

Structural reforms and hospital payment in the Netherlands

Siok Swan Tan, Martin van Ineveld, Ken Redekop, Leona Hakkaart-van Roijen

Over the past 20 years, structural reforms of national healthcare sectors have taken place in many European countries. The most common reason for such reforms is to improve the efficiency of hospital care, with the aim of containing or reducing hospital costs. Secondly, the aim is to increase transparency of hospital costs and to introduce fundamental incentive mechanisms to improve efficiency, such as systematic benchmarking and managed competition. Structural reforms in the Netherlands were implemented in 2005/6. During the previous decades, hospitals were mainly financed based on prospective global budgets, i.e. hospitals received a fixed payment for treating a pre-specified volume of activity. Thus, incentives to increase production or to produce more efficiently were mainly absent. The structural reforms entailed substantial changes in the financing, budgeting and reimbursement of healthcare organizations. A central element of the reforms was the transition from a supply-led system to a demand-led system.¹ It was the government's intent to shape the healthcare system primarily according to the needs of patients (i.e. the demand side) by: – increasing competition between health insurers – increasing competition between healthcare providers – financing the core/main care chain based on quality

Integration of health insurance schemes

Since January 2006, statutory and private health insurance have been integrated into a single and mandatory scheme that provides coverage to the whole population, including care provided by hospitals, medical specialists and general practitioners and uninsurable risks such as those related to chronic illnesses.^{2,3} Each health insurer has to accept each customer, regardless of age or medical history, at a standard premium applicable to all its customers. A risk equalization fund compensates insurers for an overrepresentation of bad risks. The expected expense associated with each customer is estimated on the basis of predictive modelling, and the risk equalization fund pays appropriately more to insurers whose customers' care is predicted to cost more than average, while insurers whose customers' care is expected to cost less than average must pay the fund.⁴ Insurers are to compete by purchasing high-quality care for their customers. Consequently, the market power of insurers would be determined by the willingness of customers to switch between insurers and the willingness of customers to go to those hospitals that are contracted by their insurer.^{4,5}

Free access to the hospital care market

In 2007, there were 8 university hospitals, 86 general hospitals, 35 specialized hospitals and 17 rehabilitation centers in the Netherlands.⁶ All hospitals work on a not-for-profit basis and provide care which is covered by the mandatory insurance scheme. Where hospital care was previously only provided by hospitals, independent treatment centers (ITCs) and private clinics have been allowed to freely access the hospital care market since 2006. Similar to hospitals, ITCs work on a not-for-profit basis and deliver care which is covered by the mandatory scheme. However, ITCs focus on straightforward, non-acute outpatient care. Private clinics work on a for-profit basis and focus on non-insured care.

The DBC casemix system

The third instrument to support the transition from a supply-led system to a demand-led system was the introduction of the national Diagnosis Treatment Combination (DBC) casemix system for the registration and reimbursement of care provided by medical specialists and hospitals. DBC includes the whole set of hospital services provided by the medical specialist and hospital resulting from the first consultation and diagnosis of the medical specialist at the hospital. This implies that the codification process starts at the beginning of the care process and ends after treatment completion when the care process has finished.

Patients are classified according to medical specialty, type of care, demand for care, and diagnosis and treatment setting and nature. The DBC system now comprises about 30000 DBCs with the 'medical specialty' dimension as the primary basis for the classification of patients. In the near future, the number of DBCs will be substantially reduced to 3,000 by means of discarding the 'medical specialty' dimension and excluding expensive/ orphan drugs and intensive care.⁷ The information used to classify patients includes clinical and resource use data. However, resource use care intensity is not used in the current classification system because demographic data, co-morbidities, secondary diagnoses, grading of severity and secondary procedures and operations are not yet registered. All hospitals and ITCs are paid for all of their inpatient and outpatient care according to the system's logic. In addition, the system is implemented in mental healthcare. All DBCs are exhaustively assigned to one of two lists – either List A or List B. The distinction between List A and List B DBCs is especially interesting in the light of the transition from a supply-led system to a demand-led system. List A DBCs have fixed national prices and are (still) largely financed according to the financing system in place before 2005 (based on production volume rather than on quality).⁸ In contrast, the prices of List B result from negotiations between health insurers and hospitals. Any deficits or earnings on List B DBCs are the responsibility of the hospital. List B DBCs are meant to encourage insurers and hospitals to negotiate on quality rather than on production volume. Insurers are not obliged to contract all hospitals, may employ different DBC prices for different hospitals and may set a maximum on the number of DBCs they want to reimburse to a hospital. Likewise, hospitals are not obliged to contract with all insurers and may employ different DBC prices for different insurers. In addition, insurers and hospitals may agree upon a lower or higher DBC price if production exceeds a predetermined figure and may determine the frequency and terms of agreements.^{4,1} The DBC casemix system aims to achieve a situation in which the core care chain is predominantly financed based on the quality of delivered care, i.e. by List B DBCs. Currently, about 33% of DBCs are in List B, but it is the government's intention to gradually increase this share to 70% over time. Major List B diagnoses include hip and knee replacement, diabetes mellitus, cataracts and inguinal hernia repair. List B DBCs are sufficiently medically coherent and costhomogeneous and should have a sufficiently high incidence/ production volume. In addition, List B DBCs concern predictable, non-acute outpatient care and are freely accessible for (new) healthcare providers. A List A DBC is eligible for transfer to List B when it meets these criteria, when the transfer is supported by the medical profession and when it is technically realisable.⁷

Evaluation of structural reforms

Integration of insurance schemes

The integration of social and private insurance schemes created strong price competition among health insurers.⁵ Many insurers tried to attract customers by offering low-priced contracts, in particular by discounts on group contracts (on average these were about 7% cheaper). In 2006, 18% of the population switched to another insurer. As a result of the heavy price competition, health insurers incurred annual losses of about 2% of total premium revenue. Since 2007 insurers started to cut operating costs, premiums converged and switching rates dropped to about 4%.^{1,5} However, insurers have been quite reluctant to selectively contract with hospitals and to offer preferred hospital contracts to their customers. There are several reasons for this.⁵ Firstly, there is limited availability of high-quality information. Insurers often do not have sufficient information to selectively contract with good-quality providers. In addition, the limited availability of high-quality information makes it difficult for insurers to explain to (potential) customers that preferred providers are selected because they offer good-quality care. When there is already a free choice of health insurer for customers, insurers fear a loss of reputation if they restrict choice to a limited network of preferred hospitals. A third reason why insurers do not have an incentive to selectively contract with hospitals is that most of the DBCs are still in List A and (still) largely financed according to the financing system in place before 2005. However, with ongoing improvements to the DBC system, the method of risk equalization in place and the increasing share of List B, the financial risk on hospital expenses has substantially increased since 2009.^{9,5}

Free access to the hospital care market In order to remain competitive, many hospitals have established ITCs over recent years. Consequently, the number of these centers has increased rapidly from 79 to 135 in 2007.⁶ The introduction of ITCs to the hospital market has led to higher accessibility for patients, especially when it comes to straightforward non-acute outpatient care (List B DBCs). ITCs are an attractive alternative to hospitals because they provide relatively high-quality care due to the routine delivery of specific treatments and they more easily respond to changes in the needs of the patients. Moreover, the introduction of ITCs reduce the waiting lists of competing hospitals and encourage competitors to improve

the quality and efficiency of care.¹⁰

Table 1 Negotiated prices in 2007 and 2004 for seven list B DBCs at four health insurers

	2004 price (€)	Minimum 2007 price (€)	Maximum 2007 price (€)	Mean 2007 price (€)	Price increase (%)
Hip replacement	8571	7603	11370	9097	6.3
Knee replacement	10228	9097	13000	10746	5.1
Inguinal hernia repair	2163	1529	3088	2254	4.2
Diabetes	409	385	1027	483	18.1
Tonsillectomy	740	433	1498	800	8.1
Cataract	1317	1044	1599	1381	4.8
Spinal disc herniation	3046	2413	5778	3308	8.6

Source: NZa, 2005¹¹

The DBC casemix system Although negotiations were intended to be based on quality, insurers and hospitals currently predominantly negotiate on price and/or production volume.⁸ Since 2006, prices for List B have increased at a lower rate than those for list A and the health insurers increasingly put pressure on hospitals to charge even lower prices. On the other hand, the production volume of List B has grown faster than that of list A, but it is unknown whether this is due to supplier-induced demand or to a learning effect in the new coding and registration system.⁵ Table 1 depicts the negotiated tariffs of 2007 compared to those of 2004 for seven List B DBCs at four health insurers.¹⁰ Negotiated prices generally vary widely between health insurers. For example, the 2007 price for hip replacement ranged from €7 603 to €11 370. Overall, List B prices have increased about 8% compared to 2004. Current practice suggests that negotiations take place annually, but that either party re-opens negotiations if required by the circumstances; for examples, when there is a long waiting list, increased public attention to a specific health problem or the introduction of new and expensive medications or medical devices.¹ In general, large negotiated price deviations only occurred for the minority of DBCs. More complex and chronic DBCs seemed to be less sensitive to market competition. Moreover, the most recent evidence suggests that hospitals negotiate on the total budget of the overall List B segment rather than at the individual DBC level.⁸ Besides the problems of having the right mix of criteria to determine quality, accurate data and having this data in a timely manner, there are several limitations for Dutch health insurers that prevent them from competing on quality.² Firstly, patients assume that the quality of care in terms of effectiveness and safety is equal among all hospitals. The public debate about quality of care is predominantly focused on topics like waiting lists and access time. As a result, insurers have no incentive to aim for quality because this might not earn back investments through higher payments for high-quality performers. Secondly, hospitals have contracts with several insurers, which might limit the effect of an insurer's effort to motivate hospitals – unless the insurer who is promoting the incentive program is responsible for a substantial proportion of a hospital's patients. An additional consideration is 'free riding'. Customers who are not insured through the insurer who sets up a value based purchasing program will also benefit from the quality improvement. Thirdly, quality is particularly important to patients who are sick. If an insurer achieves recognition for providing high-quality care, it is likely to enrol a disproportionate share of patients with chronic medical problems. However, improving the risk equalization fund might reduce insurers' concerns about risk selection.^{4,9} Because of these limitations, the only aspects that impact on how insurers can stand out from one other are (i) improving accessibility to hospitals, (ii) the service they themselves provide and, in particular, (iii) the costs related to a lower premium and/or co-payments.²

Concluding remarks

The Dutch healthcare sector has been radically reformed and the first stage of the introduction of competition between health insurers and healthcare providers has been completed. The development of the DBC casemix system to encourage insurers and hospitals to negotiate on quality is still work-in-progress.

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- Siok Swan Tan, Martin van Ineveld, Ken Redekop and Leona Hakkaart-van Roijen are health economists at the Institute for Medical Technology Assessment, Erasmus Universiteit Rotterdam, the Netherlands.*