, potentially improving quality of care and maternal and neonatal health outcomes in the long term. Only then can we truly say that the bundled payment model for maternity care is ‘a bundle of joy’.

References

1. Gilbert R, Lafferty R, Hagger-Johnson G, Harron K, Zhang LC, Smith P, et al. GUILD: GUidance for Information about Linking Data sets. *J Public Health (Oxf).* 2018;40(1):191–8.
2. Neophytou AM, Kioumourtzoglou MA, Goin DE, Darwin KC, Casey JA. Educational note: addressing special cases of bias that frequently occur in perinatal epidemiology. *Int J Epidemiol.* 2021;50(1):337–45.
3. Dimick JB, Ryan AM. Methods for evaluating changes in health care policy: the difference-in-differences approach. *JAMA.* 2014;312(22):2401–2.
4. Miller HD. From volume to value: better ways to pay for health care. *Health Aff (Millwood).* 2009;28(5):1418–28.
5. Frakt AB, Mayes R. Beyond capitation: how new payment experiments seek to find the 'sweet spot' in amount of risk providers and payers bear. *Health Aff (Millwood).* 2012;31(9):1951–8.
6. Watts S, Stenner P. Doing Q methodological research: Theory, method & interpretation. *Sage Publications*; 2012.
7. Song Z, Ji Y, Safran DG, Chernew ME. Health care spending, utilization, and quality 8 years into global payment. *N Engl J Med.* 2019;381(3):252–63.
8. Song Z, Rose S, Safran DG, Landon BE, Day MP, Chernew ME. Changes in health care spending and quality 4 years into global payment. *N Engl J Med.* 2014;371(18):1704–14.
9. Rolnick JA, Liao JM, Emanuel EJ, Huang Q, Ma X, Shan EZ, et al. Spending and quality after three years of Medicare's bundled payments for medical conditions: quasi-experimental difference-in-differences study. *BMJ.* 2020;369:m1780.
10. Pandey A, Eastman D, Hsu H, Kerrissey MJ, Rosenthal MB, Chien AT. Value-Based Purchasing Design and Effect: A systematic review of value-based purchasing programs, financial and nonfinancial features, and quality and spending outcomes. *Health Aff (Millwood).* 2023;42(6):813–21.
11. Kadakia KT, Song Z. Saving Money or Improving Health? Reconsidering Payment Reform. *Milbank Q Opin.* 2022.
12. BUZZ2 Project Team. Toolkit Funding Outcomes of Care for Pregnant Women. 2023. [in Dutch]
13. Sood N, Higgins A. Posing a framework to guide government's role in payment and delivery system reform. *Health Aff (Millwood).* 2012;31(9):2043–50.
14. Wilkinson MD, Dumontier M, Aalbersberg IJ, Appleton G, Axton M, Baak A, et al. The FAIR Guiding Principles for scientific data management and stewardship. *Sci Data.* 2016;3:160018.
15. Conrad DA, Vaughn M, Grembowski D, Marcus-Smith M. Implementing value-based payment reform: a conceptual framework and case examples. *Med Care Res Rev.* 2016;73(4):437–57.
16. Hendriks CMR, Vugts MAP, Eijkenaar F, Struijs JN, Cattel D. Alternative payment models in Dutch hospital care: what works, how, why and under what circumstances? Protocol for a realist evaluation study. *BMJ Open.* 2024;14(9):e082372.

17. Cattel D, Hendriks C, Eijkenaar F, Steenhuis S, Vugts M, Gajadien C, et al. Development and Implementation of Alternative Payment Models in Healthcare: Doing, Learning, and Evaluating. 2023. [in Dutch]
18. ZonMw. Program Text for the Framework Program 'Appropriate Care'. 2024. [in Dutch]
19. De Vries EF, Scheefhals ZTM, de Bruin-Kooistra M, Baan CA, Struijs JN. A scoping review of alternative payment models in maternity care: Insights in key design elements and effects on health and spending. *Int J Integr Care.* 2021;21(2):1–12.
20. DRIFT, NSOB. Steering in Transitions: A Framework for Strategy Development. 2020. [in Dutch]
21. Ministry of Health, Welfare and Sport. Integrated Healthcare Agreement: 'Working Together for Healthy Care'. 2022. [in Dutch]
22. Ministry of Health, Welfare and Sport. Additional Care and Welfare Agreement. 2025. [in Dutch]