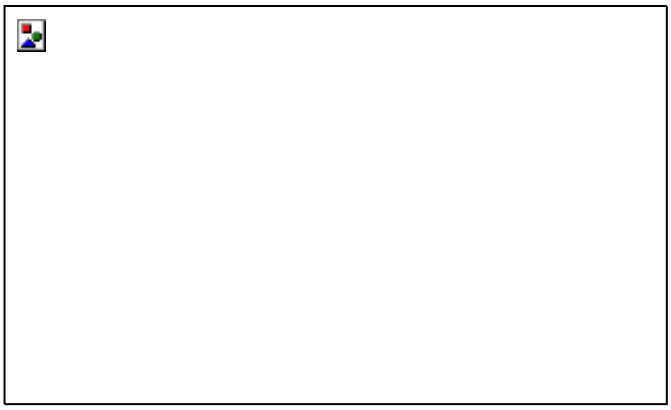


27 January 2011

Introduction

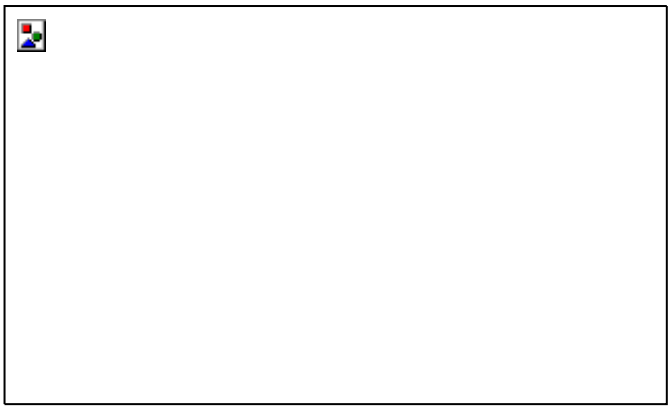
Professor Sir Roderick Floud
and The Rt Hon Lord Warner of Brockley

Good morning, ladies and gentlemen, and welcome to this seminar. My name is Roderick Floud and I am the Provost of Gresham College. I am delighted to welcome you, on behalf of the College, to this seminar. There is an account of Gresham College in your pack, and we continue, as we have for 413 years, to provide free public lectures in the City and in other parts of London. In recent years, we have worked more with other organisations, providing seminars and conferences on particular topics, in addition to the regular Gresham lectures. This conference is an example of that development, and we are particularly pleased to have sponsorship for this occasion from BUPA. In a second, I will introduce Lord Warner, as the Chair of the conference. We are very pleased that he has been able to be with us, but I would like to thank, on behalf of Gresham College, the speakers today. I am certainly looking forward very much to finding out more about the Dutch healthcare system, about which, I am ashamed to say, I know very little indeed. However, my own academic work over the last 25 years has been in the use of information on heights and weights as a measure of the standard of living of nations, and groups within nations, and, on that basis, all I really know is that the Dutch healthcare system must be extremely good because Holland is the tallest nation in the world. Without further ado, may I draw your attention to the biography of our conference Chairman, the Right Honourable Lord Warner of Brockley, in your pack. We are delighted, as I said that he is willing to be with us today. He is obviously well qualified to lead a discussion and chair a discussion on healthcare systems, so I will now hand over, with thanks, to Lord Warner.

Lord Warner

Thank you very much, Roderick. Good morning, ladies and gentlemen. It is a timely time to be actually having a discussion about some of these particular issues. The Coalition Government has done enough to keep academics in this field gainfully employed now for a good few years to come. I thought it might be useful if I briefly gave some context to this discussion on healthcare. You shall probably receive more from the speakers, but it is worth thinking about where we are now, both in health and social care. In this area the UK faces some enormous challenges. Many of these challenges are replicated in most Western countries, to one extent or another. The UK is extraordinarily insular about learning from other countries. We are not very good at doing that, despite the fact that many academics do try to draw practitioners' attention to some of these experiences in other countries. Therefore, it is very useful that we do spend some time understanding the Dutch experience. From what I know, they are facing many of the same challenges that we are. These challenges are pretty much

the same in most OECD countries: rising public expectations on the services; medical advances which, in many cases turn out to be more expensive than whatever preceded them; and the challenges and good things that come from an aging population. The bad thing about an aging population is that they then tend to consume a large amount of care services at the latter ends of their life. Those challenges do present some pretty substantial financial challenges, and, in a tax-funded health service, you have the problem that they have to compete against other public services for resources, whichever Government is in power.SEP SEPWe now face a particular set of challenges that are two-fold. The first is what Stephen Dorrell, the Chairman of the Health Select Committee, calls the Nicholson challenge which is for the NHS to receive a 4% real terms increase a year, for four years in a row. There are people in the NHS who say the Nicholson challenge understates the real challenge, which is even bigger than that. Now, you have to bear in mind that, in its 60-year history, the NHS has never achieved a 4% real terms increase in any one year, let alone for four years consecutively. I declare my interest: I am a member of the three-person commission now looking at the funding of social care. We currently have a growing shortfall in the total pot of resources to meet the needs of this population. It is bad now, but if you look at the figures in 20 or 30 years time – they get worse. Thus, we need a new settlement in and around the funding of social care. SEP SEPJust to make life really interesting, the Coalition Government has decided to reshuffle the pack, rather substantially, and deal the cards out in a new way, as far as the NHS concerned. I had a quick look, having come back from holiday, at the Health & Social Care Bill. I have, in my 12-year tenure in the House of Lords, never seen a Bill as long as this – it is 471 clauses. It will certainly keep Parliament employed, whether gainfully or not, for quite a large part of 2011. That is the context in which we are meeting, and, without further ado, I would like to welcome to the podium, so to speak, Professor Wynand van de Ven, who' will talk to us about the choice of providers and mutual healthcare purchasers and the Dutch reforms.



27 January 2011

Choice of Providers and Mutual Healthcare Purchasers
The Dutch Reforms

Dr Wynand PMM van de Ven

Thank you very much for the invitation to speak.

David Cutler did a study, about ten years ago, comparing different OECD countries, and he found that many of these countries, when it came to reforms, had three stages. When you look at the Dutch history, you can easily discern these three stages of reforms.

The first stage started around the 1940s, when we implemented the mandatory sickness fund towards universal coverage and equal access. Then, after some decades in which there was financial access for most of the people - including low-income people - cost increased. Governments became worried, so in the 1960s and 1970s, Governments implemented a lot of controls: rationing, expenditure gaps, tools to control facilities, prices and budgets. We then had a discussion about whether we could afford to persist with this model in the long run. In the mid-1980s, there was agreement that these controls did not implement incentives for efficiency. At that time, we started a discussion about markets, consumer choice, and competition.

So, from the mid-1980s, we had a few years of intense debate about reforming our system. One of the key elements of discussion centered on who the purchaser of care on behalf of the consumer was as the consumer herself cannot be a purchaser. The consumer has not enough knowledge about the quality. At a time that you need medical care, that is not the right time to go through the Yellow Pages and compare them on quality and prices. There needs to be a third party, and there is an imbalance between the consumer and the hospitals, but we needed to work out who should perform that role. We thought there were two major candidates: the Government and insurers. We had sickness funds at that time, which are called commissioners in the UK. We had tried Government and found out that was not the best way, so the simple idea was to let insurers be the purchasers of care.

The second question is was whether or not to have competition, or consumer choice, which we decided to support. That is a major difference between the healthcare reforms in England and those in Holland. You have competition among purchases, but there is no consumer choice of commissioner. There are a lot of nice aspects to our system, although it also introduces a new complication, to which I shall come.

The third question that is universal for all countries when they reform their systems is who should pay for the package.

In the Dutch healthcare system, there has been much private initiative for decades. That started around 100 years ago, and then, in the 1970s, Governments stepped in, with a lot of very detailed regulation. We also have the general practitioner, as a gatekeeper, and in 2006, a new Health & Insurance Act implemented the proposals that were accepted in the mid-1980s. That was a fifteen year time lag that we needed in order to implement all these ideas about regulated competition. So now, in the Netherlands, it is mandatory for everybody to buy a private health insurance, but there is a lot of regulation to achieve society's goals.

The core of the reform is that risk-bearing insurers are the purchaser of care, or commissioner as you say, and we have a

choice of insurer. Governments have taken away all the regulations that were implemented earlier, about budgets, prices, and required licenses. This was a very long process and we are in the midst of it. Governments set the rules of the game to achieve the public goal, which can be described, very simply, as access to good, affordable care for everyone.

Here are some major elements of the Health Insurance Act that was enacted in 2006. Everybody must buy private health insurance, with a standard benefits package, which is described in terms of functions. That looks very abstract, but it is very important. Previously, in the sickness funds that existed before 2006, the benefits package was described in terms of the providers of care, so people were entitled to receive care, provided by certain types of providers – GPs, specialists, rehabilitation institutes. Now, the benefit package is described in terms of functions of care, like rehabilitation care, and everybody can provide rehabilitation care. Of course, rehabilitation institutes can do it, but so could a GP or a hospital. So, to describe the benefit package in terms of functions means there is potential competition between different types of providers, who can deliver certain types of care. It provides very broad coverage, similar as under the NHS, and we have a mandatory deductible, which is now 170 Euro per adult.

There is a lot of consumer choice. Each year, an individual can switch to another insurer. If we are not satisfied about the quality, the services, the panel of contracted providers, or the premium, we can very easily switch – if done via the Internet it takes less than five minutes. Of course, it takes another hour to compare the different insurers and products, but there is good consumer information and all types of websites. That is a pre-condition for competition; otherwise, it is a mess for a consumer.

Insurers are allowed to selectively contract with providers, so they may offer a panel of preferred providers, but they also may give a free choice on insurance products so you may go to whichever provider you want. In practice, it is most likely that the premium for that product from another provider is higher than a preferred provider arrangement.

We can choose a higher deductible voluntarily – 5% of the population do that – and consumers as a group of at least two people can negotiate a premium rebate with the insurer of, at most, 10%.

Then, in addition to the mandatory insurance, people can buy voluntary, supplementary insurance, which is different from the supplementary insurance in your country because it is only about minor issues. It is not for passing the queue and it is not for perceived better quality of care. It is just for alternative care, such as physiotherapy or dental care, which is not included in the basic package.

So, although the benefit package is standardised, it has a lot of flexibility for the insurers to define the specific entitlements of the consumer. We can have a choice of different insurance products, per insurer, and of course, also across insurers. They need this, because, otherwise, they cannot be the purchaser of care. As a commissioner, you need some degrees of freedom to be a good purchaser of care. Selective contracting, but also vertical integration, is allowed. Vertical integration means that insurers and providers of care can work very closely together. Of course, they can have contracts, but contracts can become very detailed, and the transaction costs of having contracts are very high. To reduce these transaction costs, vertical integration, a merger, or very close cooperation between insurers and hospitals or GP groups is allowed.

However, everybody must accept open enrolment. They cannot refuse applicants and their premium is regulated. Insurers must quote the same premium to all enrolees per product, and there is a system of subsidies that makes health insurance affordable for everybody, primarily via the risk equalisation system, which is an essential issue. This is the way that we organise cross-subsidies among income groups and among risk groups.

There are two payments. The first is made via the tax collector, which is income related and goes to a risk equalisation fund. Insurers receive an equalisation payment out of that fund, which is related to the consumer risk. For young, healthy persons, it is a very low amount, maybe a few hundred Euros, and for elderly it can go up to 30 or 40 thousand Euros per person. The goal of that is to equalise the risk of all consumers for these insurers. These payments are based on the predicted expenditures for next year, and we do that via a complicated formula – the Dutch Resource Allocation Formula.

We calculate the predicted expenses, and deduct a certain amount, around 1100 Euros. Each insurer is guaranteed those 1100 Euro, on average, per consumer, and they ask that via premium. However, an efficient insurer maybe only needs to ask 800 or 900 Euros, and an inefficient one needs to ask 1200 or 1300, so that is where the premium competition among these insurers comes in. At the end of the year, November 15, all the prices of these insurers must be known. The consumer has six weeks to compare, and if she wants, she may switch insurer. This is where price competition is involved. Only adults have to pay that premium, and Government puts money in the REF for children. On top of that, we have an additional type of income-related allowance for the low-income people who cannot pay the flat rate premium. So, income cross-subsidies and risk cross-subsidies are well organised, in such a way that it is affordable for everybody in the Netherlands to buy their mandatory health insurance.

This system involves regulated competition. There is competition and consumer choice, however, there is a lot of regulation, as I described – open enrolment, risk equalisation, and so on. It is not a free market.

One and a half years ago, our group at Erasmus University was asked by Government to evaluate the new Health Insurance Act, and here you see some of the results.

We found that the Health Insurance Act was a success in the sense that there was no political party or no other group, employers, employees or whatever, who wanted to go back to the old system, where we had a mandatory sickness fund and voluntary private health insurance for the elderly. Everybody was happy with the new system, and there was also broad support for annual consumer choice of insurer. In the previous private health insurance, before 2006, one third of the population, the higher incomes, had a voluntary health insurance, but if they were dissatisfied with their insurer, and they were high risk, they could not switch whereas the regulation now allows them to switch and the insurers are not allowed to refuse them.

We found some positive effects: good cross-subsidies, that the package was available for everybody and the choice. There was strong price competition in the early years, and my impression is that there still is very strong price competition among the insurers. Although we now have about ten insurers, it is still a competitive market. A good thing is that, over the last five years, we have much more information about price and quality, which is really crucial. It does not make sense to give the consumer a choice among insurers, commissioners, if you do not know the differences. Government invested a lot. They sponsored a website which allows consumers to compare all the insurers, their products, the providers, the hospitals, although there are some competing websites. We found that insurers began to increase their purchasing activities, although not so much. A further good point was that quality was on top of the agenda, which I will explain later.

Of course, this is the good news; there is some less good news. We used an analytical framework. We said that regulated competition must fulfil certain preconditions. We described these preconditions and examined to what extent these had been fulfilled. I will first discuss them with you.

It is necessary to have a good risk equalisation system – this is crucial because, otherwise, with mandatory community rating, insurers have an incentive to select the good risks and to get rid of the chronically ill and the elderly people which they could do by not offering the best care. That is an outcome of a competitive market that we do not want. This is why good risk equalisation is so important. It makes the elderly and the chronically ill attractive for a health insurer.

You need a lot of market regulation. You see the different forms of regulation coming from all kinds of authorities, which look at different components of the market, and that is crucial. You need a Competition Authority because just deregulating is not sufficient. There is a natural tendency in the healthcare market, among providers, to form cartels and to get a monopoly. Government has to fight for competition. The Solvency Authority ensures that insurers have sufficient solvency, and a Consumer Protection Authority exists because the consumer is the weakest part in the healthcare system, and there are a lot of consumers who find out that they are real weak. The Dutch Healthcare Authority is very powerful and has sufficient tools to protect the consumer.

You need transparency in insurance products and medical products; sufficient consumer information; freedom to contract for insurers and providers; consumer choice of insurer; incentives for efficiency for all parties; and a contestable market. That means there is also potential competition and it also means that the entry to the market must be open and the exit must be open, both the insurance market and the provider market.

Let us look at the extent to which these pre-conditions were fulfilled in the Netherlands in the twenty years following 1990. 1990 was the period of the mandatory sickness funds. These were not private insurance companies, though they were private entities. They were entities that executed the Sickness Fund Act, but they are comparable. At that time, we did not have any risk equalisation, and now, we have a more or less well-functioning equalisation. It is quite sophisticated, but not yet sufficiently refined, so we have to work on it and I am convinced we can make the deal.

Twenty years ago the Competition Authority did not exist and it is now one of the most powerful authorities, with respect to healthcare. Doctors, dentists and physiotherapists, all understand the importance of the Competition Authority, and they all understand that they are not allowed to talk in a large group about the price they will ask to their insurer because we want price competition. Furthermore, hospitals are not allowed to come to agreement with a large group of hospitals about a price they ask to the insurer; that would be a cartel, and if they did that then they would be punished by the Competition Authority.

In the previous system, there was just one mandatory package so that was very transparent. If you give the consumer a choice, well, there is a price that this may become a little bit less transparent, but that is the trade-off between consumer

choice and transparency. However, there should be no small print. That is not allowed and the Health Insurance Act protects the consumers.

The level of consumer information substantially increased in these twenty years, and Government understood how important consumer information was. We do not yet have the quality and outcomes framework website that you have in your country, which is a wonderful website and I would love to have it also for our Dutch GPs.

The next issue was freedom to contract. Under the old system, there was a lot of Government regulation, and there was no freedom at all. Now, gradually, we are implementing and giving these parties, insurers and providers, increasing freedom, but it is not sufficient. It is a gradual process which takes a very long time – twenty years in total.

Consumer choice has increased. Financial incentives for efficiency have increased. Now we discuss the contestable markets. Under the sickness fund market, no new sickness funds were allowed to be established. Every insurer from the European Union is welcome, and they can sell the mandatory health insurance in the Netherlands, as long as they obey the rules of the game.

On the provider markets, it is less clear. By nature, there is a long training period – 10 or 15 years to become a medical doctor, GP, or a consultant. Also, the hospital market is a major problem, and that took some time for Government to understand it. The entrance is more or less open, but you need a lot of capital to build up a new hospital so the problem was that the exit of the hospital market was not open.

If a hospital has bad performance and is in financial trouble, in a normal market, these companies go bankrupt and leave the market, so there is an exit of the market. However, for hospitals, it is a different market. We had a case, two or three years ago when a hospital found itself in financial problems. The reaction by the Government was classical – they thought they needed to help the hospital. Government ought not to do that in a competitive market. Although it was the only hospital in the area and the nearest one was maybe 40km away. That is a long distance in the Netherlands away, but all these other hospitals had some business plans to open a satellite or to provide some types of care, and they invested in it, and then Government stepped in and gave financial support to that hospital. So, that was not an entrepreneurial competitive market.

We had a public debate about it, and now, Governments understand that they should not do it. Government now admits that it is responsible not for the continuity of one specific hospital but only for the continuity of care. Therefore, they now see that competitors will take over the provision of hospital care in that region. That is a task of the insurers. This means that there is a guaranteed continuity of coverage although it is difficult for Governments to learn.

However, there are some key issues to be solved. The first is that our insurers are still a little bit reluctant to selectively contract. There are several reasons, but the major reason is that there is a lack of information about quality of care. If an insurer offers a Dutch consumer a list of preferred hospitals - 30 preferred hospitals out of the 100 that exist in the Netherlands then they may be a reasonable distance from the consumer's home. If the consumer goes to a preferred hospital that the insurer selected, they do not have to pay the deductible or they get a lower premium. Many consumers then think that the insurer has chosen that hospital because of the low cost. Insurers know that from their market research that if you ask people "Who do you trust the most?" the doctor is on top and insurer is on the bottom. I imagine that this would be the same in the UK. It is all reliant on financing. Although what the insurers sell is trust, a lot of people do not trust them. Thus, the only way that insurers can really use the tool of selective contracting, and this is a powerful tool, is to threaten the hospitals with not being offered a contract if they do not have a good price/quality ratio or a short waiting list. It is a very powerful tool, but the only way that insurers, at least in the Netherlands, but this would also be the case in your country, can selectively contract among hospitals. They convince the consumer that they have chosen hospitals with the better quality.

A few months ago, a very good advertisement by a major insurer, with millions of members, said that they no longer contract six hospitals for certain cancer operations because the quality of these hospitals was not sufficient for our members. They started to selectively contract and use the quality argument. It took several years, for insurers, supported by Government, to get quality information, and this is very important. Information about quality is not for free, and hospitals are not voluntarily willing to provide that information. About five years ago, the Government had to force hospitals to provide certain indicators such as information about quality. After that, it became publicly known and now, insurers start to selectively contract with some hospitals, for certain operations, based on quality.

Good risk equalisation is crucial. It is not perfect, but reasonable, and we work hard on it. We discussed the issue of who is responsible if a hospital goes bankrupt. That should be primarily the insurer and not Government. Insurers should take care that their customers have access to hospital care. We have a problem with the tie-in of mandatory and supplementary insurance. Supplementary insurance is a free market, so insurers are allowed to refuse them or raise the premium, and

some of the elderly chronically ill think they cannot switch insurance for the mandatory because they cannot take with them their supplementary insurance. Although insurers say that they accept everybody, consumers are not stupid and think that if they are high risk they will not be accepted.

Another major issue is whether it is possible to combine regulated competition or managed competition with a global budget. The Netherlands was also affected by the financial crisis. We do not have an equivalent of the Nicholson challenge, but nevertheless, our Minister of Finance tells the Minister of Health that as healthcare represents a substantial part of total public spending he must reduce healthcare expenditures. They set a global budget and a cap on the total expenditure. It was wondered whether you could combine that with regulated competition. We wrote an article and said that this could not be done. If there is competition, it is free for the parties to negotiate prices, and prices are the outcome of the contracts and the negotiations and the markets. The market can offer greater efficiency, a better price/quality ratio, and if people are willing to spend more on healthcare, the Government is in no position to say that they should not spend more. However, the Minister of Finance wants to have security in this period of financial crisis, so this is a major challenge.

So the conclusion is that, on balance, despite some serious problems, the evaluation was positive. So far, the focus has been on the insurance market and the 2006 Health Insurance Act. Now, we have to reform the provider market, because the hospital market is still largely regulated. Only one third of the hospital products are free for negotiation between insurers and hospitals. Two-thirds is still organised by the classical budget so we are now trying to reform the hospital market. However, we have the financial crisis, and that is a great challenge for politicians.

There are two major challenges. Firstly, we need to know whether insurers are capable and willing of being the purchaser of care on behalf of their members. I personally think that they are able and willing to do so. However, if not, we need to decide the rationale of giving the consumer a choice of insurer. This would mean that we should choose another model and that we have worked for twenty years on the wrong model. However, I think we are on the good track.

The second question is whether the Government is willing to give up its traditional tools for cost containment, in particular in light of the financial crisis. That is a great challenge.

So, the Dutch healthcare reform is work in progress. It can take another five or ten years, and the jury is still out. Thank you.