



OSINGA CONSULT

O sistema de saúde Holandes

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Key topics

- Brazil versus the Netherlands
- Dutch insurance system
- Next steps

Brazil – Netherlands 1-2



Enne and Leao



Health Care expenditure Brazil versus the Netherlands

Health expenditure	Brazil	N.L
- Total expenditure on health (% GDP)	8.4%	9.8%
- Total health expenditure per capita, (US\$)	\$837	\$3,827
- Public part of health expenditure (2002)		62.5%
- Public part of health expenditure (2007)	41.6%	not published

Source:
OECD Health Data 2009
World Health Statistics 2010

Health Outcomes

Brazil versus the Netherlands

Health status total population	Brazil	N.L.
- Infant mortality rate, deaths per 1,000 live births	18.0	4.1
- Caesarean sections, per 100 live births	45.9	13.9
- Obesity, percentage of adult population with a BMI>30	11%	11%
- Obesity, percentage of adult population with a BMI>25	40.6%	45.5%
- Diabetes, deaths per 100,000	24.1	15.5

Source:
OECD Health Data 2009
World Health Statistics 2010
DATASUS

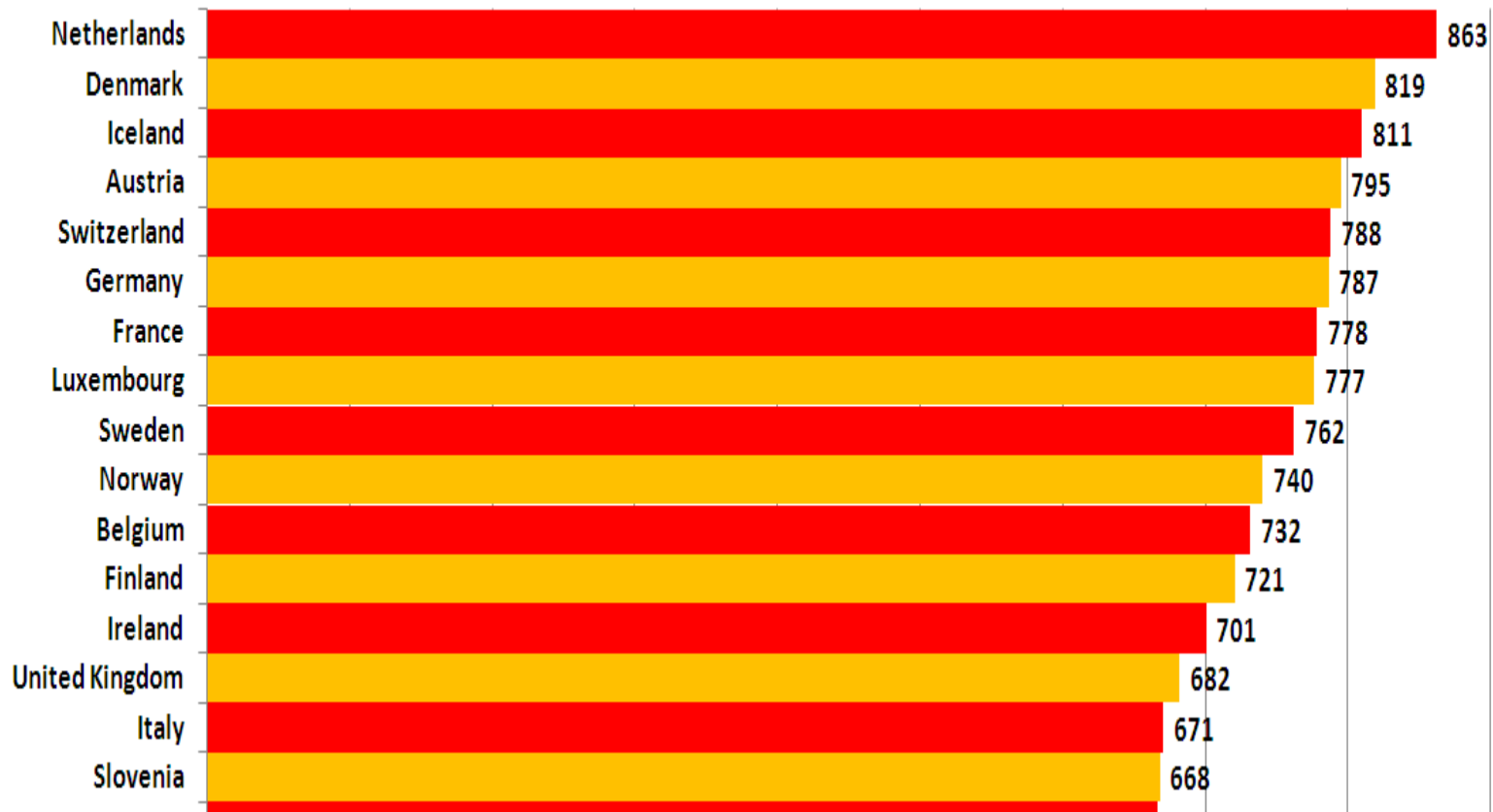
Consumers' satisfaction

“ The Netherlands is the only country that has consistently been among the top three in the total ranking of any European Index the Health Consumer Powerhouse has ever published since 2005” .

Source: Euro Health Consumer Index 2009

Euro Health Consumer Index 2009

Total scores in Euro Health Consumer Index 2009



Consumers' satisfaction

“ The NL is characterized by a multitude of health insurance providers acting in competition, and being separate from caregivers/hospitals. Also, the NL probably has the best and most structured arrangement for patient organization in healthcare decision and policymaking in Europe” .

Source: Euro Health Consumer Index 2009

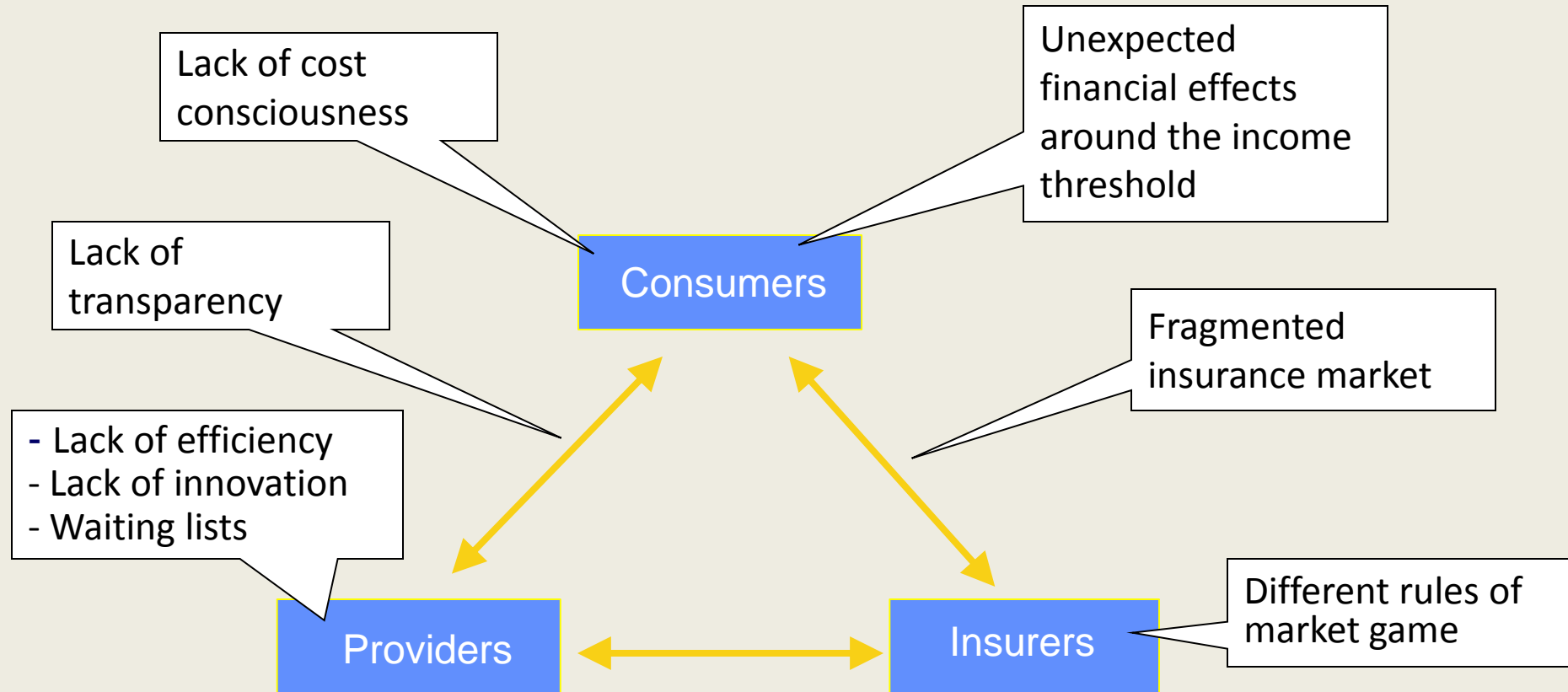
The best system

“The best health care system in the world would be the Dutch insurance system combined with fully integrated delivery systems like Kaiser Permanente.”



Alain Enthoven, PhD
professor at Stanford University

Reform 2006: Why?

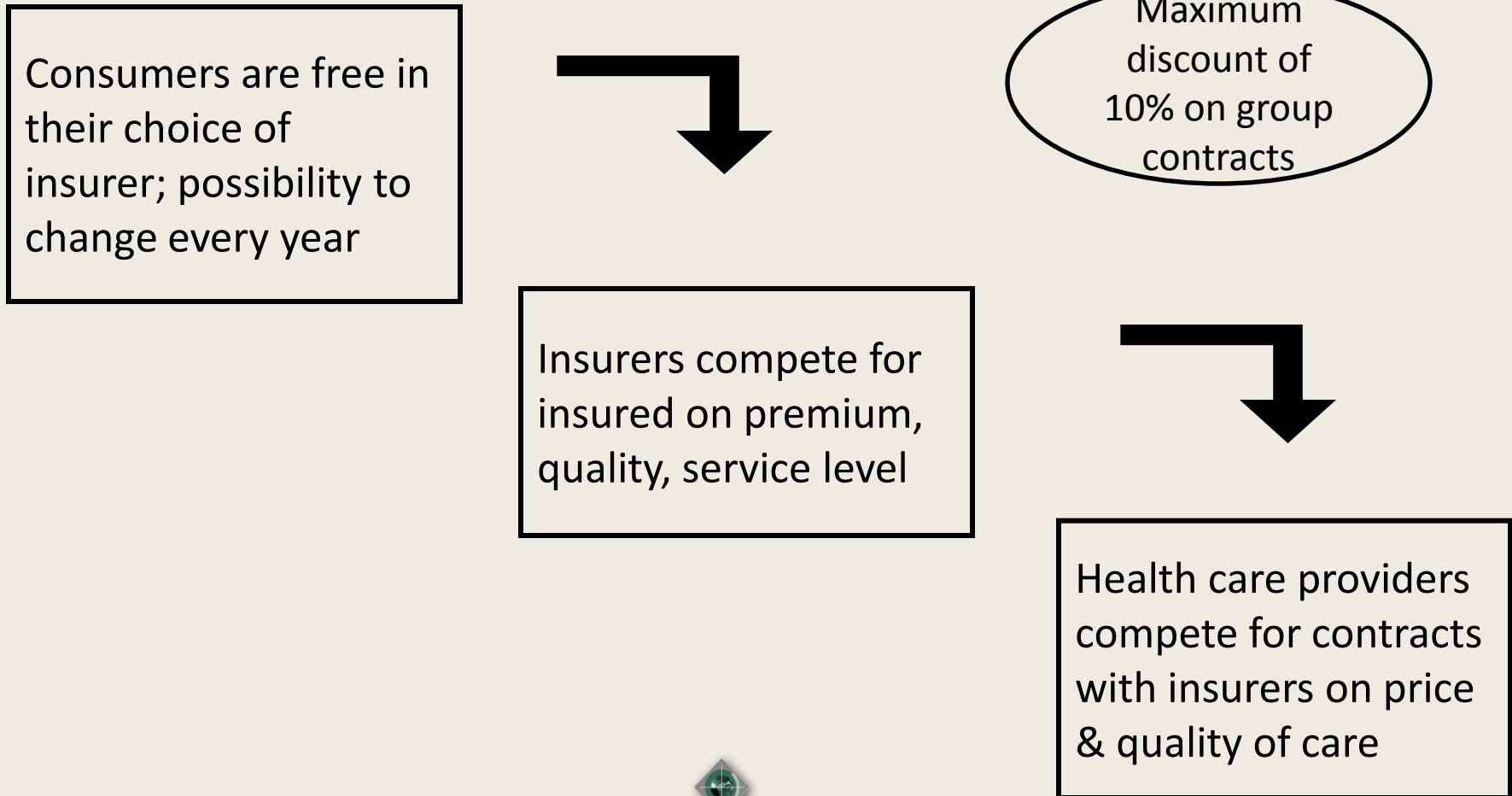


Increasing pressure on the system by: growing wealth, advancing medical technology and aging population.

Solution: less central regulation and more competition

Dutch insurance system

Managed competition



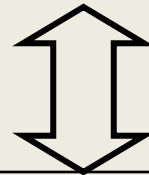
Dutch insurance system

The essence

Equity



- Compulsory insurance (consumers)
- Open enrollment (insurer)
- Legally defined coverage (insurer)
- No premium differentiation (insurer)
- Submission to risk adjustment (insurer)
- Income related contribution (consumer)

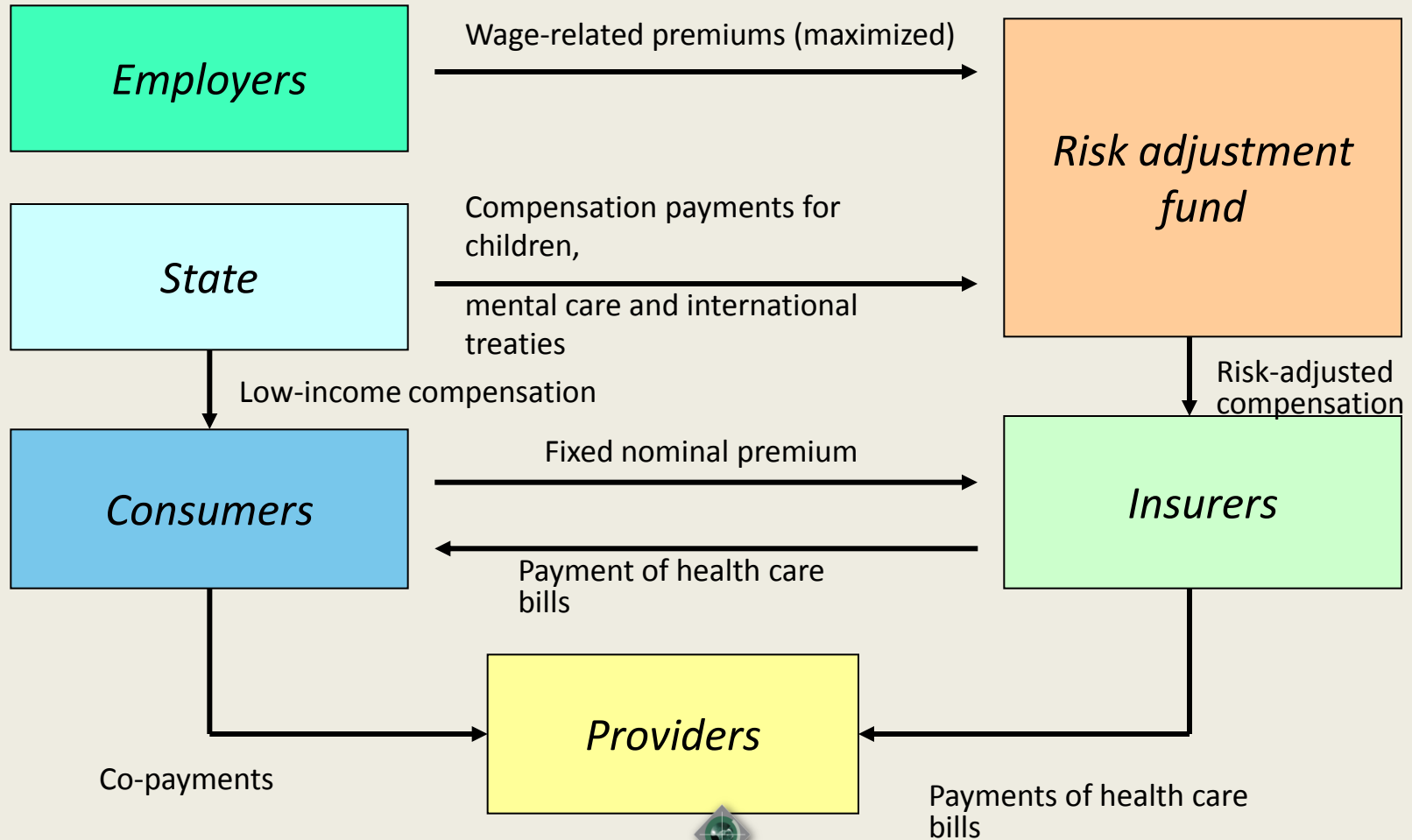


Efficiency



- Compulsory deductible (consumers)
- Free to set nominal premium (insurer)
- Free to offer different policies (insurer)
- Free to offer supplementary deductible (insurer)
- Free to engage group contracts (insurer)

Reform 2006: Financial flows



The 2006 reform: RAF

Factors in the precalculated pro capita budget

- Age and gender (38 subgroups)
- Drug consumption (72)
- Health care consumption (13)
- Economic status (5)
- Regions (10)

The 2006 reform: Example RAF

An example of a precalculated pro capita budget (€)

Woman 35-39	1.242
Drug consumption: none	-320
Drug and health care consumption class 8	8.042
Economic status self employed	-172
Region 1	<u>100</u>
Prospective budget	8.892

The 2006 reform: Example consumer

Enne's yearly decision

Employer pays 6,5%	€ 1.950	
	min	max
Premium range basic policy	€ 935	€ 1.200
Option: premium reduction deductible (€500)	-€ 250	€ 0
Option: group discount (max 10%)	€ 69	€ 0
Option: supplementary policy	€ 0	€ 780
Option: dental policy	<u>€ 0</u>	<u>€ 700</u>
Decision range	€ 617	€ 2.680

How does the reform work?

Insurers

- 25% of population changed to another insurer in 2006
- Less than 5% changed in 2007, similar in 2008
- Massive collective contracts (46%)
- Premiums lower as expected due to competition (app. 7%)
- Number of uninsured estimated 1.5%
- Premium range between insurers decreases
- Insurers are developing other ways (than premium) to differentiate themselves

How does the reform work?

Providers

- Increase in financial risks
- Increase in revenues
- Desire to measure and appreciate “health services delivered to members” next to “costs”
- Focus on efficiency
- More requests for transparency by providers to better understand their own performance

What works well in the Dutch health care market

Universal coverage in health insurance because of sophisticated **risk adjustment**.

Mix of **capitation** and **fees** let primary care physicians share the risk of over-consumption.

Specialized physicians and independent outpatient treatment centers produce elective secondary care very **efficiently**.

More complicated (**acute** and **tertiary**) care is **coordinated** by large integrated hospitals.



Where the Dutch health care market should improve

Little incentives for consumers to avoid **moral hazard** (small deductible, no co-payment).

Barriers to entry limit competition and raise prices in markets for:

1. Physician labor (licensure rules, restricted training capacity);
2. Capital (prohibition on for-profit status);
3. Hospital care (certificate of need, scarcity on physician labor and capital markets).

Physician and hospital price controls **ration** demand (waiting lists).

Lack of **reliable quality information** on hospital care.

Health care cost

$$C = P \times Q$$

Present system of tariffs

Free practitioners:

$$T = \frac{I + C}{W}$$

Institutions: budget system

Remuneration free practitioners (\$)

	income (I)	costs (C)	revenues
medical specialists	253.400	42.000	295.400
physical therapists	73.658	38.508	112.167
midwives	75.919	56.819	132.738
general practitioners	134.966	139.174	274.140
pharmacist	141.796	550.386	692.182
orthodontist	184.012	485.960	669.971

Source: CTG 2006

US\$ per year, €/€ = 1,40

Remuneration international medical specialists (\$)

Netherlands	253.000
Australia	247.000
United States	230.000
Belgium	188.000
Canada	161.000
United Kingdom	150.000
France	149.000
Germany	77.000
Mexico	25.000
Poland	20.000
AVERAGE OECD	113.000

Source: OECD 2009

Renumeration international

general practitioners

United States	161.000
United Kingdom	118.000
Netherlands	117.000
Canada	107.000
France	92.000
Australia	91.000
Belgium	61.000
Mexico	21.000
AVERAGE OECD	83.000

Source: OECD 2009

Recent developments

medical specialists (\$)

- **Financieele Telegraaf July 17 2010:**
 - Income medical specialist (self employed) increase to \$ 370.000 (€ 264.000)
- **Financieele Dagblad July 28 2010:**
 - 659 (> 10%) of the specialist (on salary) earn more than the maximum of \$ 263.000 (€ 188.000)
 - The highest earns \$ 501.000 (€ 358.000)
- **Government wants to intervene**

Case Study 1: liberalizing the Dutch hospital market

Dutch hospitals face a budget system for part of their production, where prices do not have the usual coordinating role in resource allocation.

With a new DRG-like product classification (DBC's) in place since 2005, hospitals and insurers have been bargaining bilaterally over prices and volume of 34% of these products.

The current government aims to enlarge this competitive market to the remainder of elective hospital care (50% and in the long term to 70%) .

Case study 2: the market of physical therapy

February 1st, 2005: start of **experiment** for physical therapists with free prices (duration of two years).

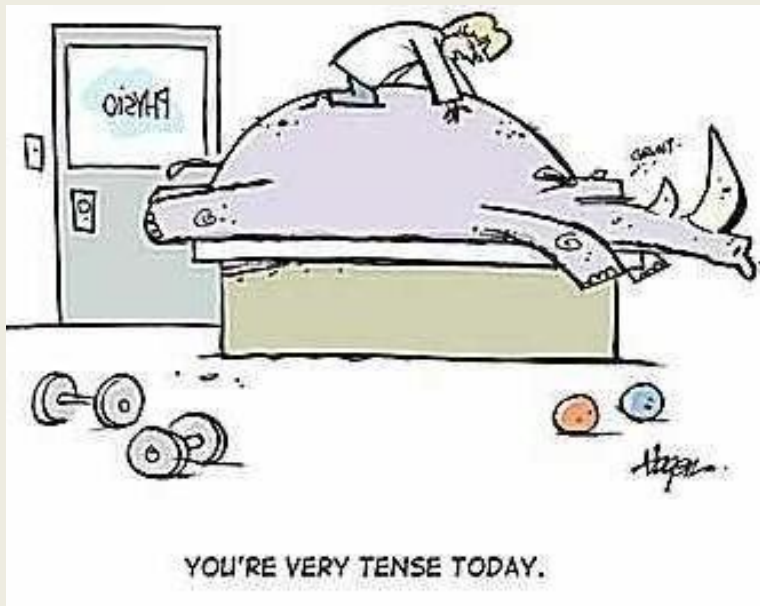
Prices increased in 2007 by 2%, but correcting for inflation the **increase was almost nil**.

Insurance have contracts with more than **90%** of physical therapists.

No referral from GP needed.

Room for **innovation** (development of new programs).

Market of physical therapists **fully liberalized**. Free prices as from January 1st, 2008.



Case study 3: the market of medical specialists



January 1st, 2008: introduction DBC's,
price per hour = € 139,50 = \$ 195

“DBC inflation” in 2008, resulting in \$
550 milion macro-cost increase

Insurance companies “want their money
back”, demanding a reduction of the
price per hour.

Case study 4: the market of orthodontists



1980-2010: technological development, resulting in orthodontic factories where assistants generate revenues for orthodontists;

2007-2010: decreases up to 50% of the tariffs;

Problem: tariffs for orthodontists are below orthodontic tariffs by dentists => orthodontists retable their activities to dental..

Next steps (1):

Align financial incentives with desired behavior

- Providers: increase financial risk
- Insurers: increase financial risk
- Consumers: introduce intelligent deductibles

Improve quality transparency on medical performance

- Inform providers about their performance compared to a peer group
- Give the consumer the opportunity to select the doctor that best fits their needs
- Create and compile patient-reported outcome measures

Next steps (2):

Create outpatient primary care centers

- Use electronic health records to manage chronic conditions
- Use evidence-based guidelines
- Introduce “email your doctor” services to reduce doctor visits and increase patient satisfaction
- More prevention

Limit free rider behavior

Privatize and decentralize (part of) CARE segment



**Don't
ever
give up**



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