Health care reform in the NL. From the recent past to the present and the future

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Health Services Research
Focusing on Chronic Care and Ageing
Overview

- The reform and its impact on the public-private mix in health care delivery
- The reform and its impact on the public-private mix in health insurance
- Some results of health insurance reform
- Towards an agency role of health insurers
- Reforms: sustainability problem health care and long-term care
- The future of health care reform
The reform and its impact on the public-private in health care delivery
The international perspective: privatization

Rothgang et al, 2010
Health care delivery

- Hospitals, nursing homes are private not-for-profit entities. No public ownership. No for-profit hospitals and nursing homes

- Majority of individual providers (GPs, pharmacists, therapists) work in private practice

- But mainly public funding according to public contract model

- Basic model: *Publicly funded services delivered by private not-for-profit providers*
Towards for-profit medicine?

- Traditionally, ban on for-profit hospital care and LTC in intramural setting

- Selective ban: in many areas for-profit medicine is permitted

- Recently, proposal the lift the ban, but only for hospitals and only under strict conditions

- Main reason: open access to private capital

- Politically very controversial
Distinction public-private in provision increasingly blurred

- Selective character ban on for-profit medicine
- Provider organizations make revenues (‘excess revenues’) which they are expected to reinvest in health care
- Many provider organizations have for-profit subsidiaries
- What about private practice in hospitals? Self-employed medical specialists see themselves as private entrepreneur (40% salaried, 42% self-employed, 18% mixed).
- A few hospitals recently acquired by a private for-profit organization. No payment of dividend.
- Rapid growth of number of independent treatment centers
Impact of the reform

- Rise of the number of independent treatment centers.
- More competition between hospitals
- More freedoms (abolishment of hospital planning)
- More financial risks (bankruptcy a possibility: has not happened yet in hospital care)
- Privatisation of management style
Growth of the private hospital sector in Germany

www.bmg.bund.de
The reform and its impact on the public-private mix in health insurance
Figure 3.1 Mean health expenditure in per cent of GDP and the mean public financing share in 23 OECD countries

Source: Rothgang et al, 2010
Structure health insurance before 2006 reform

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<tr>
<th>Medicine</th>
<th>Sick fund scheme</th>
<th>Private health insurance</th>
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<td>- coverage 63%</td>
<td>- coverage 37%</td>
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<td>- mandatory</td>
<td>- voluntary</td>
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<td>- sick funds</td>
<td>- private insurers</td>
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<th>Long-term care</th>
<th>Exceptional Medical Expenses Scheme</th>
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<td>- Coverage 100%</td>
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Social and private health insurance compared (pre 2006)

Social health insurance
- Broad coverage
- Package determined by government
- Mainly income-related premiums (with cap) set by government
- Open enrolment
- Region-based sick funds
- Little consumer choice
- Little/no competition
- Forced exit if crossing (state-set) income level

Private health insurance
- Broad coverage
- Package determined by insurers
- Risk-related premiums set by insurer
- No open enrolment
- Nation-wide operating insurers
- Both much and little consumer choice
- Competition
- Specific arrangements to protect specific groups
### Structure health insurance after 2006 reform

Integration sick fund scheme and private health insurance into single scheme

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<td>Additional services</td>
<td>Complementary health insurance</td>
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The structure of health care reform after the 2006 reform

- **National government**
  - State grant for children (6.1%)

- **Employers/self-employed**
  - Income-related Contribution (49.5%)
  - Nominal premium (40.6%)

- **Insured/patients**
  - Private payments (4.3%)

- **Risk equalization fund**
  - Risk-adjusted Capitation payments
  - Insurers
    - Contracts
  - Providers

- **Tax credit**

Based upon Algemene Rekenkamer 2011. Own calculations. Percentages are for 2009.
Social or private?

Private
- Scheme under private law
- Insurers may go for profit
- Competition
- Business style
- High financial risk exposure
- Selective contracting
- Complementary health insurance
- EU Third-Directive on Non-Life Insurance Applies

Public
- Mandatory; covers all legal residents
- Many regulations to preserve the public good (risk solidarity, income solidarity, universal access)
- ban on risk selection
- community rating + income-related contributions
- ban on premium differentiation
- tax credits for income solidarity
- Uniform package; ban on package differentiation (with exceptions)
- Insurers obligated to ensure each person access to health care
Public expenditure on health as % GNP

Health insurance reform caused a jump of 1.7% in the public financing ratio!
Decline number of insurers

Four insurance concerns have in total a market share of about 90%
Consumer mobility

- 2006: 18
- 2007: 4
- 2008: 4
- 2009: 4
- 2010: 5
- 2011: 6
- 2012: 6
Consumer mobility and age

Nza, 2012
Changing role of insurers

- Traditional:
  - guaranteeing access
  - reimbursing providers

- New
  - agency role
    acting on behalf of their insured

- Public contract model

- Regulated competition
Some observations

• Bilateral negotiations on prices, budgets, quality of care
• Selective contracting still in initial stage
• Initiatives to restructure health care: hospitals, primary care, setting up new organizational forms of care (integrated networks)
• Concentration of complex surgery in hospitals
• Vertical integration (insurers managing their own hospitals, employing their own physicians) may be prohibited
• Credible commitment problem
What we currently see is a fascinating powering game in health care. Health insurers seek to reinforce their position in health care and to transform themselves in an effective countervailing power. Some do this loudly, others work more behind the scene.
Presently, the NL is the second largest spender per capita. Only Switzerland spends more.
Key issue: long-term financial sustainability of health care financing

- According to official projections health care will consume between 22 and 31% of the GDP in 2040
- Solidarity arrangements under strain
- Further reforms necessary
  - in health care?
  - in long-term care?
**HCE as % GDP**

**Zorguitgaven totaal, % BBP**

- Nederland
- Frankrijk
- Denemarken
- Zwitserland
- België
- Duitsland
- Oostenrijk
- Spanje

*Bron: SIRM, Achtergronddocument NVZ brancherapport ziekenhuizen, 2012*
Expenditures curative medicine as % GDP

Bron: Sirm, 2012
Expenditures LTC as % GDP

Uitgaven aan niet-curatieve zorg, % BBP

Nederland
Frankrijk
Zwitserland
Duitsland
België
Denemarken
Oostenrijk
Spanje

Bron: Sirm, 2012
Future reforms

• Health care:
  - distributive measures: who pays the bill?
  - more private payments
  - focus on quality (quality saves money; concept of appropriate care; shared decision-making)
  - self-management and prevention

• Long-term care
  - greatest changes
  - Focus on most vulnerable groups
  - more private payments
  - focus on quality
  - self-management and prevention

• But reforms in health care politically a very sensitive matter
Conclusions

• Reforms prominent on political agenda

• Hard measures likely, yet politically difficult

• Moving from public to private solutions, but how the new balance between public – private will unfold in the next 10 years difficult to predict