

Health reform - one year after implementation

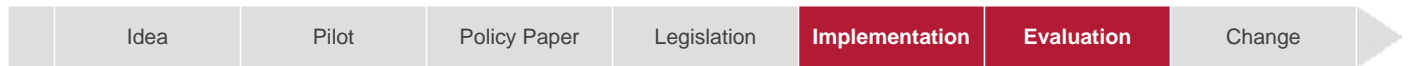
Country: Netherlands

Survey no: (9)2007

Reported by: University of Maastricht, Department of Health Organization, Policy and Economics (BEOZ)

Health Policy Issues: Funding / Pooling

Current Process Stages



1. Abstract

The new Health Insurance Act (Zorgverzekeringswet) has been in effect since January 1, 2006. The implementation of this act is just the first step in a reform process that is planned to last to at least 2012. This report briefly discusses some effects of the new law as well as some further steps scheduled for the coming 4 years.

2. Purpose of health policy or idea

The ongoing reform has several purposes:

1. to make health care more efficient;
2. to improve the quality of health care;
3. to make health care more demand-driven (consumer-driven);
4. to make health care more innovative.

The main incentives used are:

- introduction of market competition;
- enhancing the room for contracting between health insurers and provider agents;
- enhancing consumer choice;
- public reporting on hospital performance (hospital ranking).

Groups affected

hospitals and other provider agents, health insurers, consumers/ patients

3. Characteristics of this policy

Degree of Innovation	traditional	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>	innovative
Degree of Controversy	consensual	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	highly controversial
Structural or Systemic Impact	marginal	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	fundamental

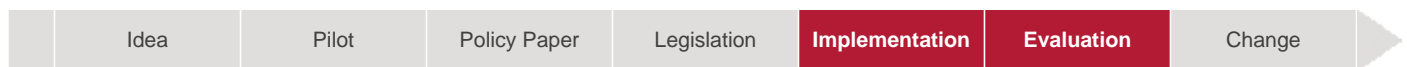
Public Visibilityvery low  very high**Transferability**strongly system-dependent  system-neutral

4. Political and economic background

The implementation of the new Health Insurance Act was just the first major step in a reform process that is to last until 2012. Further reforms are scheduled for 2008 and later years. The political background of this strategy is that the government intends to follow a cautious step-by-step strategy in the reform process in order to learn from the results and avoid policy decisions that are regretted at a later point of time.

Another element of the political background is that the former coalition government of the Christian Democrats and Liberals has been replaced since February 2007 with a new coalition government of the Christian Democrats, the Labour Party and the Christian Union. At this moment many aspects of the further reform process are unclear.

5. Purpose and process analysis



Origins of health policy idea

The origins of the health care reform process have been described in Health Policy Monitor report "[Health Insurance Reform 2006](#)". The basic idea is to introduce regulated competition in health care. Regulation by means of 'public constraints' is needed to preserve solidarity, to guarantee universal access to health care and to keep health care financing sustainable in the future. In order to optimise competition, various supervisory agents, including the Dutch Competition Authority, the Dutch Care Authority and the Public Health Inspectorate, monitor the market process. As said, the implementation of the new Health Insurance Act is just the first step in the reform process. The previous government planned various market-making policy decisions for the near future.

Initiators of idea/main actors

- Government
- Providers
- Payers
- Patients, Consumers
- Private Sector or Industry

Stakeholder positions

The current situation is unclear, because **the new government coalition has abstained so far from firm statements on the future course of action in health care reform**. Yet, the expectation is that the reform will be continued, albeit probably with a slower pace and in adapted form. A notable detail is that the present Minister of Health (Ab Klink/Christian Democrat) has declared himself the 'godfather' of market reform in health care. The reform is **still supported by the majority of hospitals and physicians**, but it is important to note that one can **also hear critical voices**. Some hospitals with plans for major capital investments in the near future are scaling back these plans (or considering to do so) because of the potentially damaging financial consequences of the new arrangement for capital investments. **Health insurers** on their part advocate quick further steps in market reform. They want more room for bilateral contracting with hospitals and other health care provider agents. As far as consumers are concerned, the overall picture is mixed. Nevertheless, the **national consumer/patient association** has declared itself consistently pro reform, because competition is likely to strengthen the position of the consumer/patient in health care.

Actors and positions

Description of actors and their positions

Government	
Ministry of Health	very supportive <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> strongly opposed
Providers	
Hospitals	very supportive <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> strongly opposed
Physicians	very supportive <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> strongly opposed
Payers	
Health insurers	very supportive <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> strongly opposed
Patients, Consumers	
Consumers	very supportive <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> strongly opposed
Workers	very supportive <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> strongly opposed
Private Sector or Industry	
Employers	very supportive <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> strongly opposed

Influences in policy making and legislation

The legislative process concerning the reforms described in section "Adoption and implementation" is under way.

Legislative outcome

pending

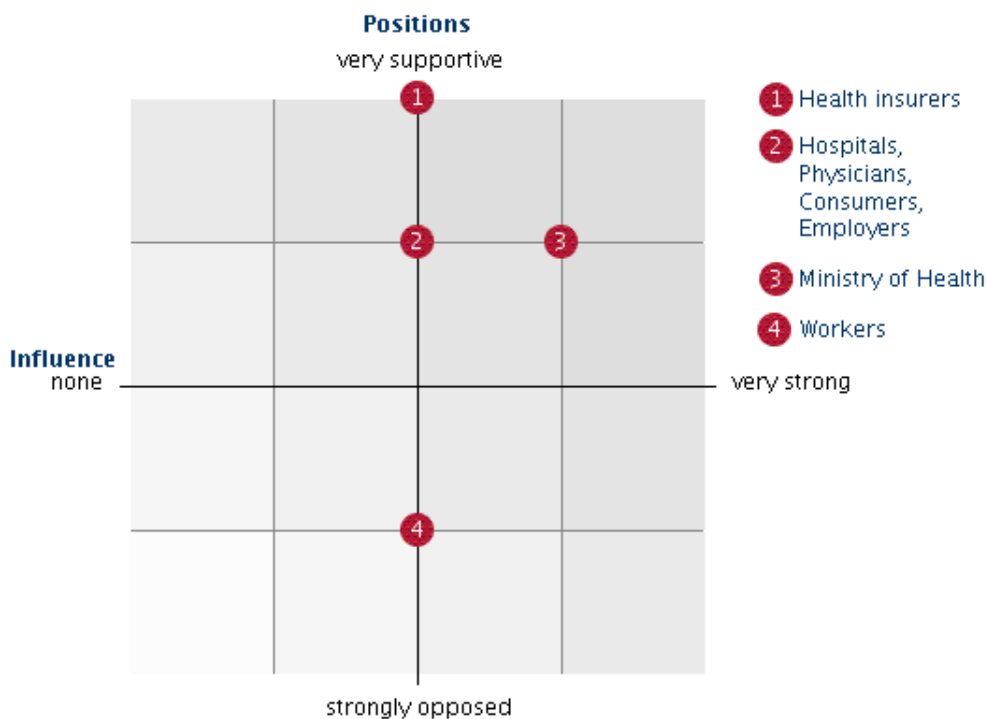
Actors and influence

Description of actors and their influence

Government	
Ministry of Health	very strong <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> none
Providers	

Hospitals	very strong	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	none
Physicians	very strong	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	none
Payers			
Health insurers	very strong	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	none
Patients, Consumers			
Consumers	very strong	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	none
Workers	very strong	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	none
Private Sector or Industry			
Employers	very strong	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	none

Positions and Influences at a glance



Adoption and implementation

The new Health Insurance Act as well as the Act of Licensing Care Provider Institutions have been in force since January 2006. But as mentioned before, various concrete market decisions are still to be taken. These include the following:

1. **Revision of the new hospital payment system** of DBC's (Diagnosis Treatment Combinations; diagnosebehandelingscombinaties; the Dutch equivalent of DRG-payments to hospitals). DBC's can be understood as a case-based payment system consisting of a combination of a diagnosis and treatment. At this moment the number of DBC's is about 30.000!

The new hospital payment system is considered as too complex and therefore needs substantial revision to simplify it. The new payment system is essential for the introduction of competition, because hospitals and health insurers are required to bilaterally negotiate on the price of (in theory) each DBC. Note that these prices can vary

per hospital/ insurer.

2. **Extending the room for negotiations on hospital prices between health insurers and hospital management** by increasing the number of DBCs selected for free price negotiations. The current number of DBCs for which free negotiation is possible covers about 8% of total hospital expenditures (hence, central price-regulation still applies to 92% of hospital expenditures). The list of hospital services open to price negotiations includes cataract surgery, orthopaedic surgery, inguinal hernia, adenoid and tonsils, diabetes care and several other services.

The previous government planned to extend the room for price negotiations to about 70% of total hospital care expenditures in 2008. However, the new government has decided to limit the extension to only 20% in 2008.
3. **Revision of the hospital planning system.** A rigid hospital planning in which the national government decides on the capacity of each hospital is considered to conflict with the strife for more competition in hospital care. A liberalisation of hospital planning is intended to make hospitals self-responsible for their capacity decisions. For this purpose the Hospital Planning Act (Wet Ziekenhuisvoorzieningen) has been abolished per January 1, 2006. This piece of legislation has been replaced with a new act: the Act on Licensing of Care Provider Institutions (Wet Toelating Zorginstellingen: WTZi). The new law is intended to enhance the room of hospitals and other provider agents for autonomous capacity decisions. Criteria for licensing are the quality and transparency of hospital administration and financial management. It has to be noted that the new law provides the government with some formal competences to regulate the capacity of hospitals if it considers the accessibility of hospital care to be jeopardised. The planning of costly and high-tech hospital facilities remains to be centrally regulated. In sum: the scope of the WTZi is somewhat uncertain yet.
4. **Reform of the arrangement for capital investments in 2008.** The reform includes a significant revision of the rules for capital investments. Under the previous arrangement hospitals needed approval for capital investment plans, whereas costs of rent and depreciation were included in the inpatient per diem rate. Neither hospitals nor banks providing long-term loans did incur a financial risk. Competition requires hospitals to incur a risk on capital investments. The solution for this problem is to introduce a normative mark-up for investments upon the DBC-rate. In this model the hospital's room for investments varies with the volume and price of its activity.

Policymakers expect that it will make hospitals more critical towards capital investments and encourage them to operate as a market agent in financing their capital investments. Banks, private investors and other financial agents will also incur a risk and, hence, be stimulated to innovate their product portfolio.

The position of the new government on this reform is uncertain yet. The problem is that it may have far-reaching implications. The expectation is that some hospitals may go bankrupt. It is plausible to assume that the government wants to avoid such effects by developing a staging-in approach or creating a kind of safety net procedure.
5. An important element of the WTZi is that the **ban of for-profit hospital care is planned to be lifted in 2012.** Lifting the ban is essential to attract private capital resources for hospital care. Yet, the government opts for a cautious approach. An important argument to postpone this market-making decision is that in its view the conditions for for-profit hospital care are not yet fulfilled. The new case-mix based payment system must be fully operative and hospitals must operate as risk-bearing entities that may go bankrupt. The government is also concerned that an immediate lift of the ban may lead to situations in which the economic value of hospitals that was created in the past with public resources in a risk-free environment may leak to the commercial sector. The position of the new government on this market-making reform is uncertain yet.

Monitoring and evaluation

The effects of the new legislation are closely monitored, not only by the government and a number of independent regulatory agencies (formal monitoring), but also by consumer and other organisations in society (informal monitoring).

Over the last few years, the Dutch Care Authority has published a number of mid-term monitoring reports. Similar reports were published by VEKTIS and CBS.

The following indicators are being monitored and evaluated:

- consumer mobility
- the number of persons without insurance (uninsured)
- price effects
- cost control
- market concentration effects (mergers)
- performance of provider organisations
- quality of health care
- structure of health insurance market
- structure of market for hospital care
- income effects
- waiting times

Dimensions of evaluation

Structure, Outcome, Process

Results of evaluation

The following evaluation results can be mentioned:

- In **2006** about **18%** of the **insured switched to another insurer** (VEKTIS)
- In **2007** about **4,5%** of the **insured switched to another insurer** (VEKTIS)
- The **percentage of insured covered by a collective contract** of an employer or another 'collective' was 57% in 2007 (was 44% in 2006). The percentage of insured with an individual contract was 43% in 2007 (was 56% in 2006) (VEKTIS).
- The **average hospital price of the DBC's** fell by 0,8% in 2006 (NZA). Note, however, that the fees-for-service of the medical specialists were not included in this percentage.
- The **impact on the quality of health care** is unclear.
- There has been a **substantial rise in the number of Independent Treatment Centres** (ZBC's, Zelfstandige Behandelcentra), particularly in the field of ophthalmology, dermatology, women-child care, orthopaedic surgery, cosmetic surgery. Their share in total hospital care is however still small, both in monetary and volume terms (NZA).
- There has been a **further consolidation in the health insurance market**.
- There has been a **further consolidation in the health care delivery market**, particularly home care, psychiatric/mental care, nursing homes and community care, care for persons with a mental handicap.
- The **number of uninsured** is estimated at about 247.000 (1.5% of the population). It is expected to rise further after July 2007 because health insurers will remove the non-payers from their list of insured (CBS).

- There are **indications that market competition has led to underpricing in health insurance**. The total loss has been estimated at €600 in 2006 (about 2%). Most health insurers are reported to make further losses in 2007. The Royal Dutch Bank (De Nederlandse Bank) does not yet consider the situation as dramatic because of high reserves of many health insurers. Yet it is clear that buying market share by underpricing cannot be continued in the near future.
 - **Waiting times for elective care** have substantially declined.
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6. Expected outcome

- better quality of care
- shorter waiting times
- more efficiency
- more room for health care innovations
- a more prominent role of health insurers in contracting with health care providers
- further consolidations

It is important to note, however, that there is still much uncertainty about the real scope of health care reform. Much depends, among others, on the market decisions that are scheduled for 2008 and later.

It is too early to assess the impact of the reforms on quality of care, the level of equity and cost efficiency.

7. References

Reform formerly reported in

[Health Insurance Reform 2006](#)

Author/s and/or contributors to this survey

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