Health insurance reform in the Netherlands: overview and update

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Overview

- Brief overview Dutch health care system
- Overview of health care reform with emphasis upon health insurance reform and public-private mix in health insurance
- Some results so far
- (only very briefly): recent developments
- Conclusions
Cutler’s episodes in healthcare reform

- Three main episodes in healthcare reform:
  - *equality*: emphasis upon extending coverage and access
  - *cost control*: e.g. fixing budgets, state planning
  - *market fundamentals*: emphasis upon micro-efficiency

- Dutch health care in third episode (but without giving up equality and cost control!)
The increase of health care expenditures, 1975-2005, per capita, USD 2000 PPP

Source: OECD Health Data 2009
The general practitioner (1)

- Gatekeeper role
- Increase of group practice (65%)
- Every individual should be registered with a GP
- Payment: a combination of capitation and fee for service
- Physician assistant
- Specialised nurses
The general practitioner (2)

- 74% consultations in practice; 8% home visits; 18% otherwise (telephone)
- Home visits declined by 17% since 1987
- In 4% of the contacts with patients referral to hospital or other care provider
- Per 1000 registered persons yearly 2.5% referred to hospital
- Pharmaceuticals prescribed in 57% of patient consultations
Hospitals

- No public hospitals
- Private not-for-profit
- Most specialists work in hospital setting
- Specialists either salary-paid or fee-for-service (but with ceiling)
- Rapid growth of ambulatory centers for specialist care: high volume, routine, profitable (‘focused factory’)
- More entrepreneurial approach
Physicians and nurses per 1000 inhabitants

Source: RIVM, 2008
## Health care spending in the NL (long-term care not included)

- Hospitals/medical specialists: 52.6%
- Farmaceuticals: 14.8%
- Mental health/psychiatry: 12.3%
- General practitioners: 6.2%
- Rest: 100.0%

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HEALTH CARE TRIANGLE

HEALTH CARE FINANCING

Third party (government agency, insurer)

HEALTH CARE PURCHASING

Consumers/patients

DELIVERY OF HEALTH CARE

STATE

Health care providers

Comprehensiveness of Dutch health care reform

Health insurance reform as trigger
Objectives of the reform

- To enlarge consumer choice and make health care more consumer-driven
- To improve solidarity
- To foster quality of care and innovation
- To improve efficiency
- To achieve sustainable health care financing
Pre-reform structure of health insurance

<table>
<thead>
<tr>
<th>Exceptional Medical Expenses Scheme (AWBZ) for long-term care: 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sick Fund Scheme: 63%</td>
</tr>
<tr>
<td>Private health insurance: 37%</td>
</tr>
<tr>
<td>Complementary health insurance</td>
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</tbody>
</table>

Dual structure in health care financing
Dual structure restricts solidarity
Call for single scheme
### Structure of health insurance after reform

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<th>Exceptional Medical Expenses Scheme (AWBZ)</th>
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<td>The new health insurance scheme</td>
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<td>Complementary health insurance</td>
<td></td>
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</tbody>
</table>

End to co-existence of social and private health insurance in second compartment

AWBZ not integrated into new health insurance scheme
Essence of regulated competition

- Market competition with public regulations to preserve public interests

- Quasi-competition: ‘institutional arrangements ...designed to extend the principle of market and competition to the provision of services, while simultaneously upholding the principle of free and universal access, fundamental to the concept of the welfare state’ (Bartlett et al, 1998)

- Regulated competition as a source of tension between freedom (market) and control (regulations)
The basic structure of the new health insurance scheme

- Single and mandatory scheme covering all legal residents
  → **public** scheme

- Implemented by private health insurers (for-profit insurance permitted)
  → **private** scheme

- Competition between health insurers
  → **private** scheme
Structure of regulated competition

From supply-driven to patient-driven health care

Ultimate goal

Regulated competition

Intermediate goal

Authority-based instruments
Treasury-based instruments
Organisation-based instruments
Information-based instruments

Howlett & Ramesh (2003), Studying policy analysis
Health insurance act (2006)

- Introduced in 2006
- Mandatory and covering the entire population
- Freedom of choice
- Open enrolment: insurers must accept each applicant
- Broad benefit package regulated by Minister of Health
- Coverage: GP-care, specialist care, hospital care, prescription drugs, maternity care, et cetera
- Competition between insurers
Health insurance act (2006)

- Nominal (flat-rate) premium set by insurer
- Income-related contribution (set by gvt) Gvt pays for children <18
- No risk-rating
- Income-related payment to subscribers on low income
- Risk equalisation
- Mandatory deductible (Euro 170)
- Voluntary deductible possible (maximum Euro 500)
The new structure

- **Risk equalisation scheme**
  - Grants for children <18
  - Income-related premium
  - Risk-adjusted capitation payments
  - Insurers
    - contracts
    - providers
  - Mandatory deductible

- **Subscribers/patients**
  - Nominal premium

- **Employers**

- **Government**
Complementary health insurance

• Voluntary
• Private health insurance
• No public control (except for solvency)
• Much diversity
• Examples of services covered:
  - dental care for adults
  - physiotherapy
  - alternative medicine
  - preventive services
  - other
• 92% of the population has CHI
Risk equalisation (1)

• Purpose:

Differences in nominal premiums must reflect differences in efficiency and/or health policy, not differences in risk profile.

• Compensation for differences in risk profile, no compensation for differences in health policy and/or efficiency
Risk equalisation (2)

- **ex ante RE:**
  age, sex, type of income, SES, region, morbidity related (diagnosis groups, pharma groups)

- (ex post RE)

- Financial risk insurers ambulatory care: 96%
- Financial risk insurers inpatient care: 47%
Example 1

- Women 5-9 € 852
- Women 30-34 €1453
- Men 30-34 € 795
- Men 85-89 €3006
Diagnostic cost groups
## Example (3)

<table>
<thead>
<tr>
<th>Example</th>
<th>Ex ante budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>woman 35-39</td>
<td>€ 1224</td>
</tr>
<tr>
<td>no pharma cost group</td>
<td>- € 315</td>
</tr>
<tr>
<td>Diagnostic cost group 8</td>
<td>€ 7922</td>
</tr>
<tr>
<td>self employed</td>
<td>- € 169</td>
</tr>
<tr>
<td>Region 1</td>
<td>€ 98</td>
</tr>
<tr>
<td>Total</td>
<td>€ 8760</td>
</tr>
</tbody>
</table>
The new structure

- Government
  - Grants for children <18

- Employers
  - Income-related premium

- Subscribers/patients
  - Nominal premium
  - Mandatory deductible

- Insurers
  - Risk equalisation scheme
  - Risk-adjusted capitation payments

- Providers
  - Contracts

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### Structure health care financing 2008

- Nominal premium (average €1049) 13,4
- Income-related premium* 17,0
- State grant for children 2,1
- Mandatory deductible 1,3
- Other 0,1
- Total EURO 33,9 miljard

* employed pay 7,2% over €31.230; self-employed pay 5,1% over €31.230
Consumer mobility: percentage switchers

Most important consumer criteria:

Premium basic policy
Premium complementary policy
Package complementary policy
Market concentration

- Continuous decline of number of insurers
- 2006: mergers between sick funds and private health insurers
- Presently 12 health insurance concerns
- Market share of the ‘four bigs’ (Achmea, Uvit, CZ, Menzis) is 88 percent
- Concerns about market concentration, in particular in certain regions
Premium increases

- Income-related premium employed: from 6,5 in 2006 to 7,75 in 2011

- Nominal premium: +38% over period 2006-2011 (from Euro 795 to Euro 1100)
Recent developments (1)

- *Health insurance*
  - ‘Delisting’
  - Raising mandatory deductible
  - Raising co-payments (mental health)

Purpose: To reign in the growth of public health care expenditures
Recent developments (2)

- Key role of *health insurers* towards managed care?
- Selective contracting
- Role of quality of care and costs in selective contracting
- Focus on concentration and specialisation of specialist care
- Patient steering
The new structure

- Grants for children <18
- Risk equalisation scheme
- Risk-adjusted capitation payments
- Insurers
- contracts
- providers
- Subscribers/patients
- Mandatory deductible
- government
- employers
- Nominal premium
- Income-related premium

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Concluding remarks

- Towards regulated competition in health care
- Complicated problem and time-consuming process
- Public-private mix in health insurance depends upon perspective taken.
- Measures to reign in growth of public health care expenditures
- Towards a more prominent role of health insurers?
- Still too early to draw definite conclusions about the reform’s success
See for more recent information:

Hans Maarse – *Dutch health care at the crossroads*

http://healthcarecostmonitor.thehastingscenter.org