

Health care reform in the Netherlands: what did we achieve so far?

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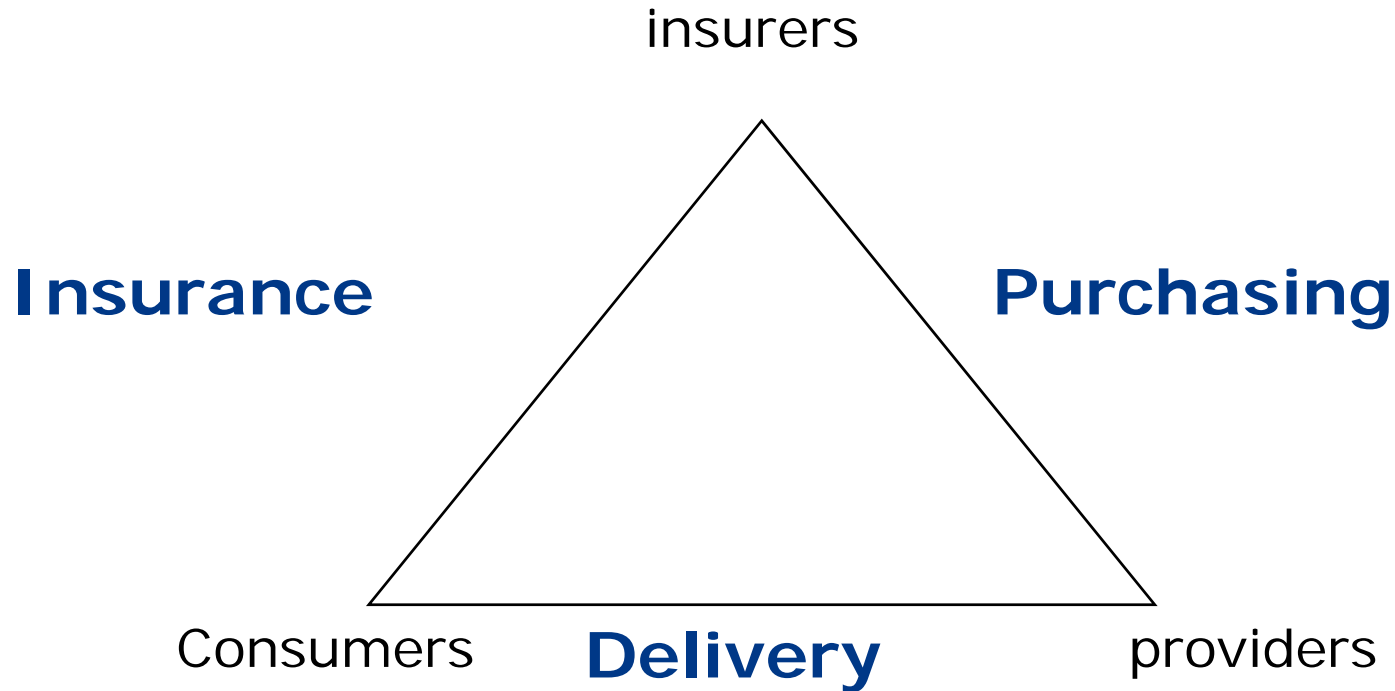


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Overview

- Brief overview of the reform
- Results: health insurance market
- Results: hospital markt
- Conclusions

A comprehensive reform



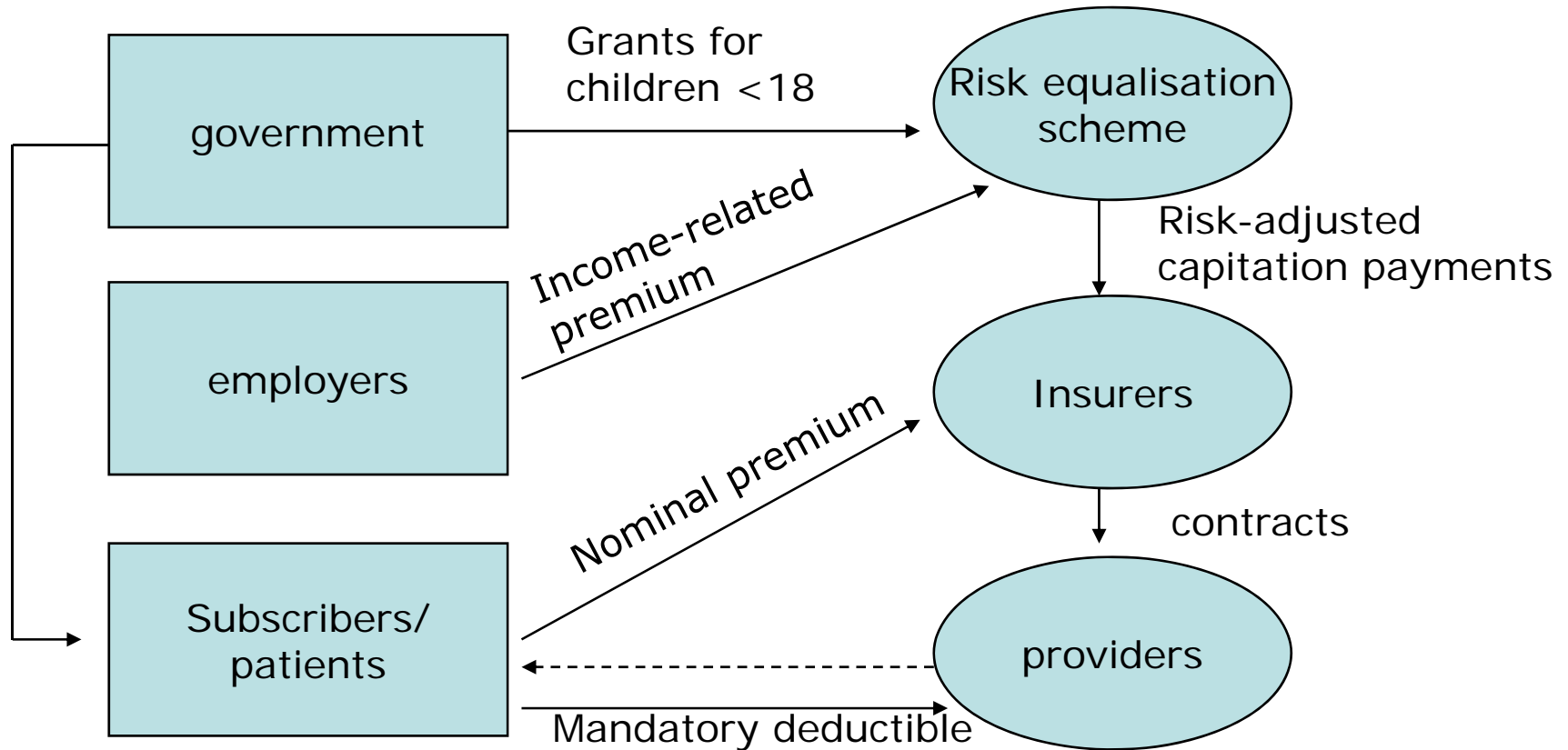
Essence of the reform

- Transition from a supply-driven system towards a consumer-oriented system
- Entrepreneurship
- Regulated competition: regulations to preserve 'the public good'
- Key values: consumer choice, solidarity in health care financing, universal access to health care
- Managerial approach to competition
- Consumers and on their behalf insurers are seen as main change agent

Health insurance reform

- Health Insurance Act 2006
- Key elements:
 - mandatory scheme covering entire population
 - consumer choice
 - competition
 - regulations for risk solidarity
 - ban on risk selection
 - community rating
 - central regulation benefit package
 - risk equalisation
 - regulations for income solidarity
- Nominal premium(€1000) + income-related premium

The new structure



Reform health care purchasing

- Freedom to contract → contracting preferred providers is possible
- But also: obligation to contract sufficient care
- Scope for negotiating prices hospital care
2005: 10% → 2009: 33%
Ergo: still much price regulation!
- Investing in health care quality information

Reform hospital care

- All hospitals are private not-for-profit
- New hospital payment scheme: Performance-based payment
→ Diagnosis-Treatment Combinations: 30,000 DTCs!
- Abolition of hospital planning (with some exceptions)
- Decentralisation of hospital investment decisions (2008/9)
- New financing scheme for capital investments (mark up on DTC) (2008/9)
- For-profit hospital care prohibited (may be introduced in 2012)

Instruments to introduce market competition

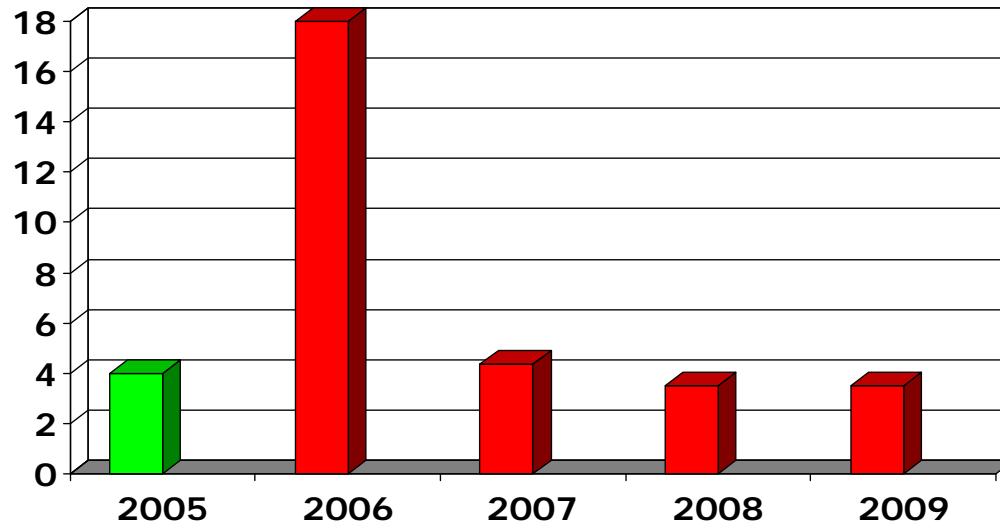
- **Authority-based** instruments:
 - regulations: property, public good, competition law, quality standards, payment model
- **Treasury-based** instruments:
 - risk equalisation + income transfers
- **Organisation-based** instruments:
 - Dutch Health Care Authority
 - independent regulatory bodies
- **Information-based** instruments:
 - information on (clinical) quality

Typology of Howlett & Ramesh, Studying public policy

Concluding observations so far

- Comprehensive reform
- Reform in many respects more evolutionary than revolutionary
- Stepwise introduction to learn, to avoid disruptive effects and to compromise
- Various market-making decisions still have to be taken
- What results is a highly **hybrid** system
- The market must be organised!
Lindblom: *'If the market is a dance, the state must provide the dance floor and the orchestra'*.

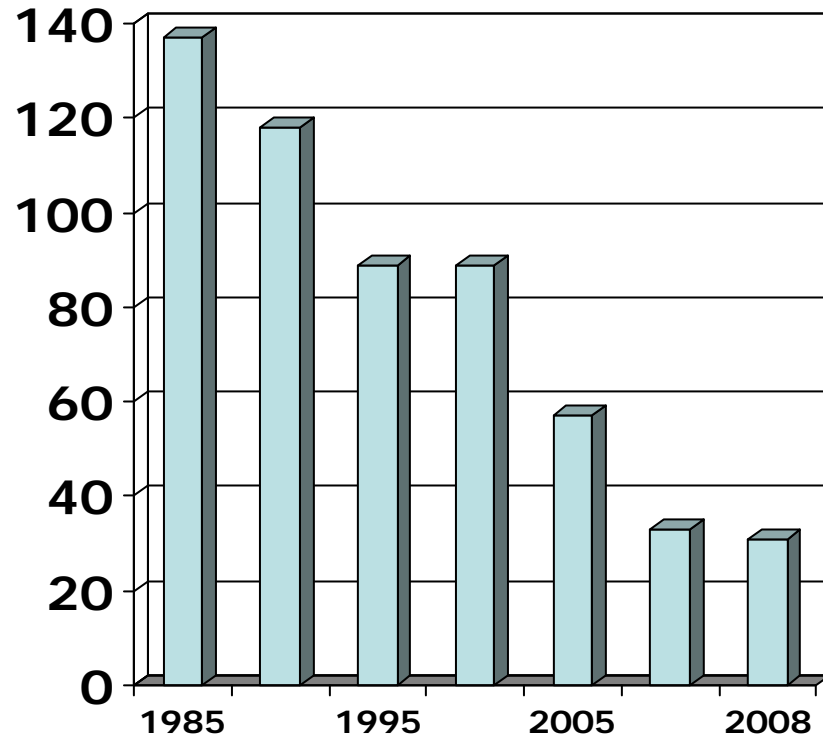
Consumer mobility: percentage switchers



Most important consumer criteria:

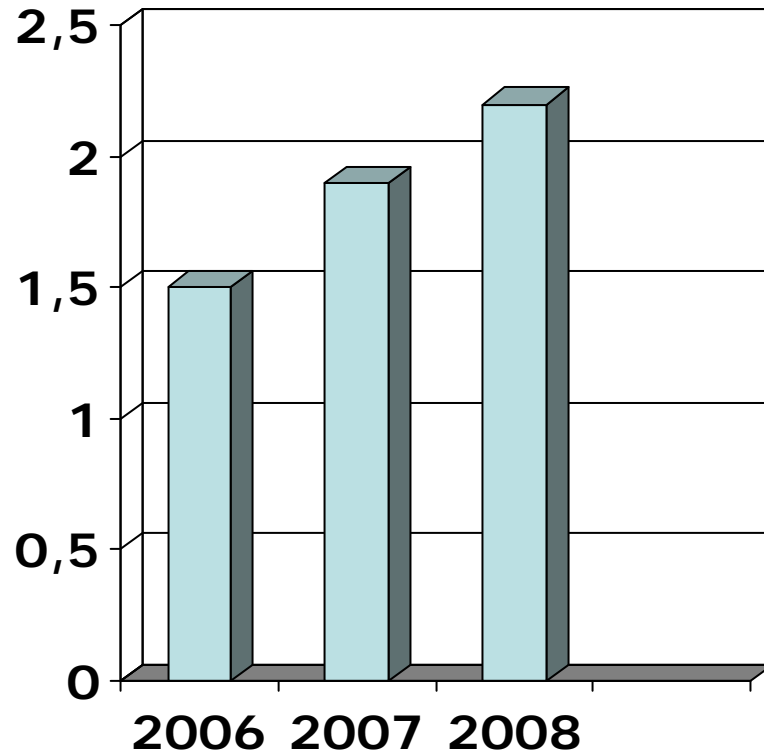
- Premium basic policy
- Premium complementary policy
- Package complementary policy

Market concentration



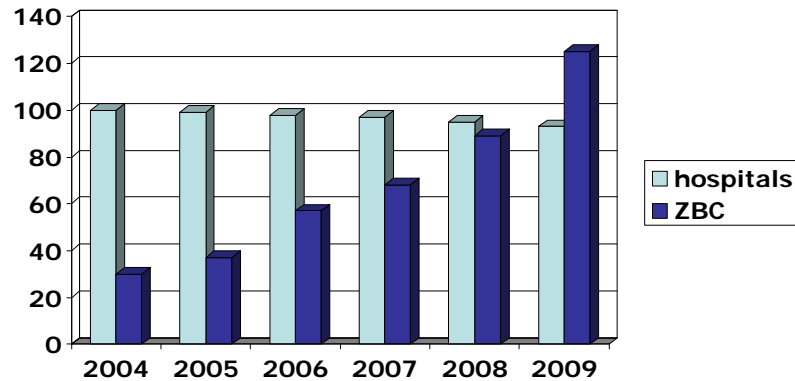
- Continuous decline of number of insurers
- 2006: mergers between sick funds and private health insurers
- Presently 12 health insurance companies
- Market share of the 'four bigs' (Achmea, Uvit, CZ, Menzis) is 88 percent
- Concerns about market concentration, in particular in certain regions

Uninsured and defaulters



- Defaulter: subscriber who failed to pay for 6 months or more
- Uninsured: 1% population
- Defaulters cannot be dispelled as subscriber
- Need for flanking policy:
 - tracking
 - penalising
 - support vulnerable groups

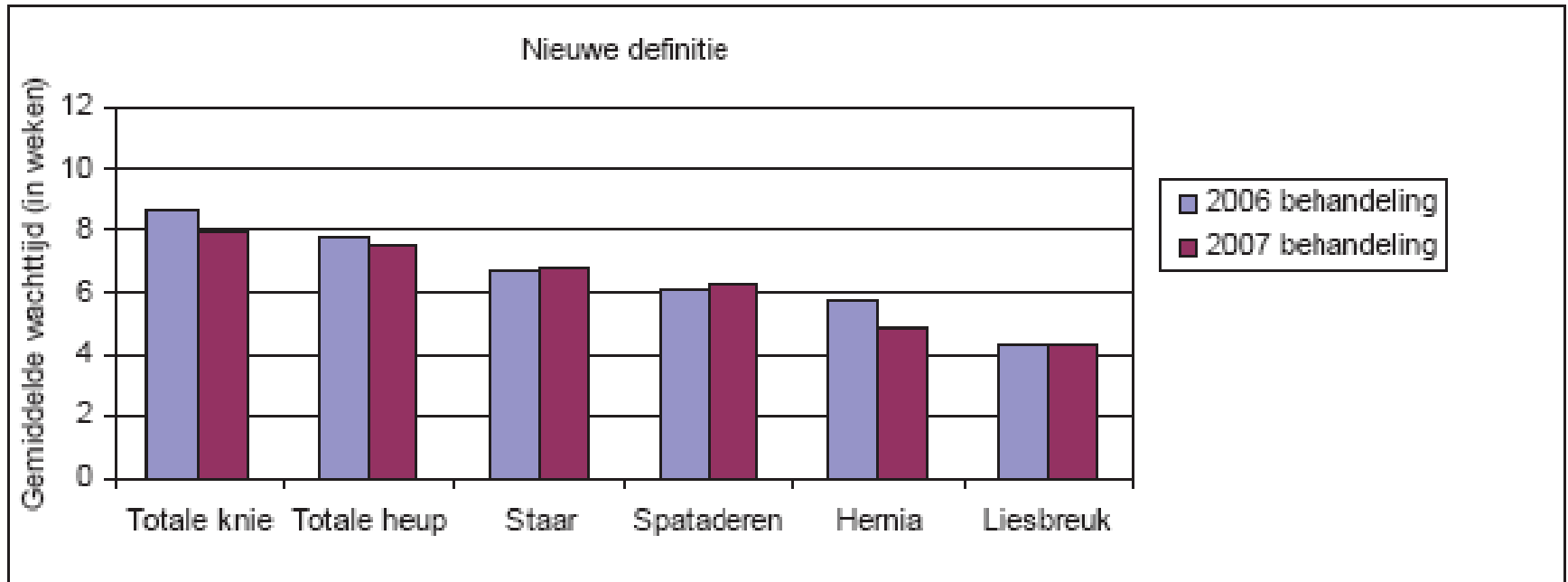
Effects hospital market (1)



- Slow decline number of hospitals
- No hospital chains so far
- Rapid growth ZBC's (specialised centres)
- High volume, routine vare

Waiting time treatment hospital

Figuur 5.2. 'Wachttijd behandeling' algemene ziekenhuizen bij de nieuwe definitie

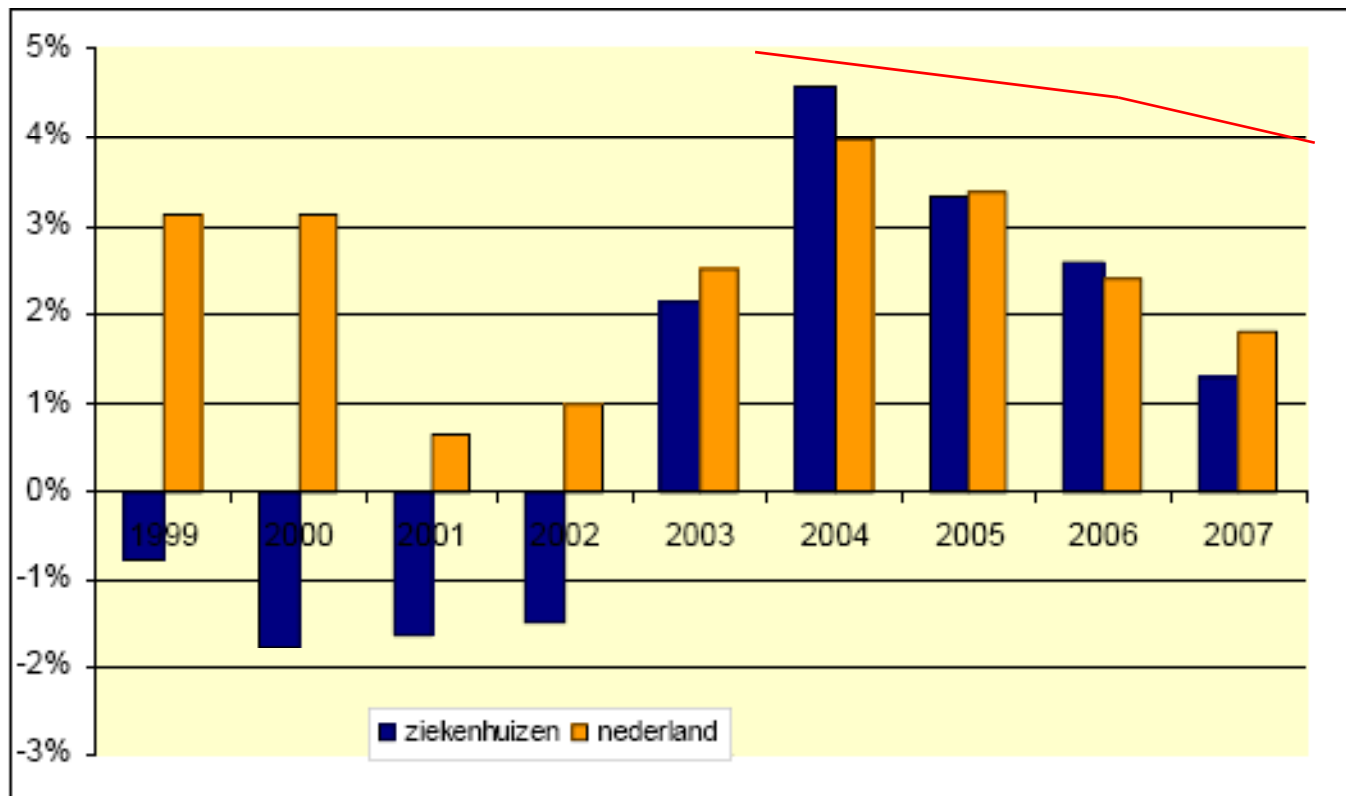


Bron: NZa

Nominal price increases hospital care

	2005-06	2006-07	2007-08
Hospital care under central price regulation Budget constraint	0,4%	1,3%	2,3%
Hospital care with price competition No budget constraint	0,0%	2,1%	1,1%

Labour productivity hospitals (annual change)



Blue =
hospitals

orange =
market

Red = sick
leave

bron: CPB, MEV 2009

Can hospitals go bankrupt?

- In theory yes, in practice difficult
 - The concept of 'system hospital'
 - Continuity in care
 - Political context
 - Recent developments
-
- In home care some provider organisations have gone bankrupt

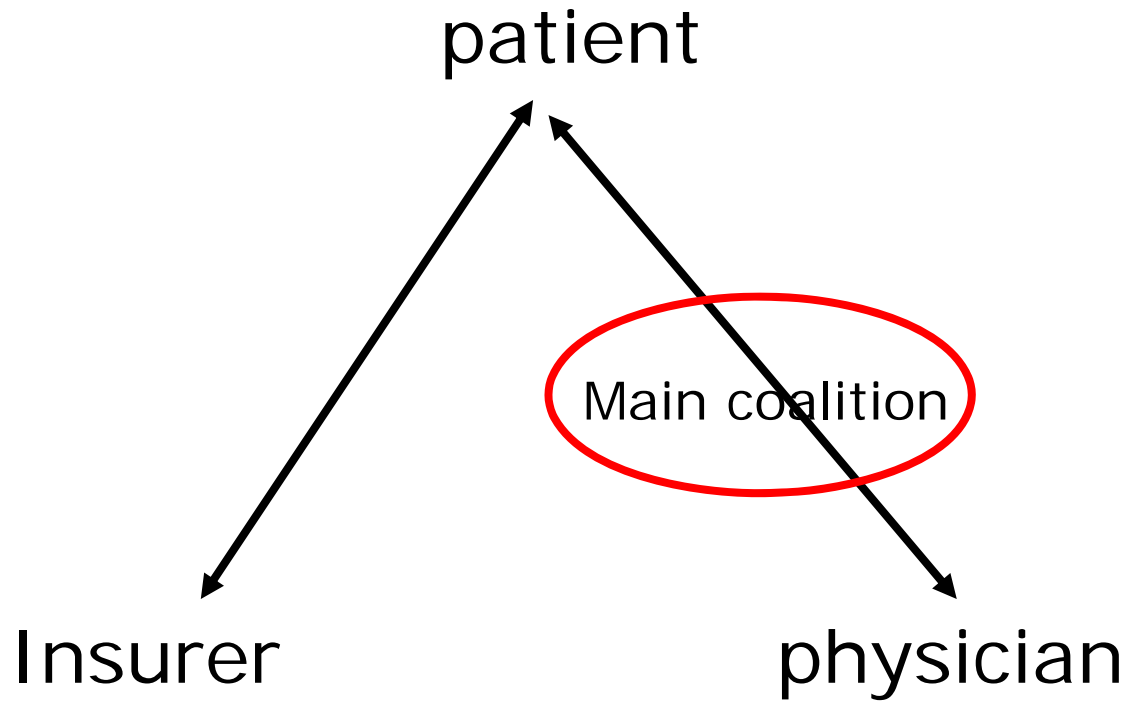
Results: purchasing (1)

- Cornerstone of reform
- Purchasing difficult → learning curve?
- Selective contracting largely absent
- Insurers with large market share manage to negotiate lower prices
- Prices ZBCs significantly lower than prices general hospitals
- Information gap (in particular quality of care)

Purchasing (2)

- Fear for negative consumer response
- Insurers are not able to acquire a competitive advantage as for quality of care
- Consumers do not associate insurers with quality of care

The 'main coalition' in health care



Contextual factors

- Scepticism market competition in delivery public services increasing
- Impact financial crisis:
 - need for cost control
 - more or less market?

Conclusions

- Comprehensive reform, stepwise introduction
- Regulated competition
- Complex box of instruments to create regulate competition
- Some signs of efficiency gains: moderate price increases, shorter waiting times, better quality
- Wide performance differences between hospitals
- Period of experience to short to draw definite conclusions
- Impact contextual factors unclear