Australian Health Insurance Association

HEALTH CARE REFORM IN THE NETHERLANDS

Gelle Klein Ikkink

Director of Health Insurance

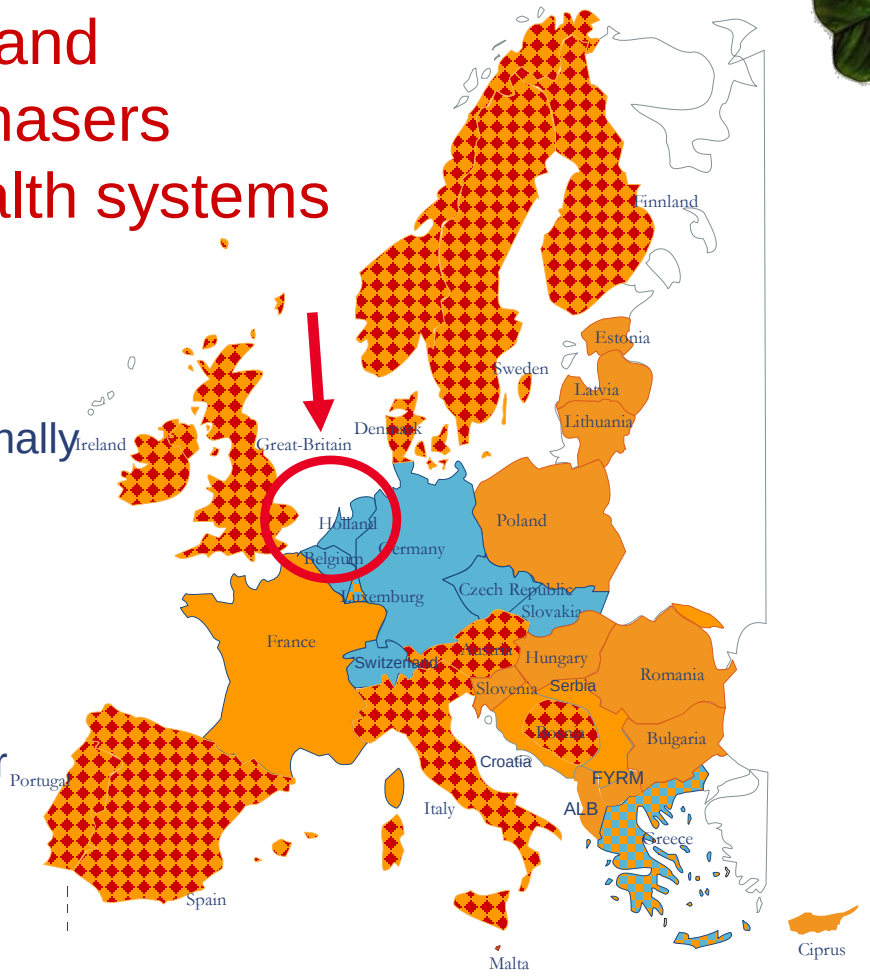
Ministry of Health, Welfare and Sport

Australian Health Insurance Association

Australian Health Insurance Association

Single, multiple and competing purchasers in European health systems

- Single purchaser
- Regional, but functionally single purchaser
- Non-competing multiple purchaser
- Competing purchaser



Australian Health Insurance Association

Goal of reform debate

1. Who is the prudent buyer of care on behalf on the consumer?
2. Which 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**
- **High responsiveness to change**
- **Efficiency seeking**

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

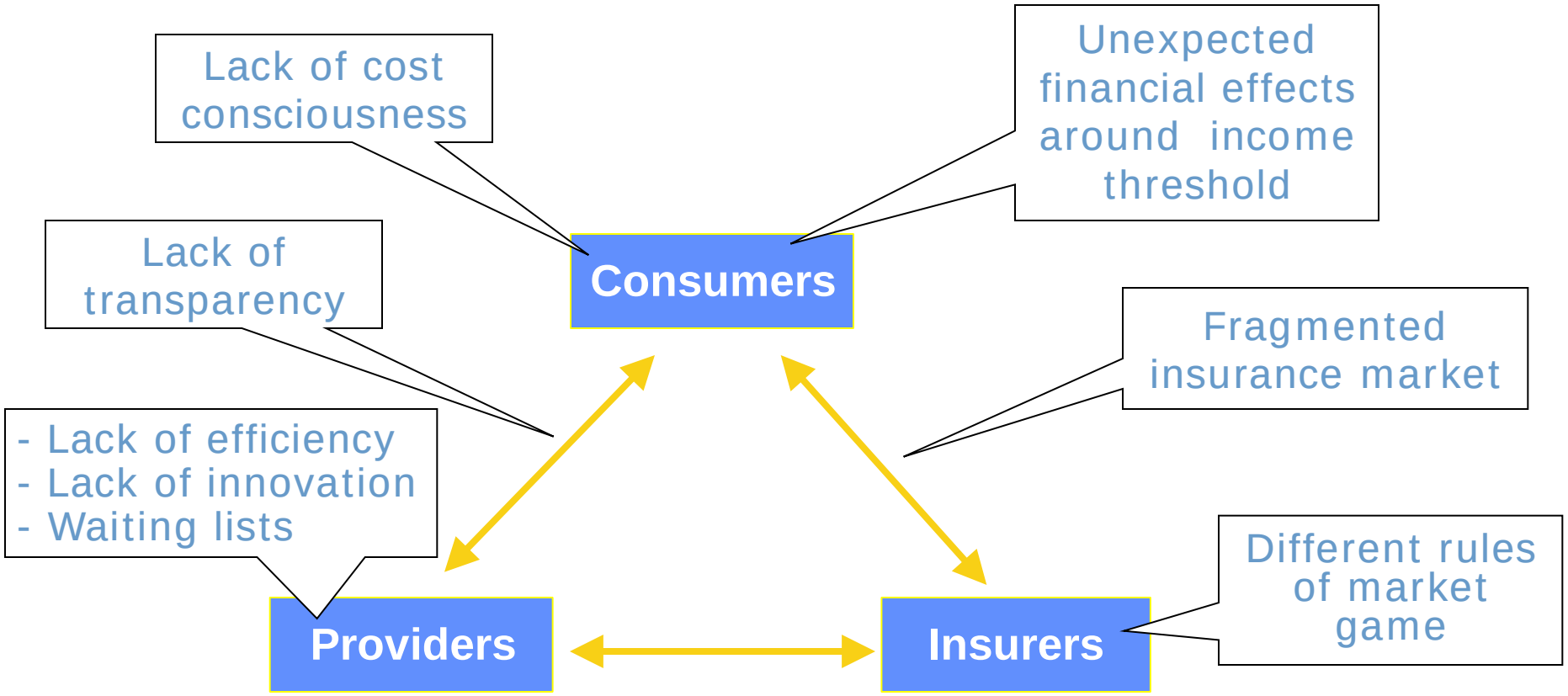
- **Pros**
  - Cost containment on macro (national) level
  - Policy implementation through intervening *in* the system
  - *Quality* (of health care delivery)

- **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

Australian Health Insurance Association

Reasons for reform



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

Purchasing health care

Health care meets demands
Price meets performance

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)

Australian Health Insurance Association

The insurance reform 2006

Health Insurance Act

Equity

- 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

Efficiency

- 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

Long Term Care Act

"Care"

- LT care elderly
- Chronically ill
- Disabled
- LT Mentally ill

appr. € 23 billion

Health Insurance Act

"Cure"

- General Practitioners
- Hospitals
- Drugs
- Equip / Transp.

appr. € 33 billion

Supple-mental Health-insurance

- Paramedics
- Dental care
- Alternative medicine

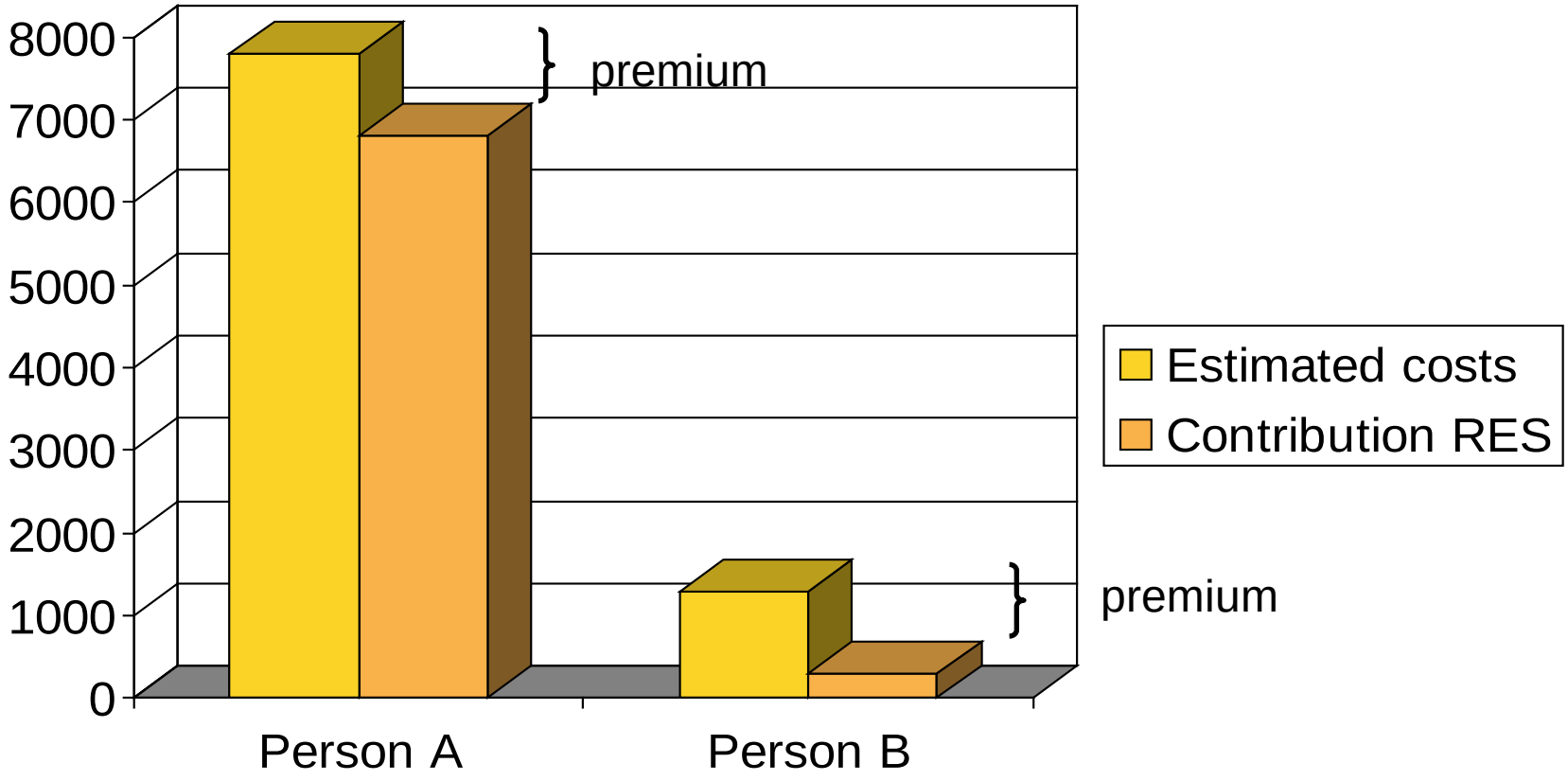
appr. € 5 billion

Social support act

- Home care
- Transportation
- Support in partici-pation in society

appr 3 € billion

Risk equalization system



Ministy of Health, Welfare and Sports

Australian Health Insurance Association

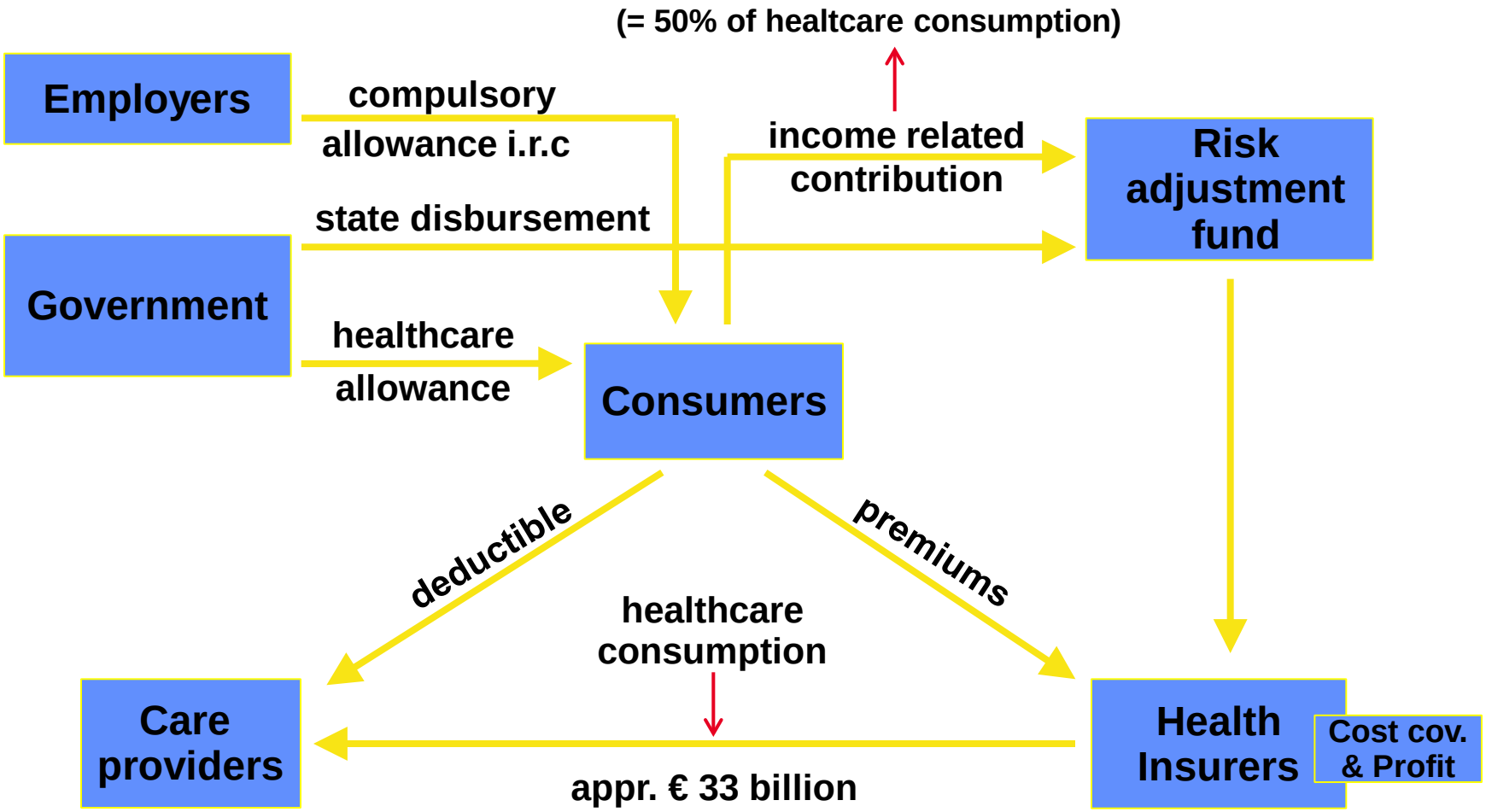
The risk equalization system

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

Ministy of Health, Welfare and Sports

Australian Health Insurance Association

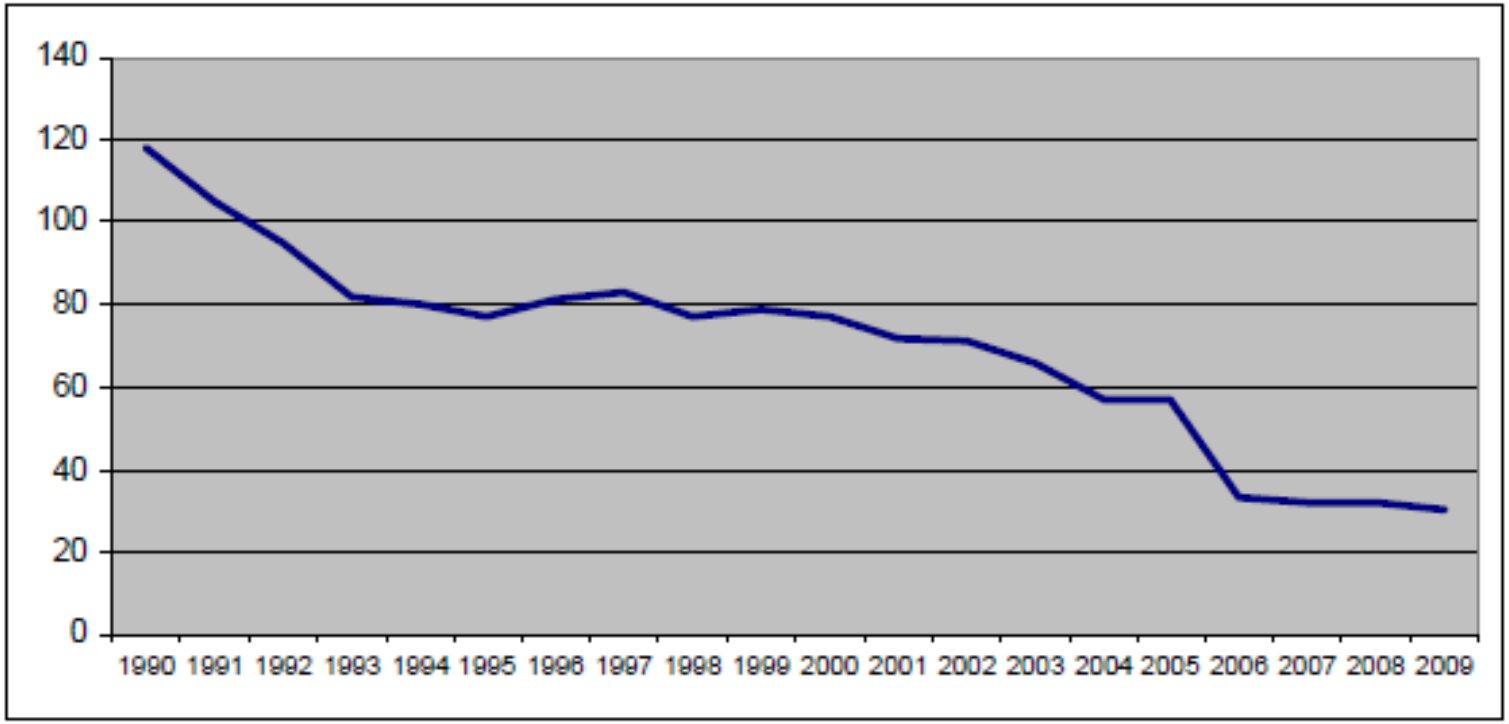
The flow of funds



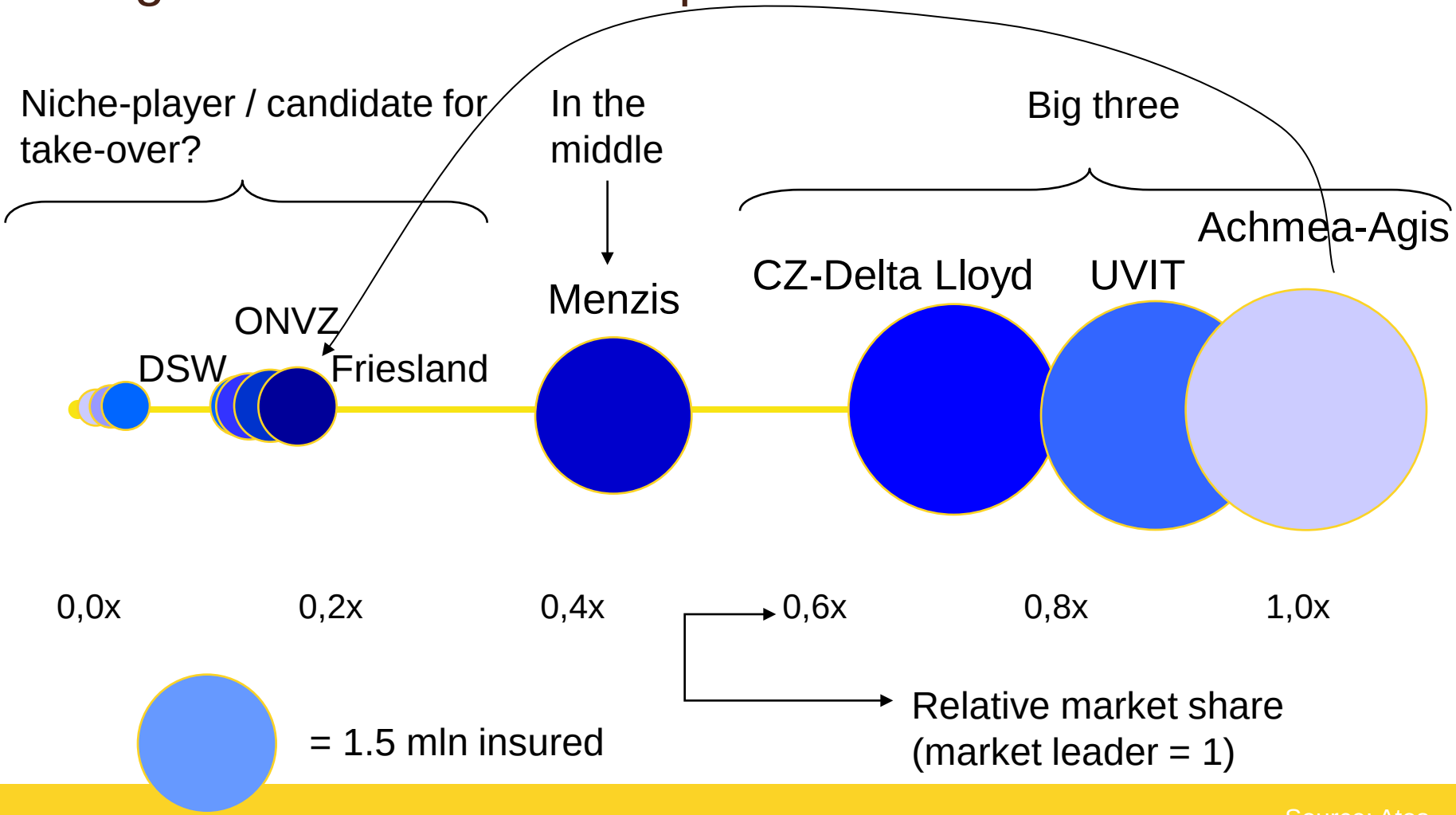
Competition on insurance market

- 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



Development estimate and actual premium

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

(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?

Australian Health Insurance Association

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 ánd 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 you energy in an system that discourages over- en 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 (feed back)

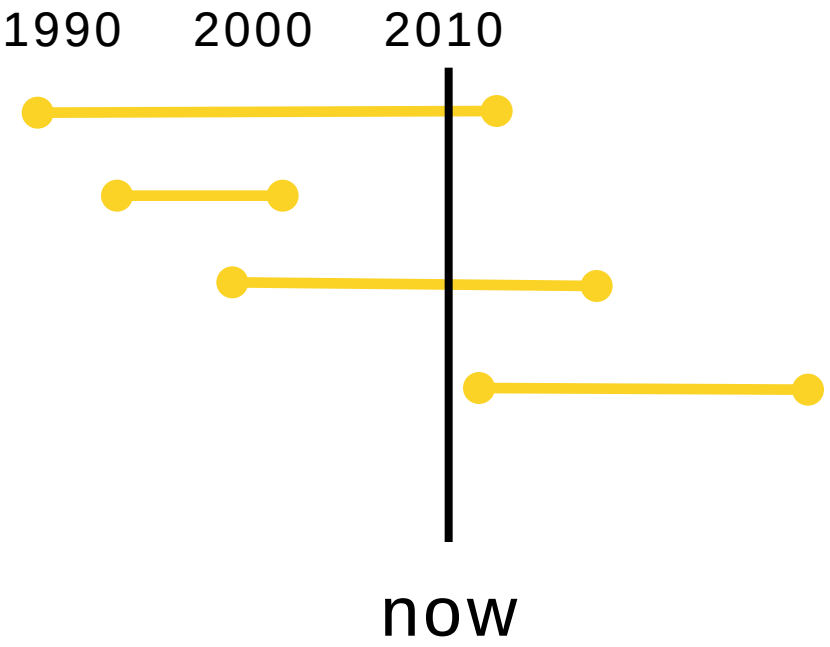
You always get what you pay for

First: : Availability

Then: : Waiting lists

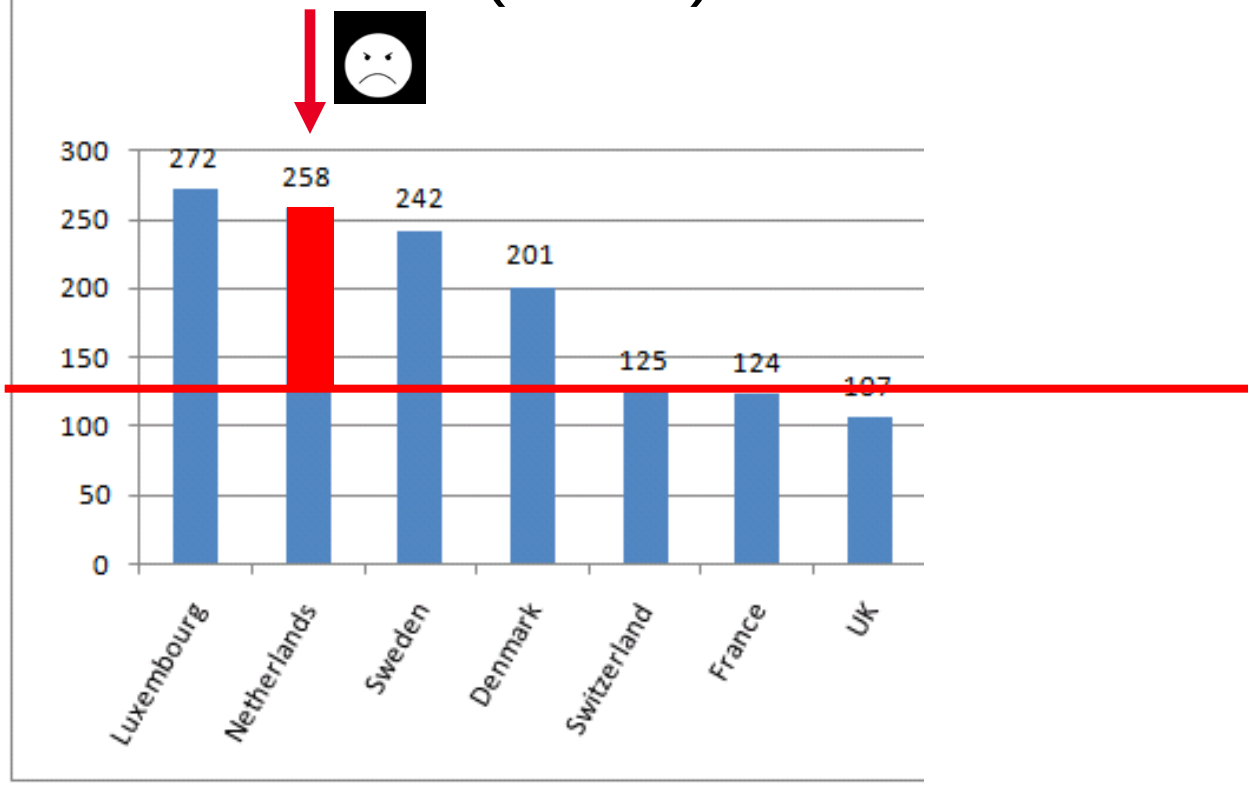
Now : Production

Later : Health outcomes



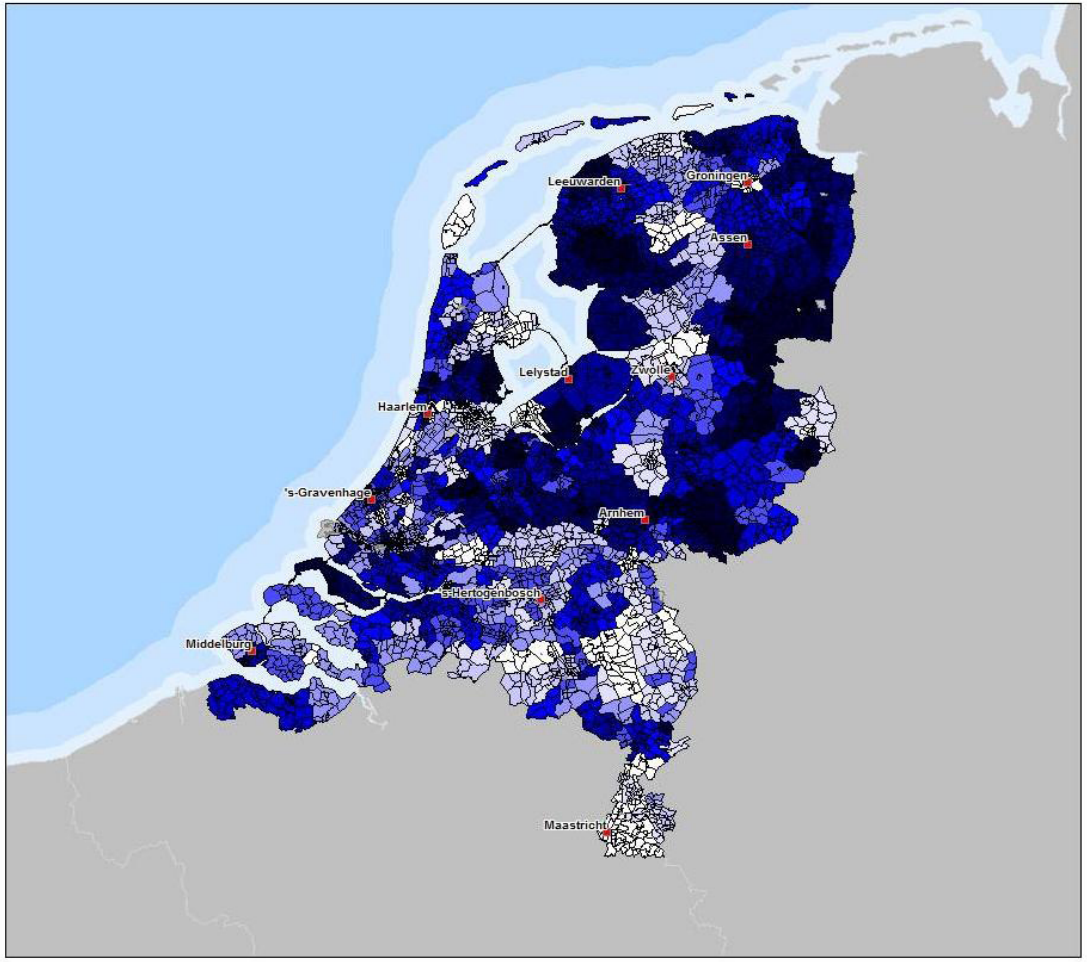
127

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….

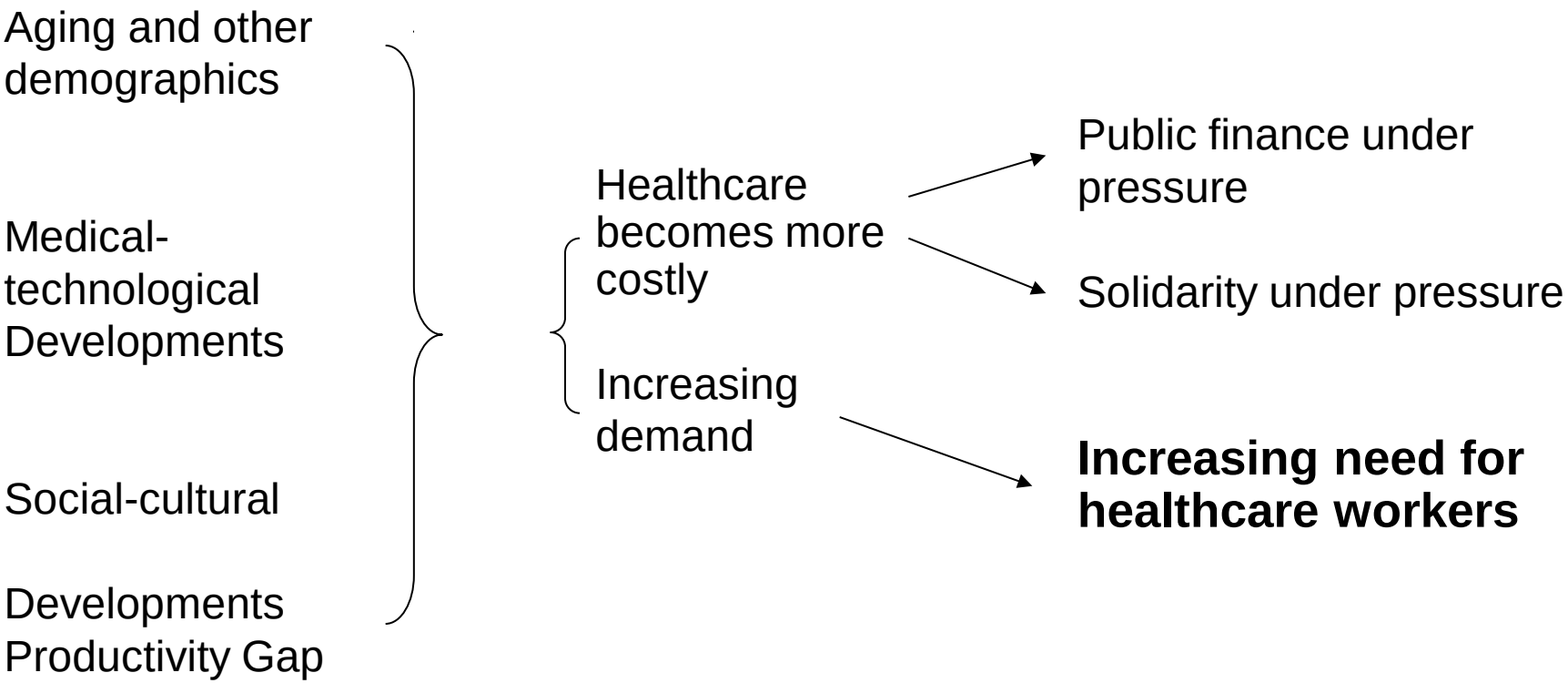
Australian Health Insurance Association

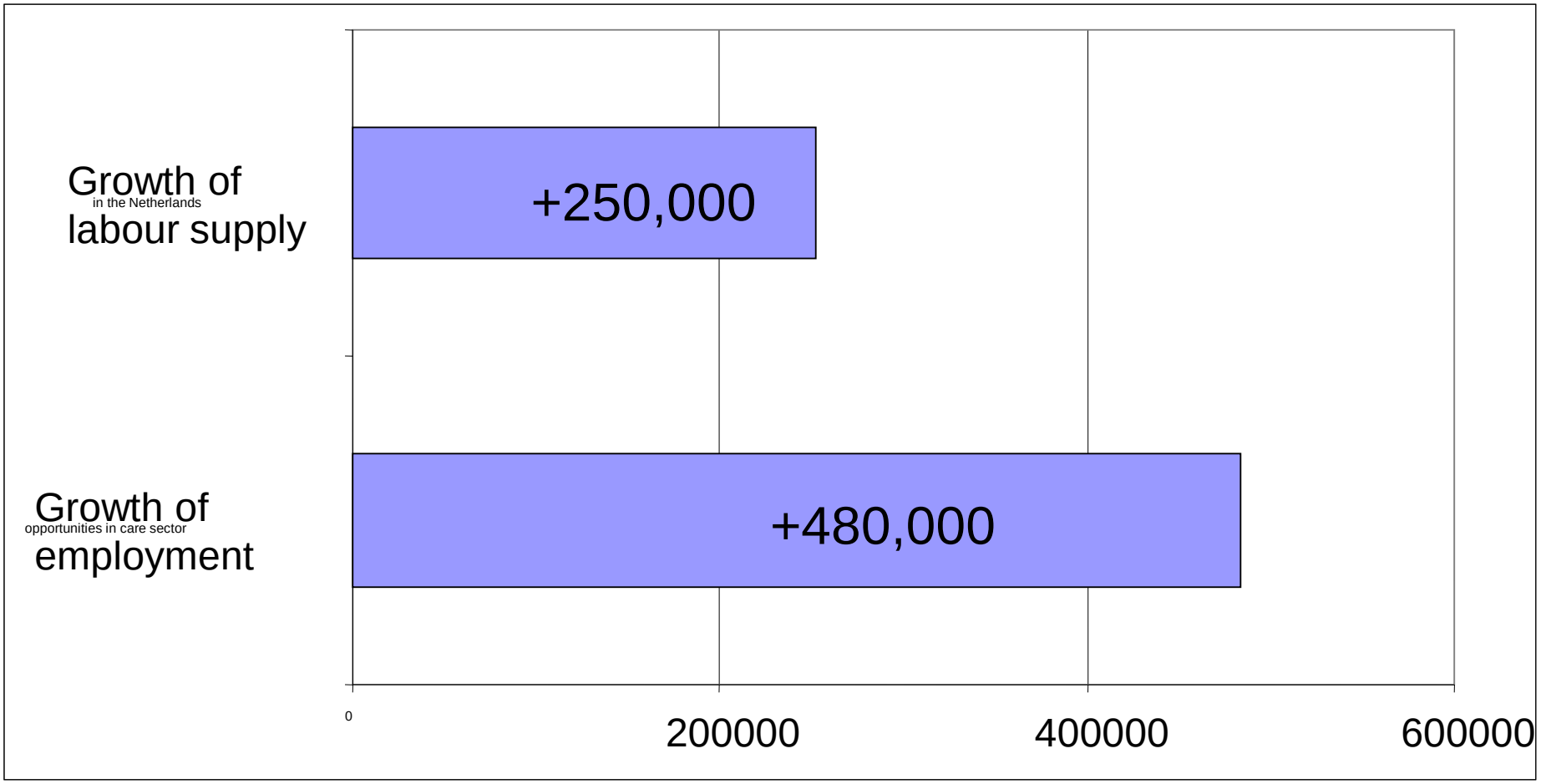
Lack of personnel in healthcare;

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

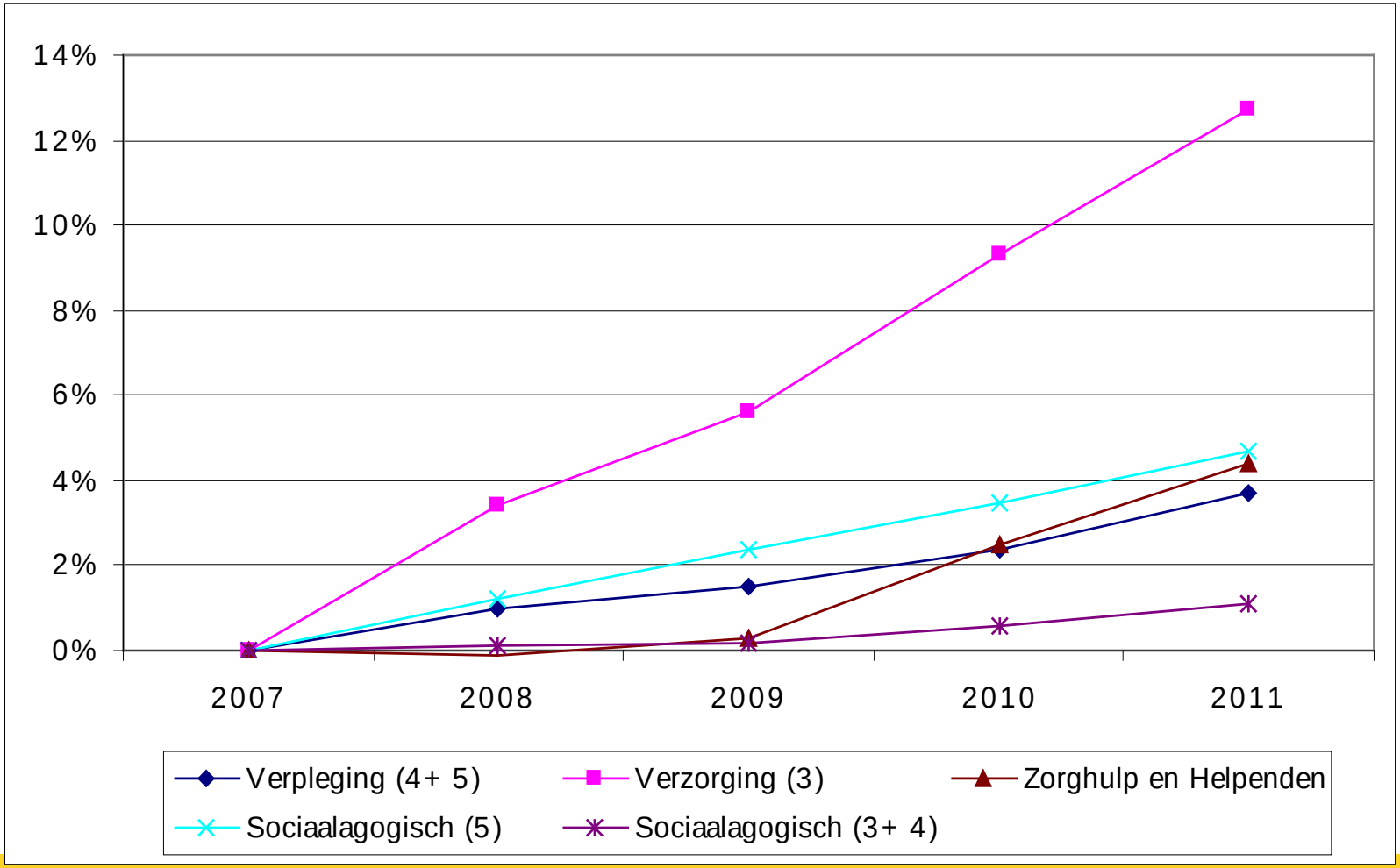
2. Contents

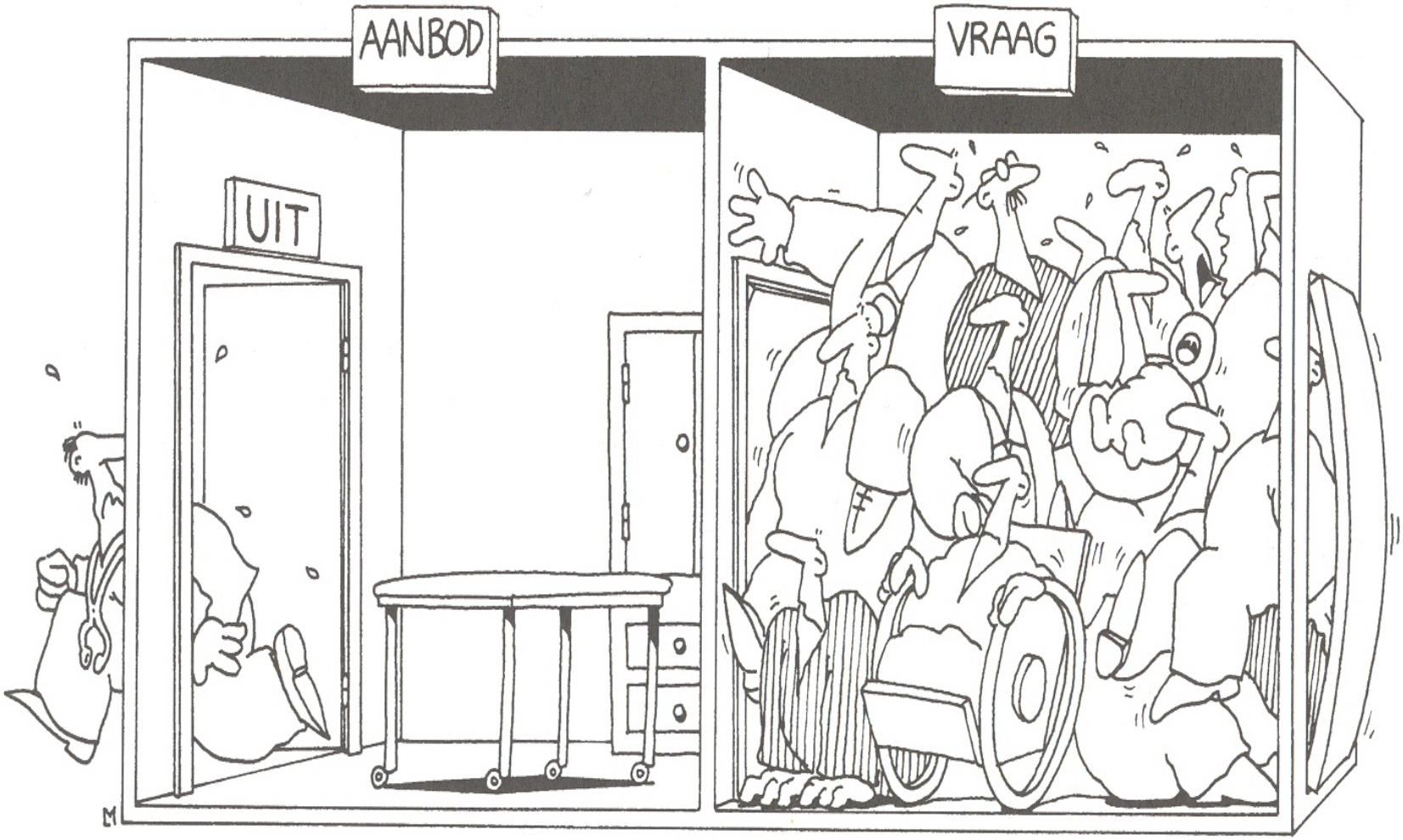
3. Developments




Growth of labour supply in the Netherlands
+250,000
Growth of employment opportunities in care sector
+480,000
0
200000
400000
600000

5. Short-term Bottlenecks for nursing personnel




AANBOD
VRAAG
UIT

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 fo 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.