Exploring Global Health Care Cost Drivers: Israel and the Netherlands

Sponsored by the International Actuarial Association Health Section (IAAHS) and the Academy’s Health Practice International Task Force (HPITF)

February 18, 2015
Presenters

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- Rian de Jonge, AAG, Actuary, Netherlands
- Moderator: Susan Mateja, MAAA, FSA Chairperson, Health Practice International Task Force (HPITF)
All nations face difficult challenges in providing health care to their people
Exploring Global Health Care Cost Drivers: Israel and the Netherlands

A series of webcasts that will highlight the health care models of various countries will take place in 2015

- February 18 (Israel & Netherlands)
- May 13 (U.S. & South Africa)
- September (TBD)
- November (TBD)

We are starting a conversation that will explore the following:

- General characteristics
- Financing system
- Cost drivers
- Methods of coping with the cost drivers
- Measurement metrics
- Insights, successes, hurdles
- Future trends
Exploring Global Health Cost Drivers – 2015 Webinar Series

ISRAEL

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Beer Sheva, Israel

18 February 2015
<table>
<thead>
<tr>
<th>Population and Demographic Indicators</th>
<th>1990</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (Millions)</td>
<td>4.660</td>
<td>8.135</td>
</tr>
<tr>
<td>Population over 65 (%)</td>
<td>9.2</td>
<td>10.6</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>10.9</td>
<td>3.4</td>
</tr>
<tr>
<td>Life expectancy at birth (Male)</td>
<td>73.8</td>
<td>80.3</td>
</tr>
<tr>
<td>Life expectancy at birth (Female)</td>
<td>78.8</td>
<td>83.9</td>
</tr>
</tbody>
</table>
 Israeli Healthcare Key Components

- **Universal mandatory coverage** *(see #19)*
  - 100% of Israeli residents
  - Comprehensive package and medical basket
  - Provides: 4 sick funds, some by the Ministry of Health *(see #20)*
  - Participants free to move between sick funds

- **Premiums**
  - Income related *(see #21)*
  - Collected by National Insurance Institute of Israel

- **Budget –**
  - Guaranteed by law
  - Annually updated
Voluntary Health Insurance (VHI) (see #22, #23-24)

- **Sick funds** (SF) – regulated by Ministry of Health (MOH)
  - Permitted to offer a voluntary health insurance to their insured
  - Based on principles defined by the National Health Insurance Law (NHIL)
  - Autonomy to define the coverage, within MOH rules
  - Each SF has two layers of VHI

- **Commercial insurance companies** – regulated by Ministry of Finance
  - Individual and group policies
  - Main coverages:
    - Health expenses; critical illnesses; dental
    - Long Term Care – with SF as policy holders
  - Based on insurance legislation
Physical and Human Resources
Financial Flow – Israeli Healthcare
(excluding insureds’ deductions and payments)

- Commercial Insurers
- Insured
- Providers
- Sick funds
- The state

- Premiums
- MOH
- ‘Health Tax’
- Capitation formula
- Agreements
- Payments
- Provision of services

Capitation F. – the allocation formula to the sick funds
Capping – Ceiling arrangements for the payments of sick funds for hospital services
Special arrangements - usually stabilization agreement or incentives to implement Pay for Performance (P4P) policy
User charges – do not appear in the scheme
Main Sources of Funding the SFs Services under the NHIL

- **Income related Health Tax**
- **User charges & cost sharing**
- **Government budget**

2013 budget = 36.6 billion NIS (app. 10 billion $)
Total Health Expenditure - % of 2012 GDP

(see #25)

Trends in Israel

Public expenditure on health as percent of the total health expenditure:
- Israel - 60%
- OECD average - 72%
- OECD median - 75%

Health expenditure per capita (USD PPPs)- 2011
- Average OECD – 3,322
- Israel – 2,239
## Governmental Expenditure:
### OECD and Israel

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of GDP</th>
<th>Health</th>
<th>Education</th>
<th>Health &amp; Education</th>
<th>Security</th>
<th>Transfers &amp; Support</th>
<th>Housing</th>
<th>Total public expenditure</th>
</tr>
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<tbody>
<tr>
<td><strong>1995</strong></td>
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<td></td>
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<tr>
<td>OECD average</td>
<td>5.9</td>
<td>5.7</td>
<td>11.7</td>
<td>2</td>
<td>17.8</td>
<td>1.3</td>
<td>51.6</td>
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<tr>
<td>Israel</td>
<td>5.4</td>
<td>7.4</td>
<td>12.8</td>
<td>8.5</td>
<td>10.6</td>
<td>1.7</td>
<td>50.3</td>
<td></td>
</tr>
<tr>
<td>Israel’s ranking among 19 OECD countries</td>
<td>13</td>
<td>2</td>
<td>8</td>
<td>1</td>
<td>19</td>
<td>3</td>
<td>12</td>
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<tr>
<td><strong>2011</strong></td>
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<tr>
<td>OECD average</td>
<td>6.9</td>
<td>5.7</td>
<td>12.6</td>
<td>1.4</td>
<td>18.2</td>
<td>0.7</td>
<td>48.8</td>
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<td>Israel</td>
<td>5.2</td>
<td>7</td>
<td>12.1</td>
<td>6.2</td>
<td>10.9</td>
<td>0.4</td>
<td>42.1</td>
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<tr>
<td>Israel’s ranking among 19 OECD countries</td>
<td>13</td>
<td>2</td>
<td>8</td>
<td>1</td>
<td>19</td>
<td>3</td>
<td>12</td>
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<tr>
<td><strong>Change (2011-1995)</strong></td>
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<tr>
<td>OECD average</td>
<td>-1</td>
<td>0</td>
<td>0.9</td>
<td>-0.5</td>
<td>0.4</td>
<td>-0.6</td>
<td>-2.8</td>
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<tr>
<td>Israel</td>
<td>-0.2</td>
<td>-0.4</td>
<td>-0.7</td>
<td>-2.3</td>
<td>0.3</td>
<td>-1.3</td>
<td>-8.2</td>
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</tr>
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</table>
Household Expenditure

% of Total Household Consumption Expenditure
Israel’s Main Cost Drivers

- Aging (see #26)
- Chronic morbidity (see #27)
- High technologies
- Wrong incentives and inefficiencies
- A growing private sector
Policies Coping with Cost Drivers

- Steps to strengthen the public sector
- Attempt to reform LTC
- Pay for Performance – incentives to sick-funds
- Regulation of private health insurance
- Capping expenditure of hospital services
- National program for Healthy Life Style & Prevention
- Annual allocation for new technologies
Israeli Healthcare Community Quality Measurements

Colon cancer screening

Percentage of adults after coronary artery bypass surgery and/or interventional cardiac catheterization with LDL levels less than or equal to 100 mg/dL (ages 35-74 years)

Body mass index (BMI) documentation for children

Percentage of individuals with diabetes mellitus with HbA1c less than or equal to 7.0% (ages 6.74 years)

State of Israel Ministry of Health

National Program for Quality Indicators in Community Healthcare in Israel

2008-2010
International Quality Measurements

Infant mortality
Deaths per 1,000 live birth 2012

Life expectancy at birth
International comparison*

Life expectancy at birth (2013):
Male - Israel is ranked 3rd (2.4 years above the average)
Females - Israel is ranked 11th (0.8 years above the average)
Strengths of Israel’s Healthcare System
(see #29-32)

- Efficient – good outcomes, moderate cost, stable finances
- Well developed and high quality primary and community care
- Good Information and Communications Technology (ICT) system
- High customer satisfaction
Challenges Faced by Israel’s Healthcare

- Match future resource allocations and functionality to changing population and technology needs
- Maintain quality of care standards
- Impacts of private sector and 3rd party payers on public systems
- Supply of specialists and professionals
- Narrow disparities
- Standardize and optimize the ICT system
APPENDIX

References to Appendix’s slides are marked in the main presentation by (see #slide-number)
Israel’s Basic Basket of Healthcare Services

- **NHIL services under SFs responsibility**
  - Primary and secondary medicine
    - Health examination, treatment, imaging, lab tests, etc.
  - Hospital inpatient and outpatient services
    - General, psychiatric, LTC
  - Medications
  - Dental services to children

- **Services under MOH responsibility**
  - Vaccinations and prevention
  - Mental health
  - Institutional LTC
  - Health promotion service to children up to 8th grade
  - Equipment to handicapped people
Market Share of SF in 2013

- Clalit: 52%
- Maccabi: 25%
- Meuhedet: 14%
- Leumit: 9%
Income-Based Health Tax

- Monthly payments to National Insurance Institute of Israel (NIII)

- Employed and independent workers
  - 3.1% of salary up to 60% of national average income level
  - 5% of income above 60% of national average income level
  - 1% of income of home support person

- Unemployed resident
  - Monthly fixed payment of 103 NIS (~$27)

- Ceiling – 5 times national average income level
Israel’s Healthcare Tier System - 2013

Percentage of each tier

Red - of population; Green - of health expenditure

* Some people are doubly insured by both SF & Private Insurance, so total is over 100%
Insured in VHI as % of Population 2011
Total 2013 Private Insurance Premiums by Type of Policy

- Total: 6.75 billion NIS
- Supplementary: 3.84 billion NIS

- Dental Services: 487 million NIS (99.8% group, 0.2% individual)
- Critical Illnesses: 641 million NIS (90.5% group, 9.5% individual)
- Health Expenses: 1,668 million NIS (35.3% group, 64.7% individual)
- Long Term Care: 1,938 million NIS (65.3% group, 34.7% individual)
Israel’s 2013 Healthcare Expenditure

Total 79.3 Billion NIS
% Growth over 1990-2013 of NUMBER of elderly (65+) Population
Expected Increase in Global Burden of Selected Diseases

Economic loss and burden

EPIC approach: lost output from five the conditions over the period 2011-2030 is estimated at nearly US$ 47 trillion.

VSL approach: the economic burden of life lost due to all NCDs ranges from US$ 22.8 trillion in 2010 to US$ 43.3 trillion in 2030.
Quality Indicators in Hospitals

Hip Operation Within 48 Hours

PCI conducted within 90 minutes to patients with STEMI
(percent of hospitals who meet the target standard)

PCI = A coronary stent placed by Percutaneous Coronary Intervention

STEBI = ST segment elevation myocardial infarction (a severe type of heart attack)
CT - Infrastructure and Utilization

- Annual number of scanning procedures per scanner 2012
- CT scanners (rates per 1 million population) 2012
MRI - Infrastructure and Utilization

**Annual number of scanning procedures per scanner 2012**

**MRI scanners (rates per 1 million population) 2012**
SFs Clients’ Satisfaction

Percent of those who reported they are 'satisfied' or 'very satisfied'


- Clalit
- Maccabi
- Meuhedet
- Leumit
Outside Reviews - 2012

- "Israel's community-focused information system sets an international benchmark in excellence and demonstrates commitment to quality monitoring and improvement."

- "Israel has established one of the most enviable health care systems among OECD countries."

- "Primary care in Israel is well-developed, accessible geographically and financially, and of high quality."

- "Israel's impressive life expectancy gains and low premature mortality from chronic conditions reflect the contribution of its primary care system."

- "Low number of admissions to hospitals for uncontrolled diabetes, while reductions in complications demonstrate ongoing efforts to improve quality of care provided to patients with diabetes."

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<table>
<thead>
<tr>
<th>Slide</th>
<th>Sources</th>
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<tr>
<td>2</td>
<td>Israel Central Bureau of Statistics, Israel Ministry of Health</td>
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<td>5</td>
<td>Based on data from OECD Health Statistics 2014, Bank of Israel 2014, and Ministry of Health, Israel 2014</td>
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<td>6</td>
<td>Administration of Strategic &amp; Economic Planning, Ministry of Health</td>
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<td>7</td>
<td>Administration of Strategic &amp; Economic Planning, Ministry of Health</td>
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<td>8</td>
<td>OECD Health Statistics 2014</td>
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<td>9</td>
<td>Bank of Israel 2013</td>
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<td>Based on data from Israel Central Bureau of Statistics</td>
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<td>Based on data from OECD Health Statistics 2014</td>
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<td>23</td>
<td>OECD Health Data 2014</td>
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<td>Ministry of Finance, Annual Report, 2013</td>
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<td>Israel Central Bureau of Statistics</td>
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<td>26</td>
<td>OECD Health Statistics 2014</td>
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<td>31</td>
<td>Myers-Joint, Brookdale Institute, Jerusalem</td>
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</table>
Exploring Global Health Care Cost Drivers: the Netherlands

The Netherlands

Rian de Jonge
Overview

- Demographics and Health expenditure stats
- Health system and funding
- Health expenditure trends analysed
- Cost drivers and ways of coping
- Challenges and strengths
Overview

Demographics and Health expenditure stats
Demographics
the Netherlands vs. U.S. (cont.)

Life expectancy at birth, total population

<table>
<thead>
<tr>
<th>2012/2014</th>
<th>The Netherlands</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>16.8</td>
<td>320,3</td>
</tr>
<tr>
<td>Fertility rate</td>
<td>1.76</td>
<td>1.86</td>
</tr>
<tr>
<td>Population over 65y</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td>Self reported obesity%</td>
<td>12%</td>
<td>29%</td>
</tr>
</tbody>
</table>

Source: OECD
Demographics the Netherlands (cont.)

Chronic disease:
More chronic diseases are diagnosed as such, partly due to Western lifestyle and partly due to improved medical analyses. This increases treatments and thus costs.

Source: Dutch CBS – Projections for healthy life expectancy until 2030
Health expenditure the Netherlands vs. U.S.

Source: OECD
Health expenditure
the Netherlands vs. U.S. (cont.)

Compare > Netherlands with United States

% of GDP

Per capita (USD PPP)

Total health expenditure

Public health expenditure

Expenditure on pharmaceuticals

Source: OECD
Health system and funding
Healthcare system overview
Base coverage for cure (GP, HC, etc.) and parts of LTC

Healthcare insurance

Dutch Central Bank

Authority
Financial Markets

Private Health Insurer
(mandatory underwriting)

Ministry of Health,
Welfare and Sports

National
Health Authority

Health Insurers
The Netherlands

Healthcare contracting

Health Institute
The Netherlands

Healthcare supply

Patient = Insured
(mandatory insurance)

Ministry of Health,
Welfare and Sports

Healthcare contracting

Health Provider

Healthcare supply

Patient Organizations

Source: PwC
Healthcare system funding
Base coverage for cure (GP, HC, etc.) and parts of LTC

- **Dutch State**
  - Funding Insured < 18 years old: 5%
  - Income dependent premium (also taxated as income): 50%
  - Insured >= 18 years old: Low income compensation

- **Employers**

- **Insured**
  - >= 18 years old
  - Low income compensation

- **Health Insurance fund (Risk equalization fund)**
  - Risk equalization benefit (risk adjusted)
  - Health Insurer
    - Insured costs
  - Health Provider
    - Cost sharing contributions + cost of excluded treatments

Progressively ex ante: in previous years health insurers were compensated based on ex post figures, limiting the impact of their actions on their financial position. More and more the ex post compensation is reduced to provide the right incentives to health insurers.

Source: PwC
LTC funding
LTC reform

<table>
<thead>
<tr>
<th>2011</th>
<th>Zvw (base cure/ care)</th>
<th>AWBZ (long term care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income related premium</td>
<td>19.666</td>
<td>14.585</td>
</tr>
<tr>
<td>Fixed premium</td>
<td>14.292</td>
<td></td>
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<tr>
<td>Government budget</td>
<td>2.319</td>
<td>5.248</td>
</tr>
<tr>
<td>Cost sharing contributions</td>
<td>1.498</td>
<td>1.720</td>
</tr>
<tr>
<td>Other benefits</td>
<td>345</td>
<td>31</td>
</tr>
<tr>
<td>Total benefits</td>
<td>38.118</td>
<td>21.584</td>
</tr>
<tr>
<td>Total expenses</td>
<td>37.678</td>
<td>25.440</td>
</tr>
<tr>
<td></td>
<td>440</td>
<td>-3.856</td>
</tr>
</tbody>
</table>

Solidarity in funding: In addition to the income related Zvw premium schemes, Zvw fixed premium payments are compensated by the State for low income individuals. The 5 percent financed by the State is mainly paid by higher income individuals through the progressive general taxation scheme. An estimate of 70 percent of the Zvw funding is thus paid based on income dependent funding. Together with the 100 percent of AWBZ that was funded by income related taxation, this leads to an overall 80 percent income related premium, which corresponds with a flat percentage equal to approximately 20 percent of the lifetime gross income that is paid or health care for all income levels.

Long Term Care reformed (Jan 2015): AWBZ and Wmo change from insurance to provision: no longer a right to receive care.

<table>
<thead>
<tr>
<th>2015 (estimated)</th>
<th>(central gov)</th>
<th>Zvw (private ins)</th>
<th>Wmo (local gov)</th>
<th>Youth (local gov)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before reform</td>
<td>(AWBZ) 26.750</td>
<td>38.750</td>
<td>2.000</td>
<td>1.000</td>
</tr>
<tr>
<td>Change youth mental care</td>
<td>-1.000</td>
<td>3.750</td>
<td>3.750</td>
<td>1.250</td>
</tr>
<tr>
<td>Change LTC</td>
<td>-8.750</td>
<td>3.750</td>
<td>3.750</td>
<td>1.250</td>
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<tr>
<td>Reduction Cure</td>
<td>-750</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction Home Care</td>
<td>-500</td>
<td></td>
<td>-500</td>
<td></td>
</tr>
<tr>
<td>Reduction LTC</td>
<td>-500</td>
<td>-250</td>
<td>-250</td>
<td>-250</td>
</tr>
<tr>
<td>After reform</td>
<td>(Wlz) 17.500</td>
<td>40.500</td>
<td>5.000</td>
<td>2.000</td>
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</tbody>
</table>

Sources: Dutch government, CPB, Rabobank Themabericht and PwC

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Market concentration
Base coverage for cure and parts of long term care

Source: PwC based on annual reports
EHCI research indicates that the Dutch healthcare system is ‘the best’ European system from a consumer perspective:
- Top 3 consistently since 2005
- 898 out of a 1000 is an all time EHCl high score following a positive trend
- Gap with #2 widens from 19 in 2014 to 43 2013 (50 in 2012)
- Netherlands (jointly) wins 4 out of 6 categories
- Weakest score is on waiting time, which is due to the GP-gatekeeper role that is intentionally built in to save costs.
- Netherlands still ranks 9th (2013 and 2014) after correcting for the cost level (BFB index)

Healthcare systems based on social insurance (‘Bismarck’ systems, such as the Dutch system), where there is a multitude of insurance organizations, who are organizationally independent of healthcare providers score better for larger countries than systems where financing and provision are handled within one organizational system (‘Beveridge’ systems like UK NHS). The top consists of dedicated Bismarck countries. Beveridge systems only seem to work in relatively smaller countries, which can also be found at the top of the index.

Cost issue indicated as not due to multi-payer model, but due to ratio of in-patient care, especially in LTC.

Source: Health Consumer Powerhouse EHCI 2014 report
Healthcare System

LTC Issues

Health expenditure, public and private, as a share of GDP, OECD countries, 2012 or latest year

Source: OECD Briefing Note Netherlands 2014

8.9.1. Long-term care public expenditure (health and social components), as share of GDP, 2011 (or nearest year)

Source: OECD (2013), Long-term care expenditure – Health at a glance
Healthcare System
LTC Issues (cont.)

In-patient healthcare expenditure as % of total
Source: WHO HfA database, July 2013

% of GDP spent on LTC / % of population 75+
Source: Health Consumer Powerhouse Euro Health Consumer Index 2013

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Health expenditure trends analysed
Projected Healthcare expenditure

**Strengths:** The Netherlands has been number one on the Euro Health Consumer Index for several years and is among the top OECD countries when it comes to waiting lists, patient rights and scope and availability of services.

**Challenges:** ‘our current health care system is not sustainable in the long-term, due to the high costs involved as well as the resources needed to provide ever increasing amounts of health care.

The rise in curative health care in the Netherlands is similar to the trend in other countries; in terms of long term care, however, the Netherlands provides a much more extensive collective package and a relatively inclusive set of criteria for patient assessment and subsequent allocation of health care. This has caused costs for care in the Netherlands to increase rapidly, and for the country to spend considerably more (collectively) on care than other countries: …nearly twice the OECD average.

Health care cost rise in recent years has resulted from health policy changes: ‘The period 1981-2000 was characterized by tight budgets necessary to compensate for government deficits in those years. This lead to limited growth of health costs, but also to long wait lists.’ In the period after this, the waiting lists were eliminated by increasing health care expenses, and bringing the cost level back to the original growth path that would result from extrapolating from the early 1980s to now.

*Is using the last 10 years as an estimation basis for the future thus appropriate as was done by CPB on the previous slide?*
Survivors show increasing health care costs with age, especially due to long term care costs for older ages and especially for older women: Total costs of survivors increase exponentially at old age mainly due to frailty, disability, co-morbidity and subsequent needs for nursing and residential care.

Decedents (people who have died) have much higher expected health care costs than survivors for hospital care and long term care (note axis scale). Note that the type of provider differs for age: HC costs are especially high for decedents of middle up to older ages, but not that much for the old ages, where LTC costs dominate the total cost.

‘It has been demonstrated repeatedly that time to death is a much better predictor of health care expenditures than age.’

GP = General Practitioners
HC = Hospital Care
LTC = Long Term Care
Med = Retail sale etc.

Source: Albert Wong, 2012
Health care cost rise less than otherwise predicted if the projections are corrected for:
1) delayed death (‘red herring’ – blue line) and thus delayed high costs, especially for hospital related care (left graph); and
2) the prolonged period that partners are both alive (household position – green line) and thus the delayed move to institutional elderly care.

Also note the following (Lubitz): The total health care costs of a 70 year old over the period to his/her death is approximately equal for all independent of the actual moment of death. It is thus not so much the increasing life expectancy until death, but the increased number of people reaching 70, that impacts the projected future health care costs.

Source: Wong, A et al, 2008 (RIVM publication)
Cost drivers and ways of coping
Cost drivers

- Ratio of in-patient care
- Culture: Western lifestyle and demanding patients
- Ageing (mixed impact!)
- Ethical considerations wrt End-of-Life ‘cure’
- Perverted incentives: treatments vs. outcomes
- Increase chronic diseases/ co-morbidity
- Mobilisation of latent demand
- Upcoding
- Medical innovation
Cost drivers
Ways of coping

- Increase out-patient care:
- Increased efficiency
- Long Term Care reform: Decreased patient eligibility
- More healthcare provided by GP practice
- Prevention
- Further privatisation of health care
- Increased cost sharing and cost transparency
- Decreased basic insurance cover
• Debate on curative treatment at old ages
• Shift from volume based to quality based incentives
• Decrease improper use of the system, such as upcoding
• Co-morbidity treated as such
• Centrally organised care for chronically ill patients
• e-Health initiatives
Cost drivers
Some Metrics

Source: ZN/ Vektis/ Plexus Report indicators variation between practices
Source: Dutch association of Hospitals
Overview

Challenges and strengths
Challenges

- High cost level linked with high in-patient care:
  Trend: LTC high in-patient care ratio and growing 50 – 70 year old population is a challenging mix
- Complex system of coding and claiming
- Supply/ incentive induced demand
- Many parties involved
- LTC quality of care
High quality, range and accessibility of curative health care

High patient involvement

Growing stability in the system

Increasing focus on transparency and collaboration between parties

Difficult reforms are implemented to lower costs
Appendix
Healthcare system overview
LTC

most LTC: Government (municipalities)

Ministry of Health, Welfare and Sports

Healthcare taxation (income dependent)

National Health Authority

Healthcare supply

Healthcare arrangements

Center for Health indications

Patient Organizations

Health Provider

Health Inspection Agency

Patient = Insured (mandatory cover)

Source: PwC
Appendix
Healthcare system funding
LTC

- Dutch State
  - Additional funding
  - Income dependent taxation
- Insured >= 18 years old
- Central government
  - In future?
  - Budget
- Local government (municipalities)
  - Covered costs
- Health Provider
  - Cost sharing contributions + cost of excluded treatments

Source: PwC
Appendix
Overview of LTC reform

Box 6. The government’s reform agenda for long term care (cont’d)

Figure 7. Main features of the envisaged reorganisation of the long-term care system

Central long-term care system (AWBZ)
- Care purchased by regional agencies (zorgkantoren)
- Assessment of patients’ needs by the Care Assessment Center (CIZ)
- Patients may opt for cash benefits worth 75% of in-kind care

Local system (WMO)
- Municipalities in charge of assessment, care purchase and cash benefits

<table>
<thead>
<tr>
<th>Institutional care</th>
<th>Home care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation care (e.g., recovery after a stroke)</td>
<td>Care purchased by individual health insurers by 2013</td>
</tr>
<tr>
<td>Other institutional care</td>
<td>Cash benefits restricted to institutional care</td>
</tr>
<tr>
<td>Personal and nursing care (e.g., help for having a wash, administration of medical treatment)</td>
<td>Assisted nursing care (e.g., help with household organisation and administrative tasks)</td>
</tr>
<tr>
<td>Assistance nursing care</td>
<td>Care for young people with a light mental handicap</td>
</tr>
<tr>
<td>No change</td>
<td>Decentralised to municipalities by 2013 (assessment, care purchase and cash benefits)</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Welfare and Sport.

Source: OECD Economics Working Paper Health Care reform and Long-Term Care in the Netherlands
Appendix

Euro Health Consumer Index 2014 scores

Appendix
Overview of abbreviations

- Zvw = Healthcare Insurance Act
- AWBZ = Exceptional Medical Expenses Insurance Act
- Wmo = Social Support Act
- Wlz = Long Term Care Act
- Youth Care Act