Responding to Ageing: Ongoing Health Care reforms in The Netherlands

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Netherlands - Some Key Data (2010)

-16.7 million inhabitants

-1259 inhabitants per square mile (area 16.500 sq.miles)

-15% population now >65, 27% in 2040 (Japan: 36,5%)

-World's 16th economy (total GDP), 9th in GDP/capita (46.986 USD) (source: IMF)

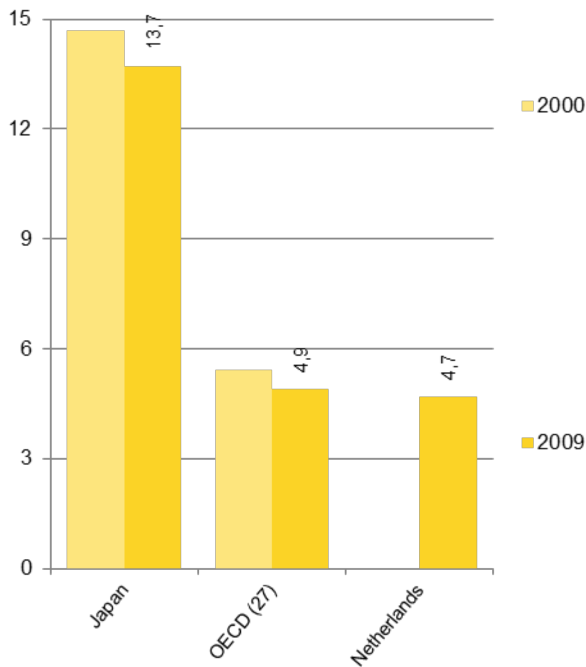
-Two tiered parliamentary system

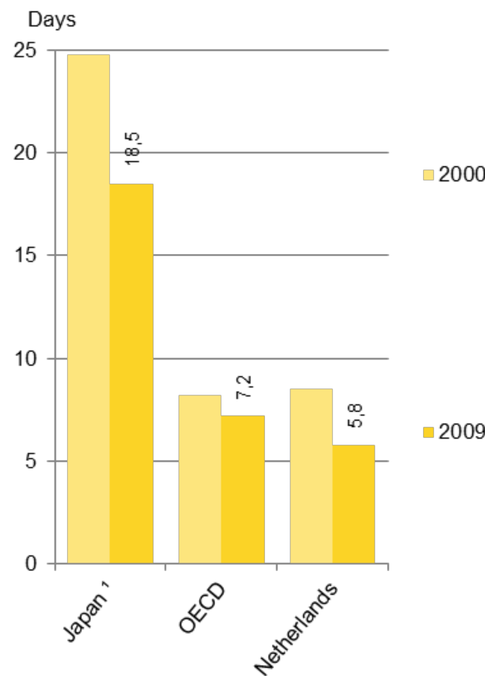
-10 parties (2-31 seats), Coalition Governments

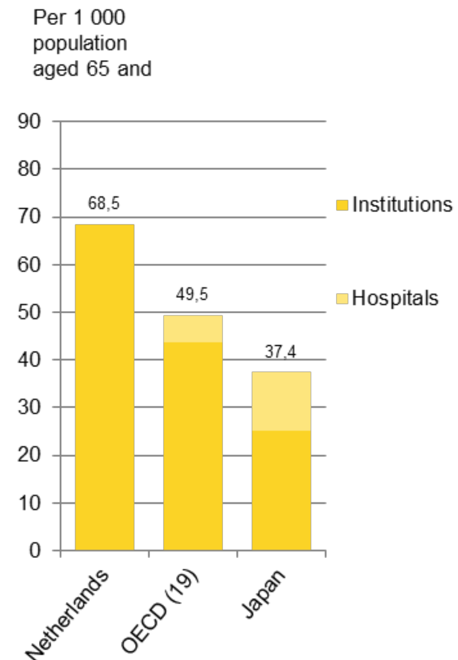
Key health data Japan - Netherlands

	Japan	NL	OECD
Life expectancy at birth	83	80,6	79,5
Health expenditure %GDP	8,5	12	9,6
Health expenditure USD/capita	2878	4914	3233
Out-of-pocket % household income	2,4	1,5	3,2
Long term care expenditure %GDP	1,0	3,8	1,39

Health and longterm care sector Japan - NL







Dutch healthcare: some institutional basics

1. Managed competition
2. Maximizing risk-solidarity
3. Small acute health care sector, large long-term care sector
4. Health care sector is private, but non-profit sector
5. GP is gatekeeper
6. Polder model

Compartments of the health insurance system

Health Insurance Act	Supple-mental Health-insurance	Long Term Care Act	Social support act
“Cure”		**“Care”**	
• General Practitioners • Hospitals • Drugs • Equip / Transp.	• Paramedics • Dental care • Alternative medicine	• LT care elderly • Chronically ill • Disabled • LT Mentally ill	• Home care • Transportation • Support in partici-pation in society
appr. €33 billion	**appr. €5 billion**	**appr. €23 billion**	**appr 3 €billion**

Dutch healthcare: how it is organized

Support

- Local Welfare institution
- Local transport for elderly
- Home care provider
- Informal care/ volunteer support
- Municipal Social Support Bureau

Cure

- National health inspectorate
- National health authority
- Primary care: GP, Physiotherapist, Psychotherapist, Other primary care
- Secondary care: Hospital
- Medical specialist
- Medication
- Health insurance company

client

Social support

Acute care

Long term care

Care

- care assessment office
- Long term care provider
- Regional joint contracting office (to be merged with health insurance companies)
- **Personal budget**
- Any provider

1. Health Insurance Act (2006):

- Individual mandate for consumer
- Legally defined benefit package of all essential healthcare
- Annual open enrolment for consumer, competition on nominal premium
- Community rating (same premium for same policy), income related contribution by employer
- Risk adjustment between insurers to prevent risk selection
- Low compulsory deductible (€ 220), freedom to add voluntary supll deductible
- Health care allowance (tax credit)
- Government taxes pay for children (< 18)

Parties in the game of managed competition

- **Health care insurers**
  - Have to compete for insured: yearly open enrolment
  - Legally defined coverage, no premium differentiation
- **Health care providers**
  - Have to compete for patients & contracts with insurers
  - Competition on price & quality of care
- **Insured/patients**
  - Free to choose between insurers & providers
  - Free to choose between reimbursement & benefits in kind
- **Government**
  - From direct intervention to (strong) market regulation
  - Emphasis on promoting quality transparency

Health Insurance Act

Employer

reimbursement
income-related
contribution

Government

state funding

income-related
contribution

Health Insurance Fund

health care
allowance

Insured person

adjustmentrisk
adjustment contribution
50% of care costs

compulsory deductible

premium 50% of health
care costs

Care provider

health care
procurement

Care insurer

Key challenges:

- Low premium increases up-to 2010; however, currently accelerating (8-10%)
- Insurers returned substantial levels of cash on balance-sheets to customers; heavy reductions in administrative expenses, but considerable growth in claims;
- Acceleration of mergers between insurance companies; currently top 5 has a 95% market-share;
- No strong incentive for insured to change insurers: 2006: 18%; 2011 6%
- Provider markets: declining prices, but increasing volumes; few selective contracting (network policies)

→ Not all conditions of managed competition have been fulfilled, especially transparency and risk-sharing

Current reform directions

- Short term: keeping **basic package** 'basic'
- Increase quality through **transparency** and **guidelines** (Quality Institute for Care)
- Increase **risk for insurers** as incentive to play their role as contractors
- From 'fixed' towards **'free' rates**: increase from 34 to 70%
- From 'automatic' towards **selective contracting** and network policies
- From all-in-one hospitals towards **concentrated complex care** (MoU last summer)

› Increase **providers risk**: freedom of capital investments (capital costs in DRG's)

› From budgeting to **output pricing** / P4P

› Grip on **remuneration of physicians**; from student caps towards free-entrance to medical schools

2. Exceptional Medical Expenses Act (AWBZ/EMEA)

Public Long-Term Care insurance (AWBZ):
- Residential care (70% of costs)
- Home care (70% of clients)

- Meant for high financial risks which private insurers cannot afford (>365 days)
- Everyone who pays payroll tax in the Netherlands is insured
- Funded by income and payroll tax systems (+ 8% personal contributions)
- Entitlements are described in 6 functions.

Personal care	Activating guidance
Nursing	Treatment
Supportive Guidance (>SSA)	Accommodation

- Need assessment by an independent office (CIZ)
- Option between In-kind care or Personal Care Budget

Key challenges

1. Rising costs / sustainability

	1968	1998	2008
Costs AWBZ/EMEA-care[1] (billion €'s)	< € 1	€ 12.8	€ 20.5
Number of clients	about 55,000	900,000 about 500,000 (excl. Psychiatric extramural)	600,000
Premium AWBZ/EMEA	0.41 %	9.60%	12.15%

2. Supply-oriented instead of client-focused

3. Shortage of labour

Current reform directions (1): improving care

- Philosophy: high trust, high penalty
- From supply-centeredness to client-centeredness
- Improving quality standards compliance (e.g. Quality Institute)
- Simplify assessment procedures
- Outcome based financing: from paying for 'inputs' to paying for 'outcomes' for clients

Current reform directions (2): ‘market’ incentives

- Compulsary contracting of care providers dropped, allow self-employed to be contracted
- Providers become risk-bearers for their real estate
- Implementation EMEA transferred to private health insurers per 2013 → Improve coordination acute health care/long term care
- Separation costs accommodation and care
- Enable more integrated care
  extramural support → SSA
  rehabilitation, devices → HIA
- Limit of Personal care budget to clients with “residential indication”
- Limit entitlements of EMEA (‘light’ support, higher personal contributions)

3. Social Support Act (est 2006)

Goals

- Stimulate self-sufficiency of all inhabitants
- Stimulate participation in society
- Stimulate civil society/social cohesion
- Support independent living of people with physical or other handicaps

- Municipalities are responsible
- No insurance, but 'public obligation'
- Local "made-to-measure" policy plan every 4 years
- Civil groups are involved in the policy making

Wmo provisions (1)

Housekeeping/ cleaning

Wheelchair

WMO/SSA provisions (2)

Housing adaptations

WMO/SSA provisions (3)

Transportation facilities

Conclusion: major trends

- Solving unfinished issues in ‘managed competition’ model
- Improving focus on quality standards
- Stronger focus on patient needs in care
- Room for integrated, innovative health care
- Re-balancing entitlements and personal contributions

Thank you!

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