Health reform in the Netherlands

introducing managed competition

Policy seminar: Reforming health insurance in Bulgaria: learning from the international experience. Presentation to the Bulgarian Minister of Health, Sofia, 26 March 2010

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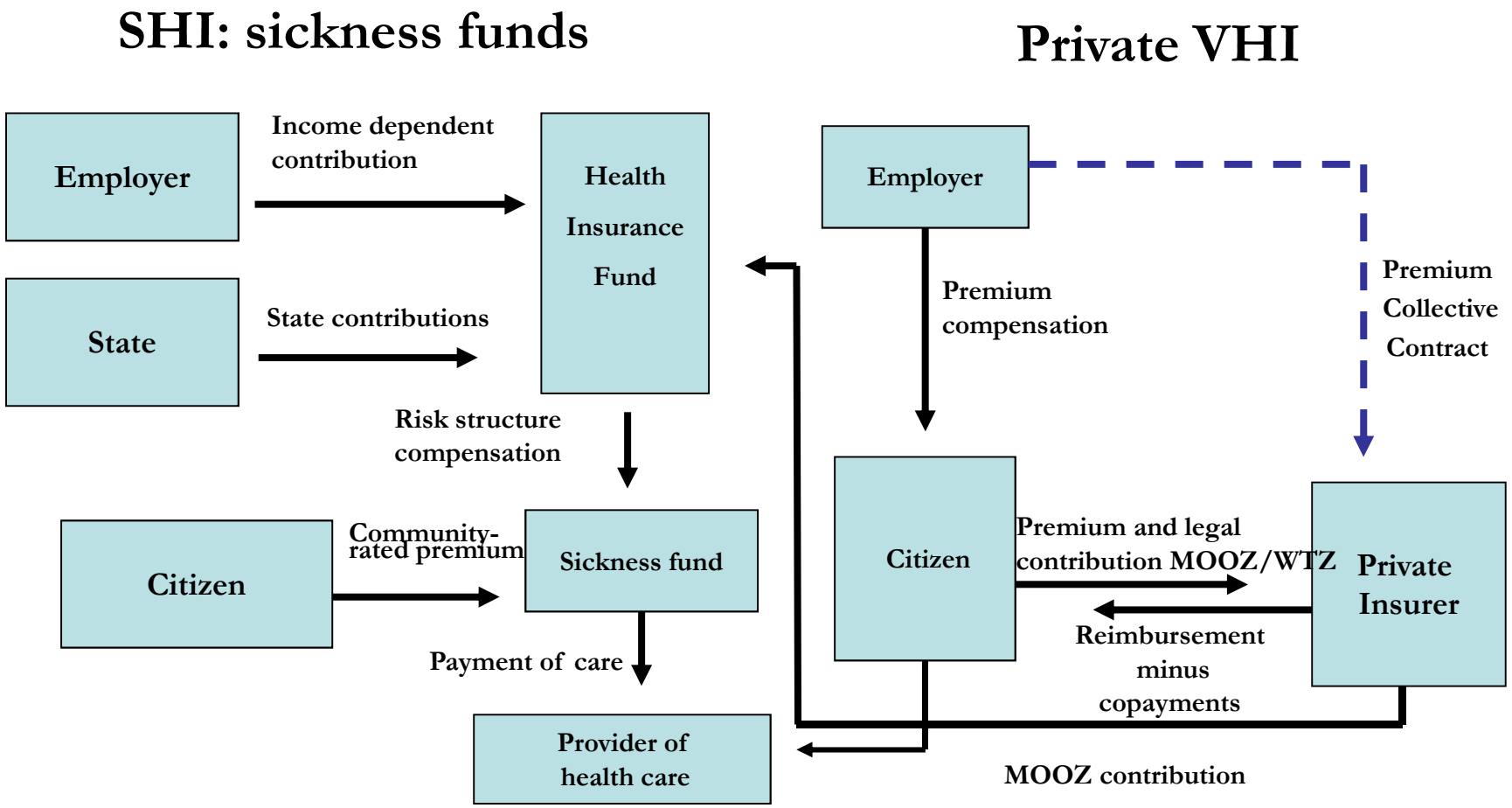
Introduction

- 16.4 million inhabitants
- Economy is ranked among the world's top 20 for GDP and top 10 for export volume.
- Annual population growth (2007) has fallen to 0.21% in 2007 (0.64% in OECD high income countries!)
- Average life expectancy is 79.7 years.
- most deaths are caused by cancer, in contrast to the EU, where diseases of the circulatory system are the main cause of death

<table>
<tr><th colspan="2">Old (- 2005)</th><th>Compartment</th><th>New (2006 -)</th></tr>
<tr><td colspan="2">Private complementary VHI</td><td>3rd Compl. care</td><td>Private complementary VHI</td></tr>
<tr><td>Sickness funds
• annual income <€29,493 (compulsory)
• 63% of population
• 85% income related,
• 15% income unrelated flat rate
• Employee 1,25% (€239-390 per year for 2003), employers 6.75%</td><td>Private insurance
• annual income >€29,493 (voluntary)
• 30% of population
• risk related
• premium level: set by insurer except “standard policies“ for €1824 (students €440) per year</td><td>2nd Curative Care</td><td>Basic health insurance (Zvw)</td></tr>
<tr><td colspan="2">Long-term care: Exceptional Medical Expenses Act (AWBZ)
• Compulsory, 13.45% of taxable income</td><td>1st Long-term care</td><td>Long-term care: Exceptional Medical Expenses Act (AWBZ)
• Compulsory, 12.55% of taxable income</td></tr>
</table>

Financial flows in 2nd compartment before 2006



Reform history

- 30 years of failed attempts to integrate social health insurance (provided by sickness funds) and private health insurance into a single mandatory scheme
- In 1987 the "Dekker report" advised introducing managed competition
- Last major attempt failed in the early 1990s

- However, smaller incremental reforms in the 1990s
  - Allowing insured to switch sickness fund
  - Allowing sickness funds to operate nation-wide
  - Harmonization of tariffs privately insured and sickness fund insured
  - Some free negotiation of tariffs
- Mergers and increases in scale between sickness funds and private insurers led to greater integration between the two types.

- 2006: Adoption of Health Insurance Act (Zvw): a model with community rated (flat) premiums under private law with public guarantees.
- The discussed alternatives
  - income related contributions
  - under public law with private characteristics (cf. old sickness fund scheme)

Rationale

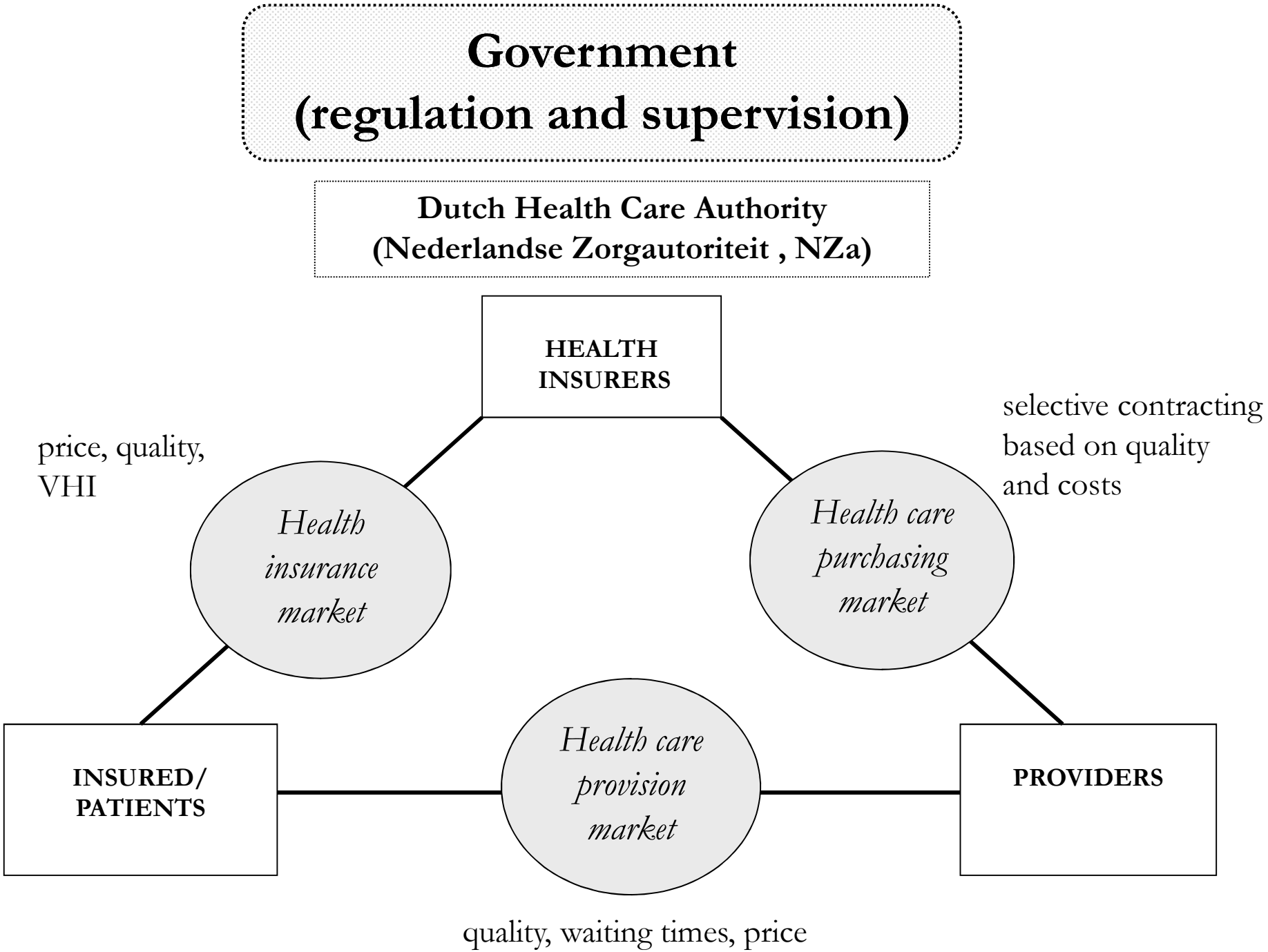
- Combat unfairness: e.g. work situation, income, health status all had potential influence on insurance form, contribution level and access to health services
  - Limited choice: switching insurers difficult due to risk selection, compulsory participation in public law scheme or mandatory collective contracts

- Increasing efficiency through increased competition

- Increasing transparency: old system was characterised by high level of government intervention, resulting in complex rules and regulations.

Essence of the reform

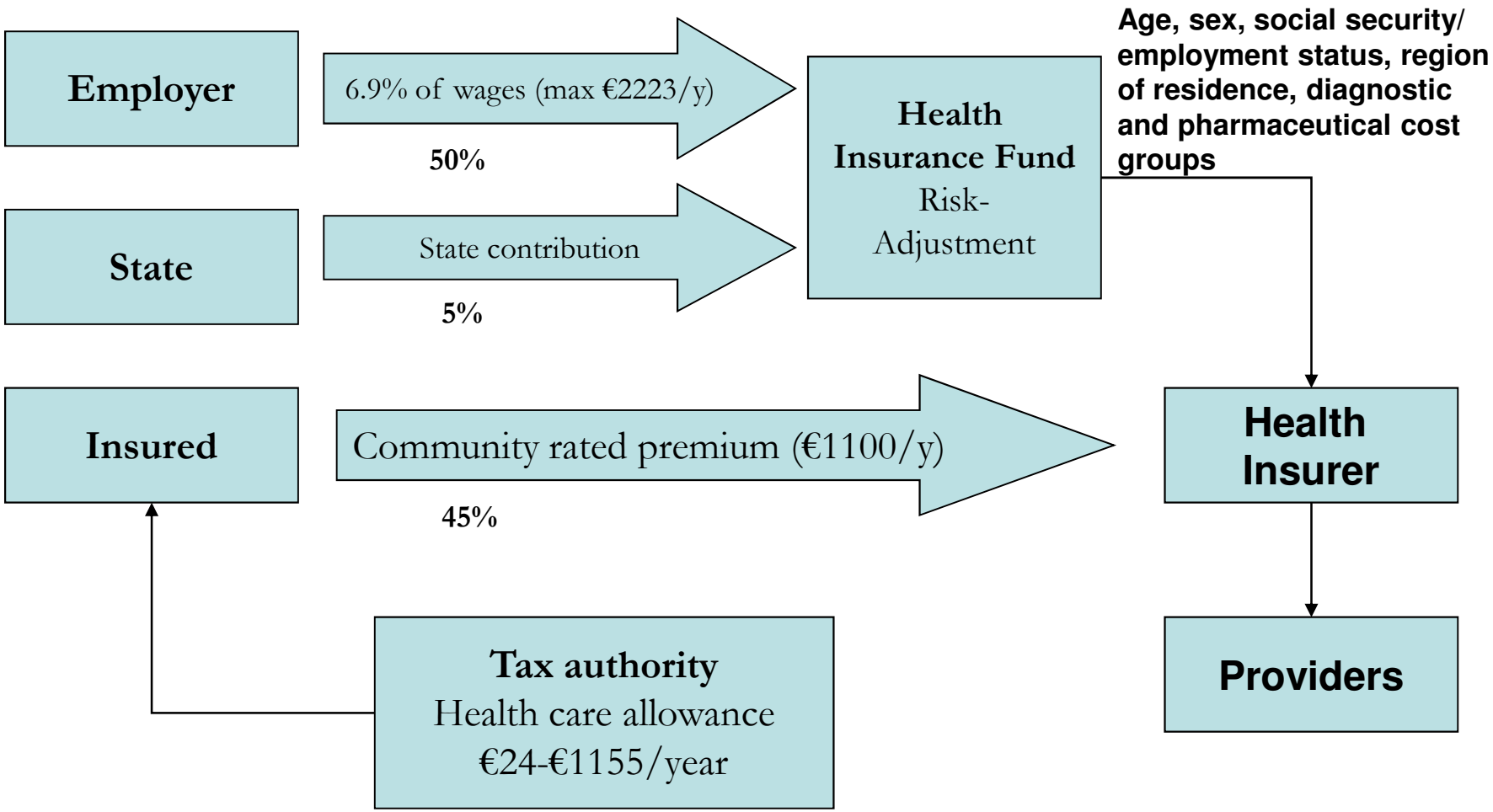
- Managed competition
- Transition from a supply-driven system towards a consumer-oriented system
- From direct steering to safeguarding from a distance
- Responsibilities shifted to insurers, providers and patients
- Government focuses on quality, accessibility and affordability
- Watchdog agencies aim to avoid undesired market effects
- An elaborate risk adjustment scheme plays a key role to create a level playing field and take away incentives for risk-selection
- Good patient information (kiesbeter.nl) and data is crucial


Government
(regulation and supervision)
Dutch Health Care Authority
(Nederlandse Zorgautoriteit , NZa)
HEALTH INSURERS
price, quality, VHI
selective contracting based on quality and costs
Health insurance market
Health care purchasing market
INSURED/ PATIENTS
Health care provision market
PROVIDERS
quality, waiting times, price

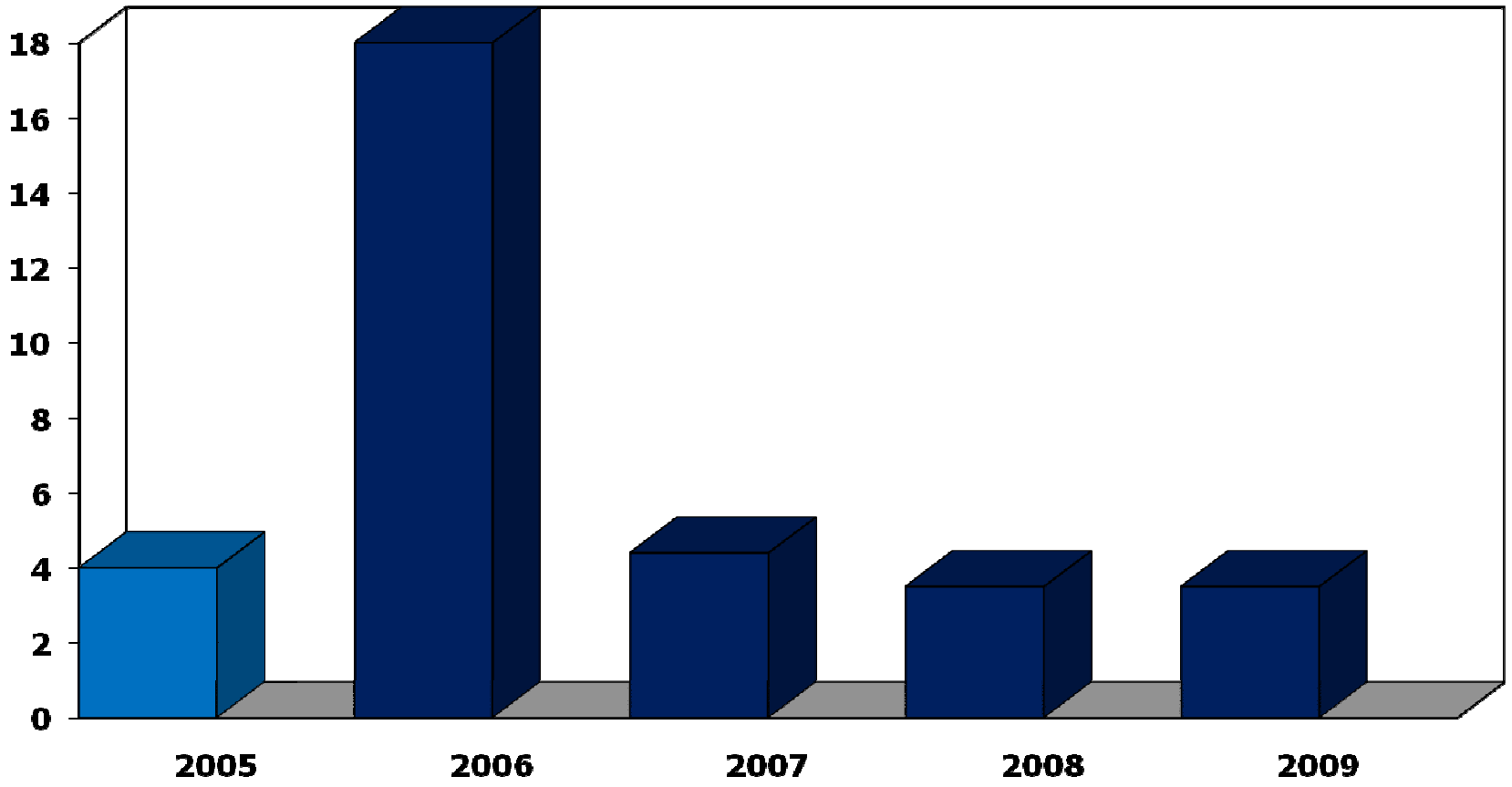
The new scheme

- Mandatory basic healthcare package for all residents
- Community rated premium and income-dependent employer contribution
- Difference between sickness fund and private health insurers disappeared
- More choice: insured can change every year, choose between benefits-in-kind/ reimbursement, deductibles (€100-500)
- Compulsory deductible (€160 in 2010) except for GP, maternity care
- Children are insured through parents
- Collective contracts still possible
- Complementary VHI: insurers are free to offer terms, benefits and rates (risk selection!)
- New separate Healthcare Allowance Act (Wtz): Compensation for people with lower incomes,
- 'Private' may be misleading: system still qualifies as SHI

Financial flows in the new Dutch health care system



Insured mobility (%)

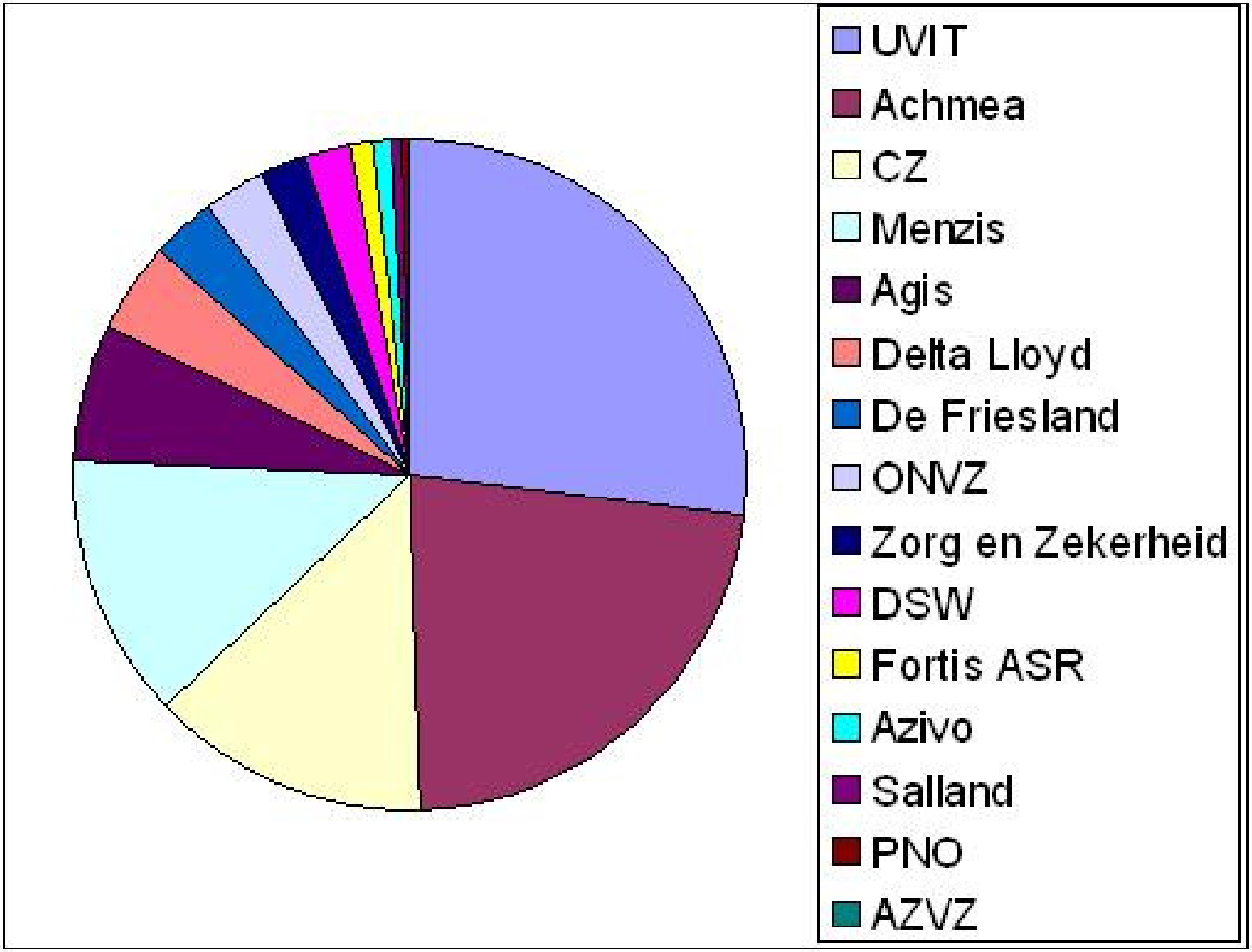


Source: Vektis Jaarcijfers 2009

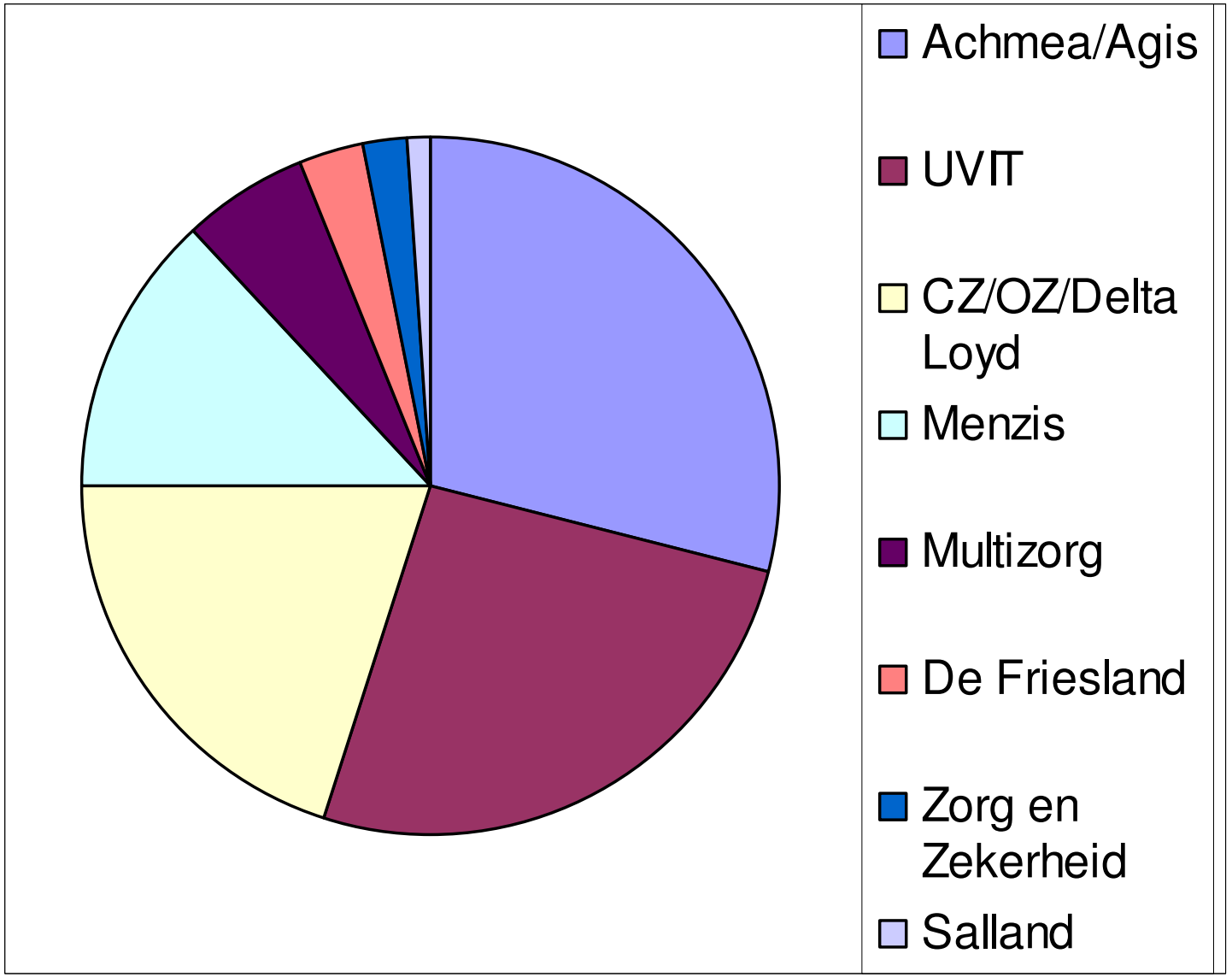
Impact on health insurers

- Premiums initially lower than expected, but future increases likely
- Health insurers now have to compete at national level
- Losses in enrolment up to 25%, increases up to 30%
- 'Losers' seem to be some of the old sickness funds (PHI had higher financial reserves – requested by law)
- Health insurers have received instruments to contain costs: e.g. selective contracting and price negotiations: however, scarcity of providers and regional monopolies and only 34% of hospital care (2009) is freely negotiable
- Need to develop more expertise
- Health insurers are now allowed to make profits

Market shares health insurers 2007



Market shares health insurers 2009



Impact on providers

- Parallel consolidation trend (private non-profit providers) – to increase negotiation power vis-à-vis health insurers
- Introduction of performance-based payment: Diagnosis-Treatment Combinations: 30.000 DBCs!
- End to two-tier system for GPs – now single remuneration system for all patients (combination of capitation and FFS)
- No longer two-tier medicine

Impact on insured and patients

- Clear empowerment of citizens
- More individual choice
- No more health-related discrimination
- However, problems occurred with specific groups (e.g. self employed)
- Flat rate premiums go up faster than contribution rates

- Clear empowerment of patients (groups): now purchasing power through collective contracts – in combination with risk equalisation scheme – move from bad risks to profitable customers: 24 collective contracts in 2006, 40 in 2007 and 42 in 2009
- However, some patient groups did not succeed in securing a contract (i.e. risk adjustment not 100%)

- Potential problem with universal coverage: in 2008: 170,000 people (1% of population) remained uninsured – 35,000 children !
- Lingering problem of financial defaulters: 210,000 people

Discussion

- The jury is still out whether managed competition will bring the intended effects
- Introducing managed competition was and is demanding on all market players
- Still work in progress, continuous refining, ad hoc measures
- Negotiation process needs to be optimised
- Patient information on price and quality is needed
- Quality has to be made visible and measurable (how?)
- Premium and compensation level?
- Is it feasible to create level playing field through risk adjustment?
- Do insurers have enough instruments to assume their role as 'director' and efficient purchaser in the health care system?
- Is the health insurer the unequivocal agent for the patient (or the shareholder)?
- Prevention? why invest when insured could change every year?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The Netherlands
Health system review
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