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CONCERNS OVER THE FINANCIAL SUSTAINABILITY OF THE DUTCH HEALTHCARE SYSTEM

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Introduction

The most pressing problem in current Dutch healthcare is how to guarantee its financial sustainability in the future (Ruwaard 2012). In the period 2001–2010 the real growth in healthcare expenditure averaged at 4.4 percent a year, compared to 2.2 percent in the period 1981–2000, while healthcare as a percentage of GDP peaked at 13.2 percent in 2010 (CPB 2011). With USD 5,056 per capita the Netherlands was the third-largest spender on healthcare in Europe in 2010; topped only by Norway (USD 5,388) and Switzerland (USD 5,270) (OECD 2012). Depending on the assumptions made, healthcare is projected to consume between 22–31 percent of GDP in 2040 (CPB 2011). The big political and social challenge is how to rein in the growth of healthcare expenditure without compromising the principles of universal access, solidarity and quality of care (Maarse 2011). This article gives a brief overview of some recent developments in Dutch healthcare and reforms to address the sustainability problem.



Health insurance

After almost two decades of political debate the Health Insurance Act (*Zorgverzekeringswet*) came into force in 2006. The new legislation introduced a single mandatory *basic* health insurance scheme covering the entire population. The regulatory framework encourages competition among insurers

and providers, but simultaneously respects the legacy of the past by upholding the principles of solidarity and universal access. The legislation obliges each citizen to purchase a basic health plan covering, among others, family medicine, maternity care, pharmaceuticals and hospital care. There is open enrolment and citizens may switch to another insurer or health plan at the end of each year. Insurers compete on their nominal premium rate which averaged at EUR 1,361 in 2012 (NZa 2012a). Insurers are required to apply community rating: any form of experience-rating is forbidden. People on low income are compensated by a tax credit system to limit the premium that they pay to five percent of their income. Those insured also pay an income-related contribution through their employer (7.75 percent over a maximum of EUR 51,000). Furthermore, the state pays the premium for children under 18. To prevent risk selection and to achieve a level-playing field, a sophisticated risk equalisation mechanism is in place to level off differences between the insurers' risk profile. The mandatory deductible, introduced in 2008 after the failure of the no claim regime, doubled from EUR 170 a person in 2008 to EUR 350 in 2013. The costs of General Practitioner (GP) consultations, maternity care and healthcare to children under 18 are exempted from the mandatory deductible.

Insurers not only compete in basic health insurance, but also in *complementary* health insurance, where they are free to apply experience-based and medical underwriting. However, they have largely abstained from using these instruments to date. They can also make up their benefit package. Complementary plans cover extra services (for example dental care, physiotherapy). Contrary to basic insurance, complementary insurance is voluntary. The percentage of people without a complementary plan is still high but has fallen from 94 percent in 2012 to 88 percent in 2012 (NZa 2012a).

Consumer mobility peaked at 18 percent in 2006, but fell back to 3.6 percent in 2009 (NZa 2012a). Since 2010 it has gradually increased to an estimated 7.5 percent in 2013, highlighting the fact that competition has intensified.

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Whereas the regulator set the minimum solvency rate of insurers at 11 percent in 2012, it averaged at about 18 percent in 2011. Administrative costs are only 4.3 percent of total premium revenues (NZa 2012a). The insurers' sound financial record was partly the result of various safety nets in health insurance to give insurers some financial protection. These nets were largely abolished in 2012 to encourage insurers to engage in efficient contracting with healthcare providers. At present insurers are at risk for 91 percent of their expenses compared to 23 percent in 2006.

Efficient contracting by health insurers plays an important role in the government's policy to attain financial sustainability. Other policy measures under discussion include a further raise of the mandatory deductible, the introduction of a co-payment regime and a critical assessment of the basic benefit package. However, political and popular support for these measures is low. An interesting question is how complementary health insurance will develop. Package reduction in basic health insurance tends to be followed by an extension of complementary health insurance. This process could result in the substantial growth of a new private insurance market next to the market for statutory (basic) health insurance. In 2011 premium revenues from complementary plans already amounted to 13.6 percent of total premium revenues from basic health insurance in 2011 (Vektis 2012).

Healthcare provision

Healthcare provision has undergone several changes over the last decade. Traditionally, general practitioners fulfil a gatekeeper role. In 2011 the number of referrals to a medical specialist per 1,000 registered patients was 199 (NZa 2012b). Various initiatives are being taken to reinforce the pivotal role of general practitioners and, where possible, to reduce the number of referrals. If successful, these initiatives could save money and contribute to financial sustainability.

A noteworthy development is the introduction of integrated care pathways for patients with chronic disease (for example diabetes, COPD and vascular risk management), which is supported by a bundled payment model to pay for the providers involved in the care pathway. Insurers negotiate with the organisations coordinating the care pathway on an overall

(bundled) tariff per patient. From a cost saving perspective, the model of integrated care pathways has failed so far (Struijs, van Til and Baan 2011).

The introduction of care pathways fits into a broader trend towards getting more value for money. Provider associations, patient organisations, the Healthcare Inspectorate and other stakeholders are devoting a lot of energy to the development of quality guidelines and quality measurement by means of health outcome and other indicators. Public reporting on quality is assumed to stimulate providers to perform better and care users to be more critical. Some experts see plenty of opportunity to perform better while *lowering* costs (Porter and Olmsted Teisberg 2006), among others, by cutting the link between volume and revenues and by encouraging providers to spend more time on discussing treatment options with their patients. Quality-based funding and shared decision-making can save costs (Klink 2012).

Concentration and specialisation point to another new development in quality management. To optimally benefit from the quality-volume spiral, several complex surgical procedures are now being concentrated in a limited number of hospitals. Many hospitals can no longer meet the quality standards set by the respective medical communities and insurers are increasingly unwilling to contract each hospital for the entire spectrum of medical care. How this development will further unfold in the future, is difficult to predict. Many experts believe that the number of general hospitals will fall significantly and that a new relationship will evolve between top-clinical centres and outreach hospital facilities.

The market reform includes a significant deregulation of state hospital planning. Hospitals have become free to decide on their specialty portfolio, bed capacity, capital investments, and other issues. The extension of discretionary power was paralleled by a prospective payment model that increased their financial risk. It is assumed that this reform will improve allocation and save costs, because providers must now take the financial risks of their expansion into full account. A realistic business plan has become an indispensable instrument in provider management.

All general hospitals are private organisations, but health legislation still includes a ban on for-profit hospital care (Jeurissen 2010). If a hospital manages

to realise a budget surplus, it can either reinvest the surplus or add it to its financial reserves. This arrangement also applies to the two hospitals which are presently owned by a commercial corporation. The government recently announced a plan to lift the ban on for-profit hospital care. However, the new regulation will feature strict conditions to keep 'unwelcome' investors outside and prevent hospitals from becoming profit-maximising agencies. For-profit hospital care is still a politically sensitive topic in Dutch healthcare.

The market reform has induced an explosion in the number of independent treatment centres. Many small-scale centres have entered the market, most of which provide routine elective care in various specialty areas such as ophthalmology, orthopaedic surgery, dermatology, radiology, and many others. The number of centres, many of which are (co)-owned by hospitals, rose from 30 in 2000 to about 180 in 2011, which is almost twice as high as the number of hospitals. Despite this rapid growth, the revenues of the centres have remained limited to 3.5 percent of total expenditure for hospital care (Boer & Croon 2011).

Contracting (global budgeting)

A cornerstone of the market reform is that insurers contract efficiently. A recent report (Significant 2012) highlighted various initiatives, but the overall picture is that efficient contracting is still at an early stage. This is also true for efficient contracting by means of selective contracting. Reasons why selective contracting has remained restricted to date include a lack of information on costs and quality, market structure, the absence of powerful incentives due to safety nets, and the insurers' fear of damage among customers. Selective contracting has only been applied for some independent treatment centres and some specific medical treatments (e.g. breast cancer surgery).

The scope of free-pricing should not be overstated. In hospital care it has gradually been extended from ten percent in 2005 to 20 percent in 2008, 34 percent in 2009 and 70 percent in 2012. The prices of the rest of hospital care, as well as the fees charged by the self-employed specialists are centrally regulated by the Healthcare Authority. With some exceptions, insurers have largely abided by collective price-set-

ting for general practitioners, physiotherapists and other providers to date. A notable event took place in 2012 when the tariffs of dental care were liberalised. Due to significant price increases the Minister of Health was forced, under heavy political pressure, to repeal the liberalisation only a few months after it had been introduced.

According to the Dutch Healthcare Authority, net prices in the liberalised hospital sector have declined relative to the regulated sector (NZa 2012c), but this conclusion has been disputed (Van der Meulen and van der Kwartel 2012). Nevertheless, the overall picture is mixed because total hospital revenues increased by an average of 6.2 percent a year in the period 2006–2010. The most important explanation of this increase seems to be a changing treatment pattern: faster active intervention, more interventions per patient and the introduction of new, more costly interventions (NZa 2012d). As regards pharmaceutical care, competition has been successful. By requiring doctors to prescribe, where possible, generics and reimbursing only the costs of low-priced generic drugs, insurers managed to implement substantial price cuts, which for some drugs even totalled 90 percent.

To control healthcare costs, the Minister of Health does not fully rely on the effects of competition. As a last resort, the instrument of budget control has remained available. Each year the minister sets a macro-budget for hospital care (and other sectors) that may not be overrun. When there is an overrun, hospitals are required to pay back the amount of overspending. Partly to avoid this unpopular measure, the minister signed a covenant with the hospital sector and health insurers in 2011 whereby the participants agreed to limit the volume growth to a maximum of 2.5 percent a year. In 2011 the Minister also signed a covenant with the association of medical specialists on the re-introduction of a macro-budget, after the lifting of a similar regime had been followed by a cost explosion. The covenant also contains substantial tariff cuts to undo the cost explosion. The use of covenants demonstrates the hybrid character of competition: market regulation is complemented with a classic form of corporatist governance.

Long-term care

The rapid growth of expenditure on long-term care (LTC) is seen as a serious threat to the future sus-

tainability of healthcare. In the period 1998–2010 public expenditure on LTC as percentage of GDP grew from 3.1 percent in 1998 to 4.3 percent (CPB 2012) and this percentage is expected to rise to 7–9 percent in 2040, depending on the assumptions made (CPB 2011). A recent OECD-report found, that in Europe only Sweden spends a higher percentage of its GDP on LTC (OECD 2011).

LTC is known as a well-developed part of Dutch healthcare. It is shaped as a mainly publicly-funded service delivered by private not-for-profit providers. The Exceptional Medical Expenses Act (AWBZ), in place since 1968, covers the bulk of expenditure, and is a truly national and largely contribution-based scheme that pays for the costs of residential care and all kinds of outpatient and home-based services for the elderly, the disabled and other categories of vulnerable people. The share of co-payments for inpatient LTC dropped from 8.8 percent in 2002 to 7.2 percent in 2011. Most clients apply for care-in-kind, but since the mid-1990s they have also been able to apply for a personal budget to purchase health services privately. The cost explosion of the personal budget scheme from EUR 413 million in 2002 to 2.3 billion in 2010 (Sadiray et al. 2011) highlights its popularity. However, experts worry that it did not lower the demand for in-kind care and also tend to crowd out informal care. Another arrangement is the Social Support Act (Wmo), in place since 2007, which pays, amongst other things, for domiciliary care. Municipalities receive a state grant to provide services which were previously covered by the AWBZ.

The ageing of the population is only one factor explaining the expenditure growth. Other factors include the government's priority around the year 2000 to reduce waiting times to socially acceptable lengths, the ambiguous description of entitlements and, consequently, the rather generous structure of the benefit package. An alarming result of recent analyses is that a substantial portion of the cost increase can be explained by the growth of less severe cases receiving LTC-services.

In recent years the government took several measures to slow down the growth of expenditure on LTC, in particular by removing some personal assistance services from the AWBZ-package and reintroducing a pseudo-budget system. For the next four-year period other substantial retrenchment programs have been announced, especially day care provisions and domiciliary services. Another mea-

sure is to upgrade the role of municipalities in LTC with the transition of domiciliary services from the AWBZ to the Wmo as prime example. Policymakers assume that local government is best informed about the local situation and also in the best position to deliver efficient, client-centred and integrated support to LTC-clients because of its responsibility for various adjacent policy areas including housing, welfare programmes, transport and local planning. Whereas competition has remained minimal under the AWBZ, municipalities have made use of competitive bidding and other strategies to cut prices. Domiciliary services have become one of the most competitive areas in healthcare. Presumably the most controversial proposal was to implement a substantial retrenchment of the personal budget arrangement whereby only a small percentage of clients would retain the option of a personal budget. Not surprisingly, the proposal was heavily disputed and when the government fell in 2012, the political crisis was immediately seized as an opportunity for mitigation.

On a more fundamental level, the government also sought to initiate a debate over individual responsibility for LTC. In its view individual responsibility has to be reinforced to keep LTC accessible to those who really need it. Each person should live as long as possible autonomously in his or her own environment and the use of intramural services needs to be scaled down. However, reinforcing individual responsibility is not only an ambiguous concept, but also a controversial strategy that keeps parties divided.

One element stands out in the political debate, however, and that is the future of the AWBZ. In its present form, it covers a wide range in inpatient and outpatient services. An important policy issue is to reform the AWBZ in accordance with its original objective: a scheme to cover the costs of people in need of long-term care (mainly people with a serious physical or mental disability). For these categories some form of social insurance scheme should remain in place. All other services must be 'delisted' and accommodated in a *provision-based* scheme. Not surprisingly, this is a politically sensitive issue.

Future perspectives

The sustainability of healthcare is a good example of what policy analysts call a wicked or unstructured

policy problem. There is little consensus on the objectives of healthcare policymaking. Opinions on how much a nation should spend on healthcare and how to translate principles as universal access and solidarity into concrete arrangements differ widely. Neither is there consensus on the instruments to achieve these objectives. One may speak of an ongoing ideological controversy, which is exacerbated by the fact that the acceptance of 'evidence' is strongly influenced by one's ideas about what a fair healthcare system should look like. At the same time the demand for healthcare continues to rise and new, often costly, interventions will become available.

It is evident that new approaches are needed to achieve the 'triple aim': better population health and higher quality for lower costs (Berwick, Nolan and Whittington 2008). However, these approaches are not easy to put into practice. For instance, there is a great need for effective prevention, but prevention may raise complex questions about individual freedom and costs. Another urgent issue is to shift the focus from health volume towards health outcome. Unfortunately, institutionalised patterns often work as a formidable barrier to change and 'best practices' do not spread quickly. Many possibilities to get more value for less money have remained unexploited yet. There is also a great need for more individual responsibility: universal access and solidarity cannot be upheld without more emphasis on individual responsibility. However, the practical implications and public acceptance of more individual responsibility appear troublesome.

Present healthcare faces a prisoner's dilemma. All players have a common interest in hard measures to guarantee its future sustainability, but none of them has an individual interest to give in and, hence, look at the other. Without political imagination and courage, the inevitable result will be paralysis in which, ultimately, all players are not only collectively, but also individually worse off.

References

- Berwick, D., T. Nolan and J. Whittington (2008), "The Triple Aim: Care, Health, and Cost", *Health Affairs* 27, 759–69.
- Boer & Croon (2011), *Zelfstandige behandelcentra: Kwaliteit van zorg, efficiëntie en innovatiekracht*, Naarden.
- CPB (Centraal Planbureau) (2011), *Financiering onder druk*, Den Haag.
- CPB (2012), *Macro Economische Verkenning 2012*, Den Haag.
- Jeurissen, P. (2010), *For-profit Hospitals: A Comparative and Longitudinal Study of the For-profit Hospital Sector in Four Western Countries*, dissertation, Rotterdam.
- Klink, A. (2012), *Toerusting in de arena van de gezondheidszorg*, inaugural speech, Amsterdam.
- Maarse, J. (2011), *Markthervorming in de zorg*, Datawyse, Maastricht.
- NZa (Nederlandse Zorgautoriteit) (2012a), *Marktscan zorgverzekeringmarkt 2012*, Utrecht.
- NZa (2012b), *Marktscan huisartsenzorg*, Utrecht.
- NZa (2012c), *Marktscan medisch-specialistische zorg 2012*, Utrecht.
- NZa (2012d), *Marktscan medisch specialistische zorg: Weergave van de markt 2008-2012*, Utrecht.
- OECD (2011), *Help Wanted: Providing and Paying for Long-term Care*, OECD Publishing, Paris.
- OECD (2012), *OECD Health Data 2012*, OECD Publishing, Paris.
- Porter, M. and E. Olmstedt Teisberg (2006), *Redefining Health Care: Creating Value-based Competition on Results*, Harvard Business School Press, Boston.
- Ruwaard, D. (2012), *De weg van nazorg naar voorzorg: buiten de gebaande paden*, inaugural speech, Océ Business Services, Maastricht.
- Sadiray, K., D. Oudijk, H. van Kempen and J. Stevens (2011), *De opmars van het PGB*, Sociaal en Cultureel Planbureau, Den Haag.
- Significant (2012), *Doelmatigheid in de zorginkoop*, Barneveld.
- Struijs, J., J. van Til and C. Baan (2010), *Experimenting with Bundled Payments for Diabetes Care in the Netherlands: The First Tangible Effects*, RIVM, Bilthoven.
- Van der Meulen, L. and A. van der Kwartel (2012), *Sturen op doelmatigheid*, KIWA, Utrecht.
- Vektis (2012), *Zorgverzekeraars- en financiering*, Zeist.