Structure of health care providers and deregulation of health care purchasing in the Netherlands

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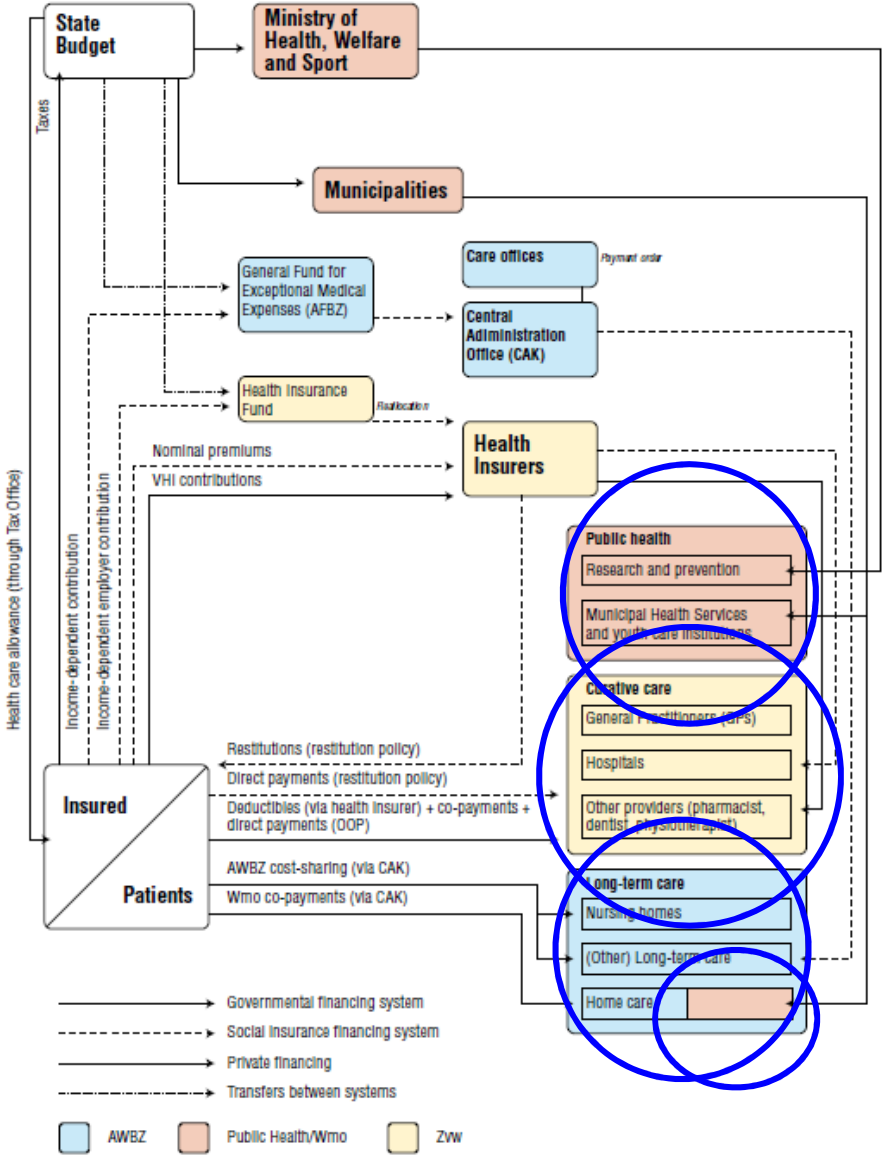
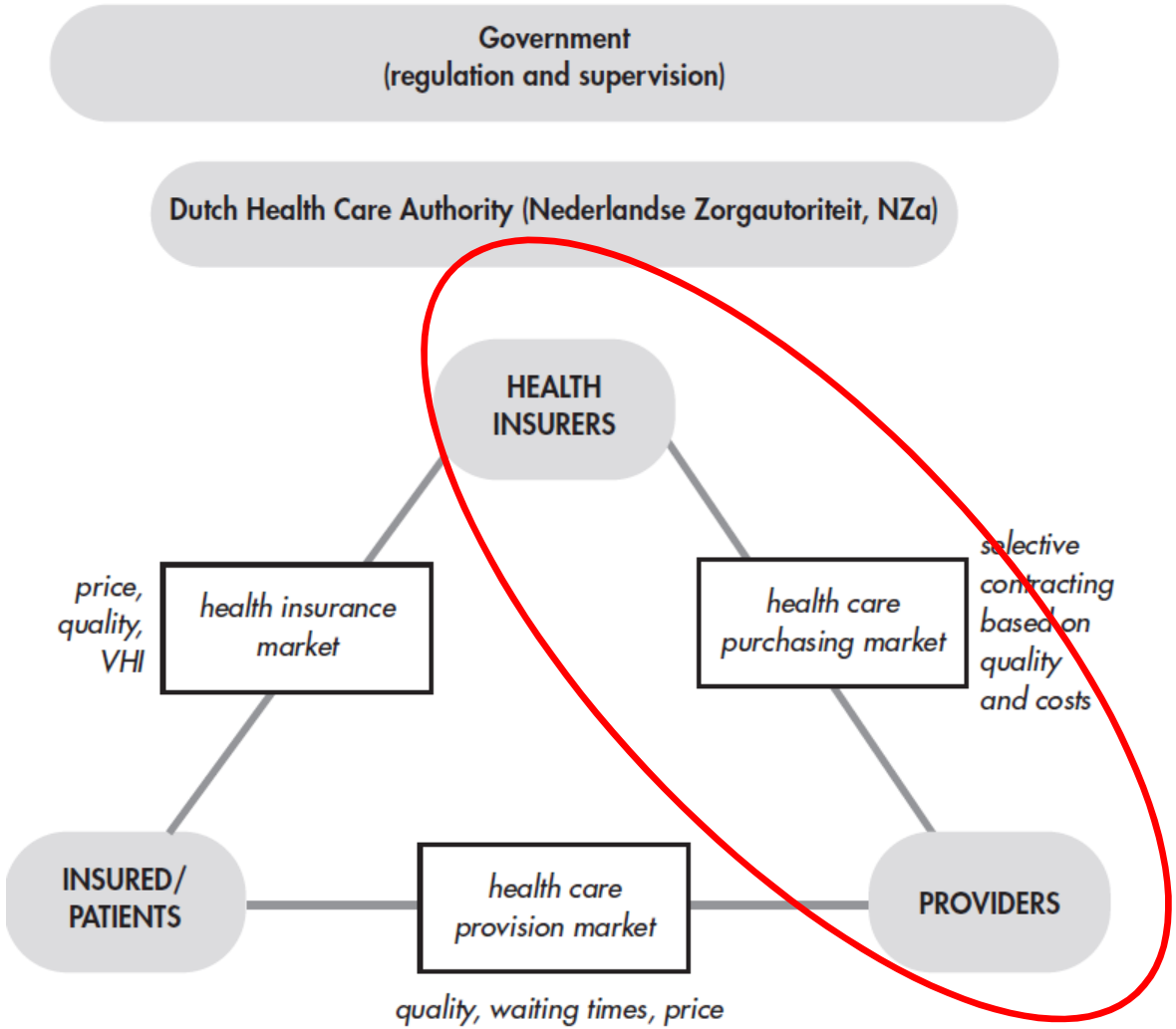
Structure of the Dutch health system: who is purchasing what?

- Insurers: curative care (Health Insurance Act, Zvw): **36% of THE**
- Care offices: long-term care (Exceptional Medical Expenses Act, AWBZ): **31% of THE**
- Ministry of Health: Public Health, Municipalities: home care (Social Support Act, Wmo): **15% of THE**



The Dutch health system: Introducing managed competition



Reforming the acute health care purchasing market

- Insurers negotiate with providers on price, volume and quality of care
- Insurers may use selective contracting
- Payment mechanisms should change to accommodate negotiations and competition
- Need for payment mechanisms where money follows the patient

Primary care

- GP payment based on contracting and through capitation and fee for service
  - Fees negotiated through National Association of GPs (LHV), Health Insurers Netherlands (ZN) and the Ministry of Health Welfare and Sports

- For other primary care providers save physiotherapists, NZA establishes the tariffs

Hospital care

Hospital care is based on Diagnosis Treatment Combinations

- Gradual implementation since 2005.
- DBCs can be negotiated between insurers and providers on price, volume and quality
- Different from DRG: DRGs group patients according to one diagnosis/procedure, DBC system provides DBCs for each diagnosis and treatment
- In 2010 34% of hospital turnover was freely negotiated, should rise to 70% in 2012

The hospital market structure

	2005	2006	2007	2008	2009	2010
General Hospitals	89	88	87	87	85	84
Academic Hospitals	8	8	8	8	8	8
Independent Treatment Centers	37	57	68	89	129	184

Some of the reform implementation experiences

- Excessive DBC tariffs have led to overfunding of hospitals (which had to be paid back)
- GPs generated more income than anticipated
- GP payments were delayed

- Although demands have been high, situation never became chaotic
- According to Nza, prices of freely negotiable DBCs show a 3% price decrease in real terms in 2010
    - Increase of cheaper independent treatment centers (ZBC)
    - But what is the influence on the macro budget?

Some bottlenecks in purchasing need solving

1. Contracting focuses mainly on price and volume not on quality
    - Sound performance indicators are lacking
    - Also in insurance market focus largely on price
2. Insufficient supply of health care providers hampers selective contracting
3. Negotiation process is slow
    - Late public announcement of legal changes in purchasing market
    - Large number of DBCs have to be negotiated (30,000!)
    - Complicates premium setting
    - (and thus transparency for patients)

Some bottlenecks in purchasing need solving

4. DBC system not yet stable: revision planned 2012 (DOT)
    - Over and underfunding
    - Differences in coding certain treatments
    - Reimbursement after treatment: real financial results known after 3 years
5. On the whole purchasing is still heavily regulated and incentives for efficient purchasing remain low

Latest developments

- New government plans: performance payment in stead of functional budgets

- DOT (DBCs towards Transparency)
  - Limiting number of DBCs to 3-4000 “care products”
  - Easier to identify, less differences in interpretations
  - Better reflection of care intensity
  - Based on ICD-10
  - Work in progress!

Conclusion

- Many learning opportunities for countries contemplating the introduction of similar purchasing arrangements
  - Shifting responsibilities to market players does not mean that government can sit back
  - Need for constant monitoring, ad hoc measures
  - Need for strong institutional structure
  - Political repercussions
  - Data is a key

… but the ultimate question remains whether managed competition will lead to higher quality care at lower costs