



Hospitals in the Netherlands

Today, the past and the future

Dik Hermans | Bern | 4/5-11-2009

Contents

- Current state of affairs – historic review
- Post-war reconstruction (1945 – 1975)
- Planning and supply regulation (1975 – 1995)
- Working towards regulated market forces (1995 - 2006)
- The future

Current state of affairs: General background

- 8 large university medical centres
- 86 general hospitals
 - 37 large
 - 23 medium-sized
 - 26 smaller
- 35 special category hospitals
- 17 convalescence institutions
- 135 independent treatment centres
- 106 private clinics

8 University medical centres

- Integration of the medical faculties and the academic hospitals
- Top-class clinical care, teaching and development
- Internationally highly esteemed
- Between 800 and 1200 beds
- Finance
 - Health insurance
 - Development funds, Health Insurance Act
 - Teaching

86 General Hospitals

- 86 hospitals with 140 locations and 60 external out-patient clinics
 - Number of hospitals still falling
 - Number of hospital locations still falling
 - Number of external out-patient clinics rising
- 26 collaborating top-class hospitals and teaching hospitals (600 to 800 beds)
- 23 other (medium-large) hospitals
- 37 smaller hospitals (250 to 400 beds)

52 Special category institutions

Most interventions/operations also available in general and academic hospitals

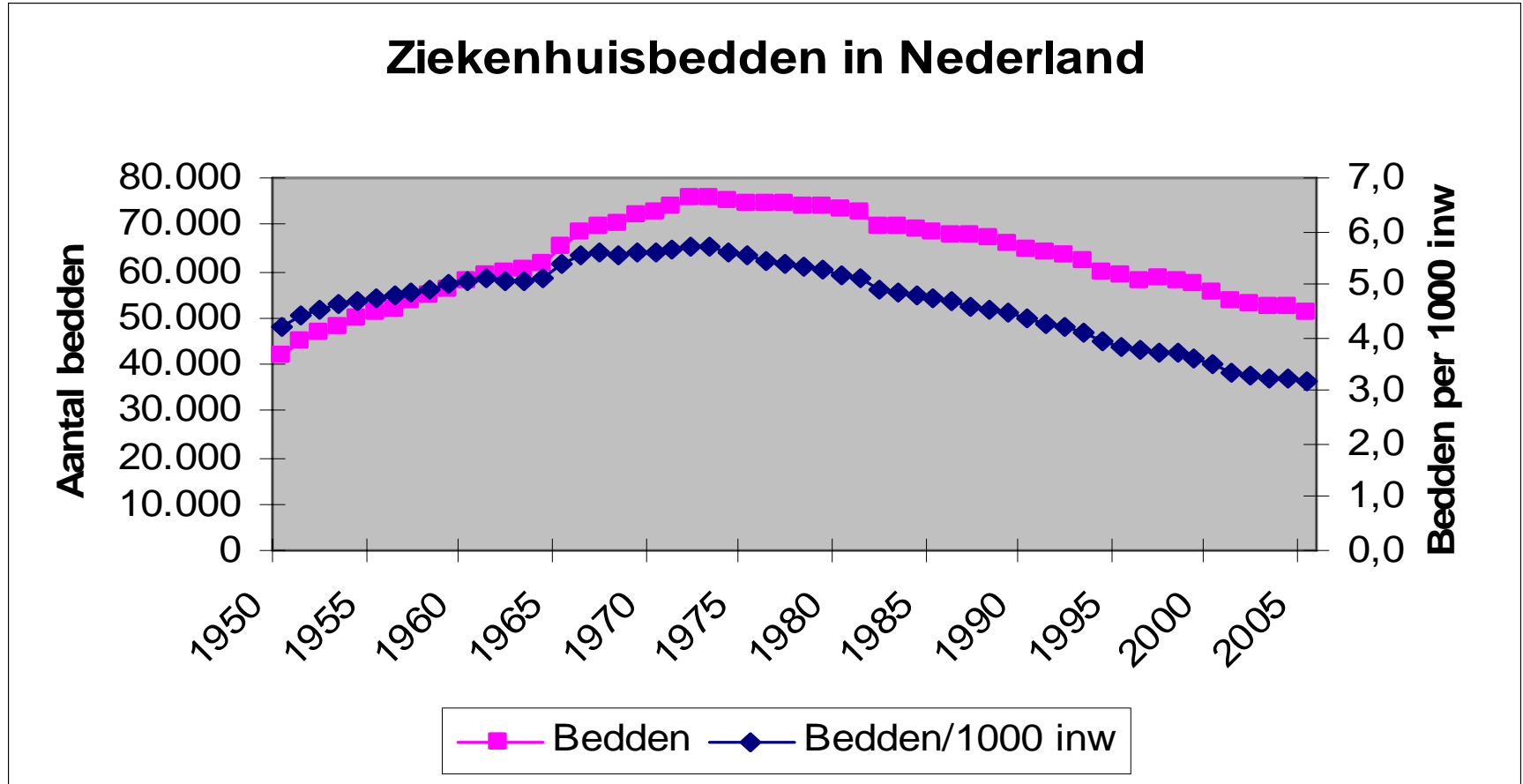
Number is falling: mergers with general and academic hospitals

- 3 independent dialysis centres
- 2 epilepsy clinics
- 4 independent radiotherapeutic institutions
- 3 asthma centres
- 17 independent convalescence institutions
- 1 specialising in cancer
- 12 institutions for other special categories

independent and private clinics

- Relatively new in the Netherlands
- Numbers increasing rapidly
- 135 independent clinic-locations
 - Small-scale, non-profit organisation
 - Only out-patient care and single-day admissions
 - Also provides (some) basic insured care
- 106 private clinics
 - Solo practices
 - Provides only uninsured, out-patient care

Historic review (excl. indep. Cl.) 1



Historic review (excl. indep. Cl.) 2

- Number of beds increased until 1975
- After 1975 steady decline numbers of beds and number of beds per 1000 residents
- Number of independent hospitals is currently one-third of total number of hospitals in 1973

Post-war reconstruction 1945 - 1975

- New vision on how to organise care, right coverage, but instruments lacking
- Uncontrolled growth beds and institutions (sixties)
- Significant compartmentalisation: each socio-political group their own hospital
- Legislation for tariffs (interventions, nursing days)
- Significant, disproportional growth in costs

Planning and regulation of supply 1975-1995

1974: Structural bill: controlled growth and solidarity

- Planning facilities
 - Health Services Act
 - Planning based on national frameworks and provincial plans
 - Bed norms falling
- Tariff regulation
 - Initially only tariffs, budgets as off 1982
- National Insurance for all our citizens (unsuccessful)
- Governmental responsibility for developments of total costs

Planning and regulation of supply 1975-1995

- Planning legislation since 1979
 - Creation of the National Hospital Facilities Board
 - Buildings (including renovations) only with a permit (i.e. ban on private clinics)
 - Planning:
 - provincial plans
 - increasingly keen bed norms
 - Norms for building costs

Tariff legislation

- Hospital Tariffs Act: only tariffs, no actual volume control, norms for production factors
- Health Care Charges Act (1982)
- Budgeting: integral cost control
 - initially mutations in historic turnover
 - subsequently integral hospital budget: function-oriented budgeting

Function-oriented budgeting

Hospital budgets based on:

- Availability: share of population visiting hospital
- Capacity: number of beds and specialist positions
- Production-agreements: initial out-patient visit, single day admission, regular admission and nursing-day
- Parameter values depending on size of hospital (larger hospitals more complex care)

Consequences

- Buildings
 - Building and renovation only when number of beds reduced
 - As a result: mergers
 - Progressive parameters stimulated modernisation, reduction in beds and mergers
- Macro-budgeting
 - Limited growth in macro-costs
 - Where exceeded: reduction in budget parameters and medical specialists' tariffs
- Sickness fund budgeting
 - introduction risk-bearing for health care costs

Further consequences

- Successful cost control
- Waiting lists
- Lots of legislation, little discretionary space
- Resistance to discounts on tariffs and budget parameters

- Influenced by the American Enthoven:
- From supply regulation to demand regulation:
Regulated market principles

Working towards regulated market 1995-2006

- Hospital budgets:
 - Retrospective calculations based on actual production
 - Gradual reduction in hospital budget (increasing non-regulated volume, non-regulated prices)
- Abandoning planning: hospitals bear the risk for new investments
- Hospital finance
 - From interventions and nursing-days, to:
 - Integral tariffs for diagnosis treatment combinations (DRG)

Working towards regulated market forces 1995-2006

The Health Insurance Act: basic insurance for all
Dutch citizens

- A single basic package for everyone
- Obligation to accept all-new comers
- Ban on premium differentiation
- Risk adjusted budgetting
- Insurers' budgeting
 - Further improvements
 - Dealing with alteration in finance of care, new groups of insured
 - Increasing risk-bearing

Since 2006

- Moving away from hospital budgeting towards performance funding (in 2011)
 - Fixed part: based on budgets (exceptional availability)
 - Semi-variable: non-regulated production, fixed prices
 - Variable: non-regulated production and non-regulated prices
 - Integral prices, including reimbursement of capital expenses
- Insurers' budgeting for all health insurers, with increasing risk-bearing
- Shift in attention for price only towards quality of care

Consequences for the hospitals

- Protection will disappear gradually
- Health insurers and insured clients more discerning in making choices
- Hospitals as proper enterprises, bearing financing responsibility (equity capital, venture loan capital)
- Strategic choices
 - better
 - really different

Future scenarios for hospital care

1. Specialisation and collaboration
2. Preferred providers
3. Conglomeration forming: HMO's

Specialisation and collaboration

- Achieve comparative advantages over competitors
- Mergers
 - other hospitals
 - primary health care providers
- Specialisation
 - advantages of scale
 - quality
- Contracting and subcontracting in chain of care

Preferred providers

- Exclusive long-term relationships between health insurers and hospitals
- Health insurers 'guide' their clients towards preferred providers
- Health care-providers remain independent

HMO-forming

- Vertical integration of health insurers and care-providers, including hospitals
- Guiding HMO's on the basis of specific goals
- Programme-based approach and preventative programmes
- Organised influence patients' associations



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