Long term care in the Netherlands: Towards managed competition?

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Abstract

In 2006, the Dutch government introduced the "Health Insurance Act" which is based on principles of managed competition. In this scheme insurers and health care providers are competing on price and quality while the regulator establishes regulation to protect public objectives such as individual affordability of health insurance. As shown by Van Kleef (2012) managed competition comes with some crucial preconditions. These include risk equalization, transparency of consumer information, appropriate incentives for cost containment, freedom of choice for consumers, contestable markets, contracting freedom, effective antitrust policy, no possibility for free-riding and guaranteed access to healthcare. So far, the "Health Insurance Act" mainly included short-term care. In the Dutch policy debate, however, some parties have proposed to expand the "Health Insurance Act" (and thereby managed competition principles) to long-term care.

This paper focusses on the question "Is managed competition appropriate for long-term care?" In order to answer this question we first update the work by Van Kleef (2012) by reviewing (anno 2014) the extent to which the preconditions are fulfilled for short-term care. In a second step we discuss whether it is likely that these preconditions can be fulfilled for long-term care. If not, what are the alternatives?

When it comes to the preconditions for managed competition, Van Kleef et al. (2014) have shown that over the past years improvements have been made with respect to short term care. Despite these improvements, there are still some important bottlenecks. First, the risk equalization system undercompensates insurers for groups of chronically ill and overcompensates them for groups of healthy individuals, which confronts insurers with incentives for risk selection. Second, there is a lack of transparency when it comes to the quality of health care and health insurance products. Without transparent quality information it is impossible for insurers to take into account such information for the purpose of selective contracting and/or remuneration of providers. Moreover, consumers will not be able to take into account quality when it comes to choosing a health plan.

We expect that for long-term care it will be even more difficult to fulfill the preconditions for managed competition than for short-term care. Moreover, there are three fundamental issues when it comes to the question whether managed competition is appropriate for long-term care. First, is it possible to organize sufficient risk equalization for long-term care? Second, are users of long-term care able to make a well-considered choice of health insurer? Third, are non-users of long-term care interested in the quality of long-term care? If the answers to these questions are negative, then managed competition may not be appropriate for long-term care.

[Key words] long term care, managed competition, risk equalization, the Netherlands

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1. Introduction

In 2006, the Dutch government introduced the "Health Insurance Act" which is based on principles of managed competition. In this scheme insurers and health care providers are competing on price and quality while the regulator has established regulation to protect public objectives such as individual affordability of health insurance. So far, the "Health Insurance Act" has applied to short-term care. In the Dutch policy debate, however, some parties have proposed to expand the "Health Insurance Act" (and thereby managed competition) to long-term care. This paper focusses on the question "Is managed competition appropriate for long-term care?" For an answer we first update the work by Van Kleef (2012) by reviewing (anno 2014) the extent to which the preconditions are fulfilled for short-term care. In a second step we discuss whether it is likely that these preconditions can be fulfilled for long-term care.

This paper is structured as follows. Section 2 provides a brief overview of the health insurance system in the Netherlands and section 3 summarizes the main principles of managed competition. Section 4 focusses on the achievements of managed competition for short-term care and discusses some remaining bottlenecks. Section 5 discusses whether managed competition can be an appropriate model for long-term care and section 6 reviews the alternatives. Finally, section 7 summarizes the main conclusions.

2. Overview of the health care system in the Netherlands

The Dutch social health insurance consists of two main components (Van Kleef, 2012). One is the health insurance scheme for long term care, which covers, for example, elderly care and care for mentally and physically disabled. In 2014 the total budget for this scheme was about 30 billion Euros. The other component is the "Health Insurance Act" which covers basic and essential short-term care such as primary care, short-term hospital stays and specialist procedures. This paper refers to these treatments as *short term care* because the duration of these treatments is normally not longer than one year. In 2014 the total budget for the second scheme was about 40 billion Euros.

The scheme for long term care and the one for short term care fundamentally differ in the way they are organized. Short term care is organized according to principles of managed competition, which means that private health insurers purchase the care for all people who have the basic health insurance. These health insurers are competing with each other, and bear financial risk. Competition and financial risk are key principles of the managed competition model. These principles are absent in the scheme for long term care where the purchasers of care bear no financial risk and are not competing.

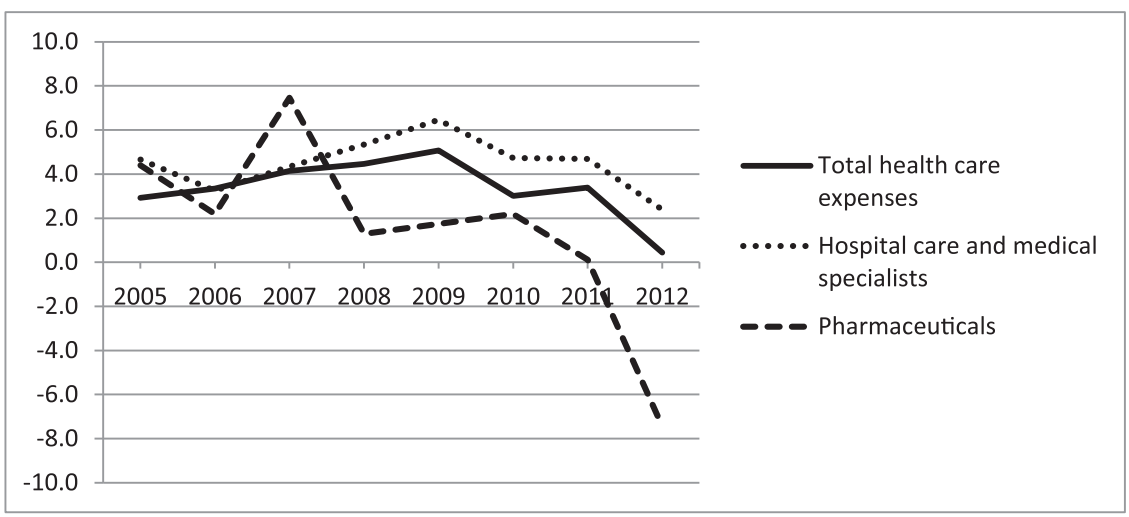
In order to improve efficiency of long-term care some people have proposed to expand managed competition to long-term care. We doubt however whether managed competition is appropriate for long-term care. As shown by Van Kleef (2012) managed competition comes with some crucial preconditions. These include risk equalization, transparency of consumer information, appropriate incentives for cost containment, freedom of choice for consumers, contestable markets, contracting freedom, effective antitrust policy, no possibility for free-riding and guaranteed access to healthcare. To build our case we will first show how that these preconditions have not yet been fulfilled for short-term care. After that we will argue that fulfillment of these preconditions may be even more difficult for long-term care. Moreover, it is questionable whether these preconditions can ever be fulfilled for long-term care.

3. Theoretical concept of managed competition

The model of managed competition has three main features (Van Kleef, 2012). A first feature is that consumers have a periodic choice of health insurer. In theory, this leads to competition among the insurers because they need to do what is best for consumers in order to attract new enrollees. The second feature is that the insurers can selectively contract with providers, which gives providers an incentive to do what is best for the patients, in order to get a contract with the insurers. While the benefit package is standardized in terms of treatments, insurers are free to decide where, by whom and how the care is delivered. The third feature is that the government has established certain regulation in order to protect public objectives such as individual affordability of health insurance. Specific regulation includes an individual mandate to buy health insurance, standardization of the benefit package, open enrollment (i.e. insurers have to accept every new applicant), premium regulation (i.e. insurers are not allowed to risk-rate their premiums according to individual risk characteristics), risk equalization (i.e. insurers are compensated for predictable variation in medical spending across individuals) and an allowance for low and middle income people.

4. What has been achieved by managed competition in the Netherlands?

Van Kleef et al. (2014) have evaluated the achievements by managed competition in the Dutch healthcare system. An important observation is that – over the past years – the increase in medical spending slowed down (see Figure 1). Since 2010, there has been a reduction in the prices and volumes for pharmaceutical care. One of the main drivers for this reduction is selective contracting of generic instead of brand pharmaceuticals. Since 2012, there has also been a reduction in the growth of hospital care. One of the main drivers of this reduction is that insurers have introduced a global budget per hospital, which provides hospitals with strong incentives for cost containment.



source: Kleef (2014)

Figure 1. Annual growth of healthcare expenses under the Health Insurance Act

Though the results in Figure 1 look promising, Van Kleef et al. (2014) also reveal an important goal that has not yet been achieved: insurers have not yet been successful in improving and stimulating the quality of care. There are two important reasons for this. The first is the absence of appropriate incentives to improve the quality of care for insurers. The second reason is that they have insufficient instruments to stimulate the quality of care. These two shortcomings have to do with the fact that some of the crucial preconditions for managed competition have not yet been fulfilled.

Table 1. To what extent are preconditions for managed care fulfilled?

Precondition	**2006**	**2009**	**2014**
1. Risk solidarity without incentives for risk selection			
• Risk solidarity	*****	*****	*****
• Sufficient risk equalization	**	**	***
• No incentives for risk selection	**	**	**
2. Transparancy and consumer information			
• Health insurance products	**	***	***
• Healthcare products	*	*	**
3. Appropriate incentives for cost containment			
• Consumers	**	**	***
• Health insurers	**	***	****
• Healthcare providers	*	*	**
4. Sufficient freedom of choice for consumers	***	***	***
5. Contestable markets			
• Healthcare providers	*	**	***
• Health insurers	***	***	***
6. Sufficient contracting freedom	*	**	***
7. Effective anti-trust policy	***	***	**
8. No possibilities for free-riding	**	**	***
9. Sufficient supervision of quality	***	***	***
10. Garanteed access to healthcare	***	***	****

source: Van Kleef et al (2014)
＊: degree of fulfillment of the preconditions

Table 1 shows the extent to which the preconditions are fulfilled in 2014. Comparison with 2006 and 2009 reveals some major improvements. Nevertheless, some preconditions are still insufficiently fulfilled. Three bottlenecks will be discussed here: the presence of incentives for risk selection, the absence of quality information and the absence of appropriate incentives for cost containment for health care providers.

A major bottleneck in the current system is the presence of incentives for risk selection. These incentives arise because insurers have to charge community-rated premiums while they know that the chronically ill are more expensive than the young and healthy. Risk equalization should compensate insurers for these predictable differences in medical spending. Though the risk equalization system substantially improved over the last decades, it still undercompensates insurers for groups of chronically ill.

Table 2. Evaluation of the Dutch Risk Equalization Model of 2014

Subgroup based on health survey information from the prior year	**Estimated size in population**	**Predictable loss per person per year in euro's**
At least one chronic condition	31.5%	-331
Worst score physical health (SF-12)	18.9%	-670
Contact with medical specialist in last 12 months	37.8%	-326
Hospitalization in last 12 months	6.5%	-571
Use of physiotherapy in last 12 months	21.8%	-328
Use of prescribed drugs in last 14 days	35.7%	-186

source: Van Kleef et al (2014)

Table 2 shows the undercompensation for several groups of chronically ill. For people with at least one chronic condition, about one third of the population, insurers are undercompensated by more than 300 Euros per person per year. Since insurers are not allowed to risk-rate their premiums, these undercompensations confront them with incentives for risk selection. More specifically, insurers are discouraged to meet the preferences of the chronically ill, e.g. if an insurer improves the quality of care for people with a chronic disease he will probably attract relatively many consumers with large predictable losses.

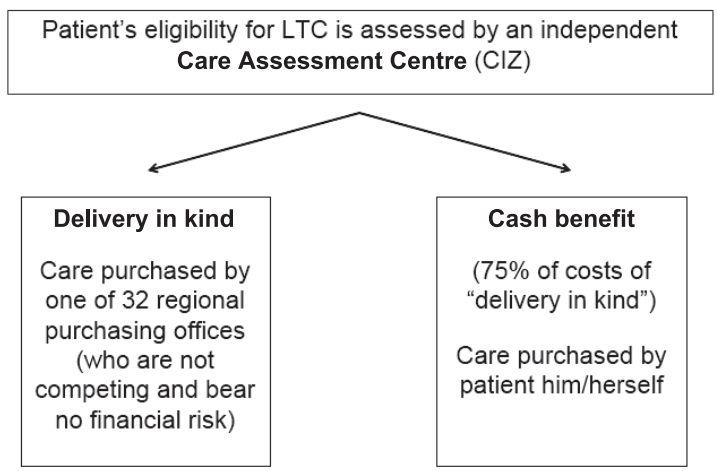
A second major problem is the lack of transparency when it comes to the quality of healthcare products. Despite the presence of a classification system for health care products (i.e. all health care products are more or less defined) it is hard to compare the quality of these products across providers. This is a problem for both consumers and insurers. For insurers the lack of quality information makes it impossible to take such information into account in the negotiations and remuneration of providers. In an ideal world, insurers would selectively contract and pay providers on the basis of "performance". As long as quality information is absent this ideal world is far away.

Van Kleef et al. (2014) conclude that – in order to reap the fruits of managed competition – it is crucial to improve the risk equalization system and to develop a practical set of quality indicators. With respect to the latter the Dutch could learn from experiences abroad such as with the QOF model applied in the United Kingdom (Smith, 2015).

5. Managed competition: an appropriate model for long term care?

(1) Procedures for long term care in the Netherlands

Figure 2 summarizes how the current long term care system in the Netherlands works. If a patient or a consumer is in need of long term care, he or she can go to the so-called Care Assessment Center (CIZ). This is an independent organization that assesses whether and to what extent the patient is actually in need for long term care. There are similar procedures in Japan, Germany and the Nordic countries.



source: Author

Figure 2. Procedures for long term care in the Netherlands (2014)

Once the care assessment center decides that the patient is in need of long term care, there are two options: 1) the patient can get the care in kind or 2) via a cash benefit. In the first case, the care is purchased by one of 32 regional purchasing offices who are not competing and bear no financial risk. In the second case, the care is purchased by the patient himself. About 90% of long term care budget is spent on in-kind care and 10% of the budget is spent on cash benefits.

(2) Bottlenecks in the scheme for long term care in the Netherlands

There are at least seven bottlenecks that have been mentioned in the Dutch health care debate over the past years. Hence we will briefly describe these bottlenecks:

- The first problem is the lack of financial incentives for efficiency for the purchasers of care. These purchasers are just administrative offices that do not compete and bear no financial risk. Financial incentives for cost containment are absent.

- In the second place there are serious incentives for undesirable substitution. With separate schemes for short term care (for which insurers bear financial risk) and long term care (for which insurers bear no financial risk), insurers have a financial incentive to transfer spending from the first scheme to the second.

- A third problem is the lack of opportunities for integration and coordination of short term and long term care due to differences in the way these schemes are financed.

- A fourth bottleneck is that consumers are confronted with different windows and offices for short-term care and long-term care. This can be particularly stressful for those who are in need for both types of care.

- In the fifth place, there is a relatively strong dependence on institutional care. It has been studied that a major part of the long term institutional care can potentially be substituted with home care, which is must cheaper.

- A sixth problem is that the healthcare benefits are not well targeted. There is evidence that healthcare benefits are also provided to people who are not really in need of long term care.

- In the seventh place long term care utilization is increasing steeply due to aging of the population. That is a common problem in developed countries.

These bottlenecks have triggered a political debate on long term care in the Netherlands. One of the main questions is "Should long term care, or parts of it, be transferred to the scheme with managed competition?" For example, the government has decided recently that in 2015, home care (4 million Euros per year) will be transferred to the Health Insurance Act. A crucial question, however, is whether the managed competition model is appropriate for long term care. It may be appropriate for short term care, but that does not necessarily mean it is also appropriate for long term care.

(3) Is managed competition an appropriate model for long term care?

The answer to this question depends on the extent to which the preconditions for managed competition are fulfilled for long-term care. The current bottlenecks in the scheme for short-term care (e.g. imperfect risk equalization and the lack of quality information) are also present for long-term care. This in itself would be a reason to wait with managed competition for long term care until all preconditions for short term care are fulfilled. But even when - one day – the preconditions are fulfilled for short-term care is doubtful whether this will also be the case for long-term care. There are at least three fundamental issues when it comes to managed competition for long term care. First, is it possible to organize sufficient risk equalization for long term care? Second, are users of long term care able to make a well-considered choice when it comes to health insurance products and health care providers? Third, are non-users of long term care interested in long-term care? Hence, we discuss these issues in more detail.

(4) Is it possible to organize sufficient risk equalization for long term care?

Risk equalization is the cornerstone of managed competition. With imperfect risk equalization, insurers have no incentive to invest in quality of care for people with a chronic disease. As mentioned earlier in this paper, the current risk equalization for short-term care is still not sufficient, despite 25 years of policy research. For long term care, it will be even more difficult to organize a sufficient risk equalization system. The explanation is simple. Compared to short term care, the group of long-term care users is relatively small. Moreover, these people incur relatively high, or very high spending, which is quite predictable for insurers. For instance, when a patient is in a long term care facility in year t it is very likely that the patient will be in the same facility in year $t+1$. This implies that insurers can easily identify high-cost patients just by checking the cost history of their clients. A problem with historical costs, however, is that this type of information is generally not appropriate for risk equalization. For example, when long term care spending in the previous year were used as a risk adjuster for next year, incentives for efficiency would be substantially reduced. More specifically, such a risk adjuster would encourage insurers to inflate spending on long-term care in order to receive higher risk equalization payments in later years. Ideally, risk equalization should not create such incentives and endogenous risk adjusters should be avoided.

If it is not possible to organize sufficient risk equalization for long term care, then what will be the motive for insurers to invest in the quality and service regarding long term care? The Dutch government recently decided to

transfer "home care" from the long term care scheme to the Health Insurance Act. Recent research has shown, however, that people using long term care this year are undercompensated for short term care next year by on average more than 1000 Euros per person per year (Van Kleef et al., 2014).

(5) Are users of long term care able to make well-considered choices?

Another fundamental question is whether the users of long term care are able to make well-considered choices when it comes to selecting a health insurance product or a health care provider? This is an important precondition for managed completion. If consumers are not able to "vote by foot" insurers have no incentives to meet the preferences of these people. For some types of long term care it is doubtful whether patients are able to make well-considered choices. Clear examples are patients suffering from dementia, drug addiction and psychiatric disease. If these people do not respond to quality differences among health insurers, then what will be the motive of the insurers to invest in the quality of the specific long term care used by these patients?

(6) Are non-users interested in long term care?

The third issue is that the majority of the population does not expect use of long term care in the near future. As mentioned before, the group of long term care users is very small. If the majority of the population is not interested in long term care, what will be the motive for the insurers to invest in the quality and service regarding long term care?

6. What are the alternatives?

(1) Two alternative options

If managed competition is not an appropriate model for long term care, than what are the alternatives? In the Netherlands there are two options under consideration. The first is to transfer long term care or parts of long term care from the central to local governments. The second is to maintain the long term care in a public scheme.

(2) Transition of long term care from the central government to the local government.

With this option the local government becomes responsible for organizing long term care. This alternative has some advantages compared to the managed competition option: the integration with other local services will be easier, there will be no risk selection problems and voting by foot will not be necessary for long term care patients (instead the incentives to invest in long term care result from a democratic process).

Next to these advantages, there are also some disadvantages compared to the managed competition option. For example, integration and coordination of short term care and long term care will be more difficult when the two remain in separate schemes. A second potential problem is the possibility of variation in quality and service between regions. From a social perspective this may be regarded unfair. A third problem is that there may be less freedom of choice for patients. If the long term care contracted by your local government is very poor, you have to move to another region in order to receive better care. It is unlikely, however, that people are that flexible.

The most likely option for the Netherlands is that only parts of the long term care will be transferred to local governments. In fact, in 2007, a part of the long term care, including assistance with daily living, was already transferred to local governments. Municipalities receive a non-earmarked budget for this type of care, which means that if they succeed in not using the entire budget, then they can spend the remaining part on other things. In fact, this means that municipalities bear financial risk. Municipalities can selectively contract with health care providers, which gives these providers strong incentives for efficiency. The results of this new system were very appealing. The competition among health care providers has helped reducing the average price of one hour assistance with daily living by more than 20%, compared to the old system. In 2007, the municipalities saved 150

million Euro out of a total budget of 1.2 billion Euro for assistance with daily living (SCP, 2009). However, the effects on quality were unclear.

(3) Maintaining long term care in present scheme

The other option is maintaining long term care in the public scheme as it has existed since 1968 (Van Kleef, 2012). Particular advantages of this option are that voting by foot is not necessary, risk equalization is not necessary, and there are no risk selection problems. With this option, new ways have to be found for tackling the bottlenecks discussed in Section 5.2. One promising direction may be to implement some form of pay-for-performance, but given the lack of quality indicators this is a long way to go.

7. Conclusion: Lessons from the Netherlands

The considerations in this paper lead to the following conclusions. In the first place, managed competition in the Netherlands seems to have slowed down the growth in health care spending. But in the second place, it is not yet clear whether managed competition has been effective in promoting quality of care. The reasons may be the lack of accurate quality information and the fact that risk equalization still discourages insurers to invest in the quality of care for some groups of chronically ill. These bottlenecks must be tackled soon in order to avoid that the Dutch health care system will slow down the cost growth at the expense of the quality of care.

Fulfillment of the preconditions for managed competition may be even more difficult for long term care than for short term care. In this paper we have discussed three fundamental problems when it comes to managed competition for (particular parts of) long term care: accurate risk equalization may not be feasible, patients may not be able to make well-considered choices and the majority of the population does not expect to use long term care in the near future and is therefore not interested in long term care.

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