HEALTH CARE REFORM IN THE NETHERLANDS

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Ministry of Health, Welfare and Sport
Single, multiple and competing purchasers in European health systems

- Single purchaser
- Regional, but functionally single purchaser
- Non-competing multiple purchaser
- Competing purchaser
Goal of reform debate

1. Who is the prudent buyer of care on behalf on the consumer?

2. Yes/No competition among:
   - Providers of care?
   - Sickness funds / Insurers?

3. Which benefits package?

4. Which premium structure?

How to build a sustainable health care system

• Fair share of solidarity
• Efficiency seeking
• High responsiveness to change
1. History & change process
2. Reform results & evaluation
3. Challenges & opportunities
- 16 million inhabitants
- 100 hospitals
- 16000 medical specialists
- 8000 general practitioners
- 21 insurance companies
- € 60 billion spent on health care = 10% GDP
Characteristics of the Dutch Health Care system

- **Tradition of private initiative**
  - Hospitals, nursery homes are *privately* owned
  - Medical specialists and general practitioners are mostly *private* entrepreneurs

- **Former health insurance system**
  - 60% social insurance (below average income level)
  - 30% *private* insurance (no government interference)
  - 10% civil servants, elderly etc.

- **Growing government interference (from ± 1980 onwards)**
  - Main objective: cost containment
  - Detailed price regulation, budgeting
  - National & regional planning & licensing
Pros & cons of the former system

• Pros
  ➢ Cost containment on macro (national) level
  ➢ Policy implementation through intervening *in* the system
  ➢ *Quality* (of health care delivery)

• Cons
  ➢ Macro efficiency, micro inefficiency
  ➢ Lack of spirit of enterprise & innovative climate
  ➢ Rationing → waiting lists

• Growing pressure on the system
  ➢ Demographics (ageing & labor market)
  ➢ Technology developments
  ➢ Law suits
Increasing pressure on the system by: growing wealth, advancing medical technology and aging population.

Solution: less central regulation and stronger competition
Means and ends

More room to move (choice, invest, contract)

Decentralized responsibilities (duty of care, duty to insure)

Innovation

Entrepreneurship

Health care meets demands
Price meets performance

Purchasing health care
Not by insurance alone..

• **Room to move**
  - Freedom of contracting (insurer ↔ health care provider)
  - Freedom of price negotiations (2009: 34% of hospital care)
  - Freedom of capital investments (capital costs in DRG’s)

• **Incentives & responsibilities**
  - From budgeting to output pricing / p4p
  - Insurers & providers have to compete for clients
  - Quality indicators for hospital and outpatient care
  - Increase amount of risk of insurers and providers
  - Duty of care for health insurers
Not by insurance alone (2)

Government safeguards:

- Accessibility (of health care delivery & insurance)
- Affordability (of health care delivery & insurance)
- Quality (of health care delivery)

- Health Care Inspectorate (quality of care)
- Health Care Authority (market development, price regulation)
- Health Insurance Board (package of entitlements, risk equalization)
The insurance reform 2006

- Compulsory insurance (consumers)
- Open enrolment (insurer)
- Legally defined coverage (insurer)
- No premium differentiation (insurer)
- Submission to risk adjustment (insurer)
- Income related contribution (consumer)

Managed competition

- Compulsory deductible (consumers)
- Free to set nominal premium (insurer)
- Free to offer different policies (insurer)
- Free to offer suppl. deductible (insurer)
- Free to engage group contracts (insurer)
## Compartments of the Social Insurance System

<table>
<thead>
<tr>
<th>Long Term Care Act</th>
<th>Health Insurance Act</th>
<th>Supplemental Health-insurance</th>
<th>Social support act</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“Care”</strong></td>
<td><strong>“Cure”</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LT care elderly</td>
<td>General Practitioners</td>
<td>Paramedics</td>
<td>Home care</td>
</tr>
<tr>
<td>Chronically ill</td>
<td>Hospitals</td>
<td>Dental care</td>
<td>Transportation</td>
</tr>
<tr>
<td>Disabled</td>
<td>Drugs</td>
<td>Alternative medicine</td>
<td>Support in particip.</td>
</tr>
<tr>
<td>LT Mentally ill</td>
<td>Equip / Transp.</td>
<td></td>
<td>in society</td>
</tr>
</tbody>
</table>

- **Apologies**: € 23 billion
- **Cure**: € 33 billion
- **Cure**: € 5 billion
- **Care**: € 3 billion
Risk equalization system

![Bar chart showing estimated costs and contribution RES for Person A and Person B.](chart.png)
### The risk equalization system

<table>
<thead>
<tr>
<th>In €’s / yr</th>
<th>Women, 40, disability allowance, low SES, urban area, PCG: Diab. type I, DCG: none</th>
<th>Man, 38, employed, high SES, prosperous region, PCG: none, DCG: none</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age / gender</td>
<td>€ 1231</td>
<td>€ 980</td>
</tr>
<tr>
<td>Type income</td>
<td>€ 1003</td>
<td>-/- € 54</td>
</tr>
<tr>
<td>SES</td>
<td>€ 83</td>
<td>-/- € 98</td>
</tr>
<tr>
<td>Region</td>
<td>€ 46</td>
<td>-/- € 79</td>
</tr>
<tr>
<td>Pharm Cost Group</td>
<td>€ 3327</td>
<td>-/- € 347</td>
</tr>
<tr>
<td>Diagn Cost Group</td>
<td>-/- € 113</td>
<td>-/- € 113</td>
</tr>
<tr>
<td><strong>Total pred. costs</strong></td>
<td>€ 5577</td>
<td>€ 289</td>
</tr>
<tr>
<td>Base premium</td>
<td>-/- € 947</td>
<td>-/- € 947</td>
</tr>
<tr>
<td>Comp deductible</td>
<td>-/- € 155</td>
<td>-/- € 71</td>
</tr>
<tr>
<td>Contr.from RAF</td>
<td>€ 4485</td>
<td>-/- € 729</td>
</tr>
</tbody>
</table>
The flow of funds

**Employers**
- compulsory allowance i.r.c
- state disbursement

**Government**
- healthcare allowance

**Consumers**
- deductible
- premiums
- healthcare consumption
- (≈ 50% of healthcare consumption)

**Risk adjustment fund**

**Care providers**

**Health Insurers**
- approx. € 33 billion
- Cost cov. & Profit

Ministry of Health, Welfare and Sports
Australian Health Insurance Association

The flow of funds
Competition on insurance market

- 2006: nearly 20% switched
- 2010: app. 4.5% (“just enough”)
- Fierce competition, particularly on premium
- Cumulated losses 2006-2007 500 mln €, small earnings now.
- People satisfied with their insurer (between 7 & 8 out of 10)
- Product differentiation below desired level (modest initiatives on preferred providers)
- Four insurance companies have almost 90% of the market (“just enough”)
Mergers sickness funds / insurance companies
Mergers of insurance companies

Niche-player / candidate for take-over?

In the middle

Big three

Achmea-Agis

DSW

ONVZ

Friesland

Menzis

CZ-Delta Lloyd

UVIT

Relative market share (market leader = 1)

Source: Atos

= 1.5 mln insured

“4 is few, 6 is many”
## Development estimate and actual premium

<table>
<thead>
<tr>
<th></th>
<th>2006 (2)</th>
<th>2007 (2)</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated premium according to National Budget (1)</td>
<td>1106</td>
<td>1166</td>
<td>1105</td>
<td>1124</td>
<td>1123</td>
</tr>
<tr>
<td>Average nominal premium paid by citizens (1)</td>
<td>1061</td>
<td>1146</td>
<td>1094</td>
<td>1104</td>
<td>1147</td>
</tr>
<tr>
<td>Highest</td>
<td>1140</td>
<td>1224</td>
<td>1161</td>
<td>1205</td>
<td>1211</td>
</tr>
<tr>
<td>Lowest</td>
<td>964</td>
<td>1056</td>
<td>975</td>
<td>963</td>
<td>996</td>
</tr>
<tr>
<td>Bandwidth</td>
<td>176</td>
<td>168</td>
<td>186</td>
<td>242</td>
<td>215</td>
</tr>
</tbody>
</table>

(1) Estimate and nominal premium without collectivity deduction

(2) 2006 & 2007 incl. no-claim premium (91 euro)
Performance of the new system

• Take off: with caution
• There is more space available than used until now

Explanation:
• Shortcomings in incentive structure
• Government oriented → self oriented → each other oriented → future oriented
• Period of incubation, trust building, management of expectations
• In order to become trusted 3rd party, insurance companies have to invest in personnel, knowledge systems, contracting skills
• Not very much between claustrophobia and agoraphobia..
So far, so good (..?)

- Initiatives managed care, DRG contracting
- More focus on prevention
- Substantial steps in increasing risk providers and insurers
- Collective schemes for chronic conditions
- Impressive results on preference policy pharmaceuticals (generics)
- More relaxed attitude on preferred providers
- Quality awareness moving upwards
- Patient channeling with refund of compulsory excess
License to operate, spring 2010

• Spring 2010
• Financial crisis
• Taskforce on Health Care to save 20%
• Conclusion: the system is “stuck in the middle”
• Old an new mechanisms counteracting
• Move either ahead or backwards, or you will have the “worst of both worlds”
• License to operate for insurance companies is expiring:
• What value is added? Anyone could pay the bills.
• Get out of the comfort zone!
Any growth yet?
31 + 21 + (24) = (76)
Coalition agreement (30/09/10)

• Move ahead!
  - increase free pricing
  - increase amount of risk bearing
  - allow for private capital

• Health care is only sector with significant growth

• Integrated care delivery nearby

• Coverage shrinking (lower disease burden)

• More copayments

• Long term care to be carried out by health insurers
  (presently by regional offices)

• Establish Health Care Quality Institute
CZ initiative breast cancer

• 4 hospitals will no longer contracted: do not live up to “CZ” standards
• 45 `so so`
• 44 ok or better

• “Unnecessary”
• “Inaccurate”
• “Teamwork over volume”

• Court ruling: CZ may proceed
• Oncologist society: 33-50% of hospitals should stop cancer treatments
Still a long way to go: challenges

- Improve quality transparency & measurement
- Increase risk insurers: less ex-post corrections RES
- Limit free rider behaviour: defaulters and uninsured
- Encourage insurance companies
  - to play their role as health care contractors
  - to feel responsibility for quality, price and volume
- Keep the coverage of the health insurance “lean and mean”: the necessary health care, but not more than that
- Intensify relationship between social security (i.e. employers, reintegration of employees & health care / health insurance
... even longer

- Stimulate Disease Management Programs, Stepped Care, selfmanagement, e-health
- Promote shifting from secondary to primary care and from primary care to self-management and prevention (DMP’s, Stepped Care)
- It’s the EMD stupid!
- Discourage the “everybody does everything” in hospitals, concentrate specialized low volume health care
- Strengthen role and rights of patients as driving force in the system
Dangerous rocks...

• Narrow political margins: government with minimal majority in parliament, limits change capacity
• Affordability under pressure: accumulating effects of more co-payments, higher premiums and shrinking of legal coverage
• Risk of conservation of the status quo. Everyone wants change, but all in a different direction. The status quo is everybody’s second choice.
• Waterbed: when you press down in one spot, it moves up somewhere else: supply induced demand.
.. but quite a strong undercurrent!

- In a grown up system of managed competition government has only two instruments for macro cost containment:
  - shrinking of the benefit package (insurance coverage)
  - increasing level of co-payments
- If you want to avoid those, put your energy in a system that discourages over- and undertreatment (only “appropriate care”): there is a lot of unnecessary and costly variation out there!
- Therefore you will need:
  - (clinical) guidelines: what is the prevailing standard
  - (financial) incentives that stimulate guideline compliance
  - (market) interests in enforcing efficient behaviour
  - (up to date) performance measurement (feedback)
You always get what you pay for

First: Availability
Then: Waiting lists
Now: Production
Later: Health outcomes

1990    2000    2010
now
Tonsillectomy rates per 100,000 (2007)
Tonsillectomy rates per ZIP code

- 85 - 259
- 259 - 290
- 290 - 320
- 320 - 342
- 342 - 361
- 361 - 388
- 388 - 416
- 416 - 446
- 446 - 501
- 501 - 722

Europa landen
How to approach

• Clear clinical guidelines, indication criteria
  => watchfull waiting
• No compliance
  => no reimbursement
• Informed consent
  => shared decision making
• Outcome measurement
  => public assignment?
... You don’t want to get stuck in the middle...

Thank you
Don’t ever give up
Defaulters & uninsured

**Both:** 1.5% (240,000 each)

**Defaulters**
- Large portion didn’t pay as from 2006 (Σ 4000 €)
- Due to yearly open enrollment: merry-go-round along insurers
- 2007: ban on canceling policies
- 2009: withholding 130% nominal premium on income source

**Uninsured**
- Comparable approach from 2011

**You need public enforcement to sustain a private system….
Lack of personnel in healthcare;

Han Middelplaats
Head of Unit Labour Market Policy
Ministry of Health, Welfare and Sport
2. Contents

Analysis of Developments in Demand for Care and in the Labour Market
Role of the government
Possible Solutions
Innovation Policy
3. Developments

Aging and other demographics

Medical-technological Developments

Healthcare becomes more costly

Social-cultural Developments

Increasing demand

Productivity Gap

Increasing need for healthcare workers

Public finance under pressure

Solidarity under pressure
4. Long-term Bottlenecks in the Labour Market

Growth of employment opportunities in care sector:
- +480,000

Growth of labour supply:
- +250,000
5. Short-term Bottlenecks for nursing personnel

![Graph showing short-term bottlenecks for nursing personnel over the years 2007 to 2011. The graph includes lines for different categories such as 'Verpleging (4+5)', 'Verzorging (3)', 'Zorghulp en Helpenden', 'Sociaalagogisch (5)', and 'Sociaalagogisch (3+4).']
6. The Future?
7. Differing Roles within the Labour Market

Primary responsibility lies with employers who are in a dialogue with ‘social partners’ such as trade unions.

The government is responsible for the system as a whole guarantying accessible, good quality and affordable healthcare.
8 The role of the Government

Active: Sufficient training and traineeship opportunities
Taking responsibilities within the field itself into account by:

- Stimulating;
- Putting the subject on the national agenda;
- And encouraging and showcasing best practices regarding employment policy in health care.
9. Classic Solutions

**Investing in current personnel**
- Horizontal and vertical mobility of personnel within the sector
- Supplementation of part-time contracts
- Life faze conscious employment policy
- Professionalisation

**Increasing the inflow of new personnel**
- Creation of an traineeship fund
- Increased cooperation between care facilities, educational institutions and municipalities
- Investing in those with less education and in women who come from somewhere other than the Netherlands
- Information and selection before beginning training
10. Training and traineeship

An traineeship fund is being created to improve: (Training yield; Professional gains; Sector yield)

More financial room for traineeship in healthcare facilities

Stimulating regional cooperation between care facilities and educational institutions
11. Mathematics exercise

Part-timers who work 2 hours longer = 75,000
Older employees retire one year later = 25,000
Share in labour market 14–16% = 175,000
Increasing productivity by .5% per year = 115,000
Self-supporting care = 90,000

Total = 480,000
12. innovation policy

In order to solve the problem it is not only necessary to invest in current employees and attract new ones. We also have to think about:

Innovative care processes
An Innovationplatform
Experimentation policy
Labour-saving devices
Increasing work productivity
Increasing self-sufficiency of care seekers
13 Experiment Policy

The core aim of the policy is to remove perceived obstacles in legislation which impede innovation.
Support the invention and implementation of innovations in healthcare
Scrap rules and regulations where necessary
14. Conclusions

Innovation
Training

The Ministry of Health will also facilitate discussion between all parties who have a stake in solving this problem.