Responding to Ageing: Ongoing Health Care reforms in The Netherlands

Tokyo, January 17, 2012

Reinier J. Koppelaar
Counselor for Health, Welfare and Sports
Royal Netherlands Embassy, Beijing, P.R.C.

reinier.koppelaar@minbuza.nl
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

<table>
<thead>
<tr>
<th></th>
<th>Japan</th>
<th>NL</th>
<th>OECD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life expectancy at birth</strong></td>
<td>83</td>
<td>80,6</td>
<td>79,5</td>
</tr>
<tr>
<td><strong>Health expenditure %GDP</strong></td>
<td>8,5</td>
<td>12</td>
<td>9,6</td>
</tr>
<tr>
<td><strong>Health expenditure USD/capita</strong></td>
<td>2878</td>
<td>4914</td>
<td>3233</td>
</tr>
<tr>
<td><strong>Out-of-pocket % household income</strong></td>
<td>2,4</td>
<td>1,5</td>
<td>3,2</td>
</tr>
<tr>
<td><strong>Long term care expenditure %GDP</strong></td>
<td>1,0</td>
<td>3,8</td>
<td>1,39</td>
</tr>
</tbody>
</table>
Health and longterm care sector Japan - NL

Average length of stay in hospital (per 1000 aged 65 and over)

Long term care beds in institution and hospitals

Per 1000 population aged 65 and over
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
“Cure”
- General Practitioners
- Hospitals
- Drugs
- Equip / Transp.
appr. € 33 billion

Supplemental Health-insurance
- Paramedics
- Dental care
- Alternative medicine
appr. € 5 billion

Long Term Care Act
“Care”
- LT care elderly
- Chronically ill
- Disabled
- LT Mentally ill
appr. € 23 billion

Social support act
- Home care
- Transportation
- Support in participation in society
appr 3 € billion
Dutch healthcare: how it is organized

**Primary care:**
- GP
- Physiotherapist
- Psychotherapist
- Other primary care

**Secondary care:**
- Hospital
- Medical specialist
- Medication

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

**National health inspectorate**

**National health authority**

**Personal budget**

**Care:**
- Long term care provider
- Urgent care
- Personal budget

**Long term care**

**Any provider**

**Regional joint contracting office** (to be merged with health insurance companies)

**Health insurance company**

- 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 supplementary 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
  - health care allowance
- Insured person
  - compulsory deductible
  - premium 50% of health care costs
  - state funding
- Health Insurance Fund
  - adjustment risk adjustment contribution
  - 50% of 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
  - Nursing
  - Supportive Guidance (>SSA)
  - Activating guidance
  - Treatment
  - Accommodation

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

1. Rising costs / sustainability

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs AWBZ/EMEA-care¹ (billion €’s)</td>
<td>&lt; € 1</td>
<td>€ 12.8</td>
<td>€ 20.5</td>
</tr>
<tr>
<td>Number of clients</td>
<td>about 55,000</td>
<td>900,000</td>
<td>600,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>about 500,000 (excl. Psychiatric extramural)</td>
<td></td>
</tr>
<tr>
<td>Premium AWBZ/EMEA</td>
<td>0.41 %</td>
<td>9.60%</td>
<td>12.15%</td>
</tr>
</tbody>
</table>

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

- Compulsory 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!