Health and Global Policy Institute Congressional Briefing

Minutes of HGPI Congressional Briefing

Hosted at Diet Members' Building of the House of Representatives

Tuesday, January 17th, 2012

The briefing was opened by HGPI Director Ryoji Noritake, who thanked everyone for their attendance and gave a brief introduction to the aims of the congressional briefing and the background of Dutch healthcare reform.

Opening comments were made by Her Excellency Nienke Trooster, Head Economic Department/Minister Plenipotentiary Economic and Financial Affairs, Kingdom of the Netherlands. She thanked everyone for their attendance and expressed the increasing importance of addressing the issue of aging. She introduced the reforms in the healthcare system that had begun in 2006 as a means of maintaining the sustainability of universal coverage, but also noted that this was an ongoing process and therefore there was mutual benefit from bringing together experts from both the Netherlands and Japan. She went on to introduce the main speaker Dr. Rienar J. Koppelar, and expressed her hope that the briefing would provide "food for thought".

Dr. Koppelar began by remarking that the process for healthcare reform is not an easy one, as the recent reforms in the Netherlands in 2006 were preceded by attempts at reform dating back as early as 1974.

Six basic principles underlie the Dutch healthcare system – these are 'managed competition' (the combination of market incentives with public safeguards), maximization of risk solidarity (sharing healthcare risks across society), a small acute but large long-term health care sector, a private but non-profit health care sector, general practitioners acting as the first point of consultation before individuals can be referred on to secondary and tertiary care, and the "polder model" (cooperation between associations and governments for reform).
The Dutch health insurance system can be divided into three compartments; "cure" oriented care, which is funded by compulsory individual insurance payments in accordance with the Health Insurance Act and optional supplementary health insurance, "care" oriented support for chronic disability and illness in accordance with the Long Term Care Act which is funded mainly by income/payroll tax, and non-medical social support that must be provided by municipalities in accordance with the Social Support Act. At the individual level, in addition to insurance every person must pay the first €220 towards their medical bills which helps to encourage healthy people not to use healthcare unnecessarily. Low income individuals are provided with a health care allowance to help them afford premiums, and government taxes are used to pay for children under the age of 18.

A key point of the Health Insurance Act is that consumers can change their insurance company year on year, generating competition between providers to provide high quality service and competitive premiums through negotiating contracts with the healthcare providers. This then also incentivizes providers to improve their quality and efficiency to gain contracts. The combination of patient choice, healthcare insurer/provider competition and government market regulation make up the managed competition system.
Challenges in the Health Insurance Act and managed competition model include the recent acceleration in premium increases, acceleration in insurance company mergers reducing the incentive to compete, and lack of incentive for individuals to change insurer. Current reform directions looking to address some of these issues therefore include things such as increasing risk for insurers to encourage them to play their role as contractors, moving towards free rates for medical services and products to create more negotiation between insurers and providers, and promoting more selective contracting with complex care procedures being concentrated in certain hospitals with experienced specialists. Quality is also aimed to be raised through the establishment of the Quality Institute for Care and increased transparency on health outcome measures for healthcare providers.

The Long Term Care Act, or Exceptional Medical Expenses Act, covers high financial risks that cannot be afforded by insurers. Seventy percent of costs are represented by residential care, despite 70% of clients being in home care. An interesting feature to have come out of this act was the option for patients to set their own care budgets which enabled them to make their own contracts with providers, and although this is now being restricted because its success led to high costs there will still be support for independent small scale care projects.
Challenges for this system include the sustainability and rising costs of the system, the need for a more client-focused as opposed to supply oriented system, and the shortage of labor expected as a result of aging of the population. Current reform directions for this act therefore aim to improve quality of care through quality standards implemented by organizations such as the care institute, and market incentives such as dropping the compulsory contracting of care providers so that contracts are no longer guaranteed, and allowing the self-employed to be contracted. Although finances will be kept separate, the implementation of this act will be transferred to private insurers to enable coordination of acute and long term health needs and the assignment of things such as case managers to patients. Higher personal contributions are also required for sustainability, and there will be a separation of the care and accommodation aspects of what is covered by the act.

Dr. Koppelar concluded his talk by considering the major trends required to make healthcare sustainable despite increasing strain from an aging population. Improvement of quality standards, focus on patient needs and solving issues in the managed competition model are all important, as is re-balancing entitlements with personal contributions. In addition to this, there is also a need for ongoing integration and innovation in health care, with medical technology and life science developments becoming increasingly important, making this a key area for government investment.

Ryoji Noritake then opened the floor for questions.

One participant asked about three areas of Dutch healthcare; these were the standardization of quality and who is responsible for ensuring appropriate standards are met, the coordination between municipal support and nationally organized private healthcare, and how long term care issues fit in with the topic of euthanasia laws in the Netherlands.

In response to the first question on quality, Dr. Koppelar explained that medical associations already have a long tradition of self-regulated standardization of their professions, utilizing peer review, working groups and accreditation systems for specialists. The inspectorate for healthcare also has a quality control function and has powers to shut down institutions that do not meet standards. The newest addition to improve quality control is the quality institute which will investigate how to organize care in a better way, for example through nurses taking over some of the roles of doctors where appropriate. In addition to this, it will also collect examples of best practices and performance indicators such as mortality rates and make them accessible and transparent to everyone working in healthcare.
For the second question, Dr. Koppelar responded that ultimately there was not much intervention required from the government for the main bulk of healthcare, as national insurers were responsible for buying services from private providers. Integration of "lighter" social care provided by the municipality with other medical care will be increasingly coordinated by using case officers, who will write plans of care for patients.
As to the third question on euthanasia laws, Dr. Koppelar commented that these laws were separate from the healthcare reforms and more a matter of ethical considerations. The law did however result in improvements on the accessibility and quality of palliative care and hospices.

Another participant enquired as to the breakdown of money for the compartments, and whether these were total amounts or just the amount of tax money invested.

Dr. Koppelar explained that health insurance is entirely financed by insurance premiums, and individuals who are uninsured will be responsible for the whole cost of health bills. Costs for children under the age of 18 are however completely covered by the government. Special medical expenses (such as long term care) are financed through income tax. Municipal social care costs are the responsibility of municipality budgets, with contributions made by central government.

Another questioner asked to confirm whether access to secondary care absolutely had to always come through a GP referral, or whether there were some exceptions.

Dr. Koppelar explained that as a general rule, all secondary care was the result of referrals, however in the case of emergencies this is of course not the case.

Another participant asked as to whether any kind of system was in place to help give advice to citizens trying to choose their insurers.

Dr. Koppelar responded that it was a necessity that citizens can also gain access to transparent information on insurers. Presently there is an online initiative called "Choose Better", which enables individuals to compare insurance companies. The numbers of such websites are now also on the increase.

Finally, closing comments were given by Pieter Terpstra, policy adviser at the Embassy of the Netherlands. He expressed gratitude on behalf of the Embassy for this opportunity, and commented that he hoped the provision and exchange of information regarding this topic could be an ongoing.