3 Specialist health care in the Netherlands

In the first section of this chapter (3.1), the organisation of Dutch health care will be described with particular attention to specialist health care. The situation before the experiment is described, as well as the general organisational changes that took place during the experiment. The second section (3.2) deals with the problems with specialist health care before the experiment. In the third section (3.3) it is shown how the experiment was initiated on account of frustration with these problems.

3.1 Organisation of Dutch health care

Health insurance

Dutch health care is divided in three compartments. The first compartment is covered by social insurance. The Exceptional Medical Expenses Act (Dutch abbreviation: AWBZ), was originally intended to cover risks that were virtually impossible to insure privately, e.g. long-term institutional care. As time went by, other risks were included and sometimes excluded again at a later date. An example of this are prescription medicines. Every Dutch resident is automatically insured for a number of large risks under the AWBZ-scheme. The premium is income-related.

The second compartment concerns the other health care services about which the social consensus is that all Dutch residents should have access to them. It covers a large package of health care costs, the most important of which are the services of the general practitioner (GP), hospital care, care provided by medical specialists and prescription medicines.
In the second compartment, there are three types of health care insurance. For some categories of civil servants there are special arrangements for health insurance, which are obligatory. People who do not belong to these categories are obliged to take part in a public insurance scheme (ZFW) when their income level is below a specific amount. Otherwise, they have to enrol with a private insurance company if they want to be insured. Employees with an income below a certain threshold and their dependants, social security recipients and certain old-age groups are compulsorily insured in the ZFW with a premium that is largely income-related. From 1 January 2000, self-employed persons with a low income are also included in the ZFW. A small part of the premium is flat rate.
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('nominal premium'). Compulsory insured persons have to choose a sickness fund to join. The flat-rate premium differs between sickness funds. This is a way for the funds to compete with each other in attracting consumers. Within a sickness fund all adult insured persons pay the same nominal premium, regardless of risk. The benefits of public health insurance are in-kind. At the start of 1997, modest co-payments were introduced for the publicly insured, to be abolished again on 1 January 1999.

Persons with a higher income can make their own decisions about private insurance. The premiums for private insurance are not based upon income, but upon perceived risk. Many private arrangements include a deductible, meaning that the insured have to pay some fixed amount before the insurance company starts reimbursing their medical costs. The higher the arranged deductible is, the lower the premium. Private insurance is a restitution system: the insured do not get care from the insurer, they get their bills reimbursed (taking into account the deductible). In 1994, before the start of the experiment 31 % of the Dutch population was privately insured. In 1997, at the end of the experiment, this was 30 %. In 1997, 63.7 % of the population were publicly insured and 5.2 % were insured under the special arrangements for civil servants. The proportion of uninsured persons is very low in the Netherlands (1.1 % in 1997).\(^39\)

The third compartment covers care that is perceived as ‘luxury’ or care that consumers are able to pay for themselves, like certain forms of plastic surgery and part of the services of the dentist and the physiotherapist. People can decide to take out complementary (private) insurance for these services with their sickness fund or private insurance company.

Institutions

Institutions traditionally play a large role in Dutch health care. This is the case for organisations created by the government to perform a specific task, as well as organisations of professionals that aim to promote their joint interests. Within the former category, the COTG (Centraal Orgaan Tarieven Gezondheidszorg, National Health Tariffs Authority)\(^40\) and the Zfr are especially relevant to the study of the experiment with the payment system for specialists. The COTG is

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\(^40\) This organisation is now called the CTG: College Tarieven Gezondheidszorg.
the organisation which determined tariffs and budgets for Dutch physicians and hospitals before the experiment as well as during and after. The different tariff systems and types of tariffs that were in place before the experiment will be described below. During the experiment, the old tariff system for medical specialists was formally maintained, but it was no longer used to determine the income of the specialists. For the experimenting hospitals, external lump-sum budgets were determined for specialist care. In Chapter 4, it will be described in detail how this was done. The determination of these external lump-sum budgets was performed by the COTG.

The Zfr was the organisation that was responsible for the supervision of the public health insurance organisations (the sickness funds). The Zfr is important for this study, because it coordinated the coalition that supervised and facilitated the experiment with the payment system for medical specialists. The COTG was also part of this coalition, as well as the Dutch Ministry of Health. The Zfr played a role in subsidising the experimental projects and also supervised and financed the evaluation study concerning the experiment that is the basis of this thesis.

In the period before the experiment, the organisations of interest groups in health care played an important role in discussions and negotiations about the organisation of health care. The government did not feel able to ignore the wishes of these organisations (even if it had wanted to do so), considering their large influence on the functioning of health care. This way of deciding how to arrange things in the Netherlands was a good example of what later would be called the “poldermodel”. An advantage of this model is that all relevant parties are concerned in the decision making, so it is possible to try to find consensus. A disadvantage is that it is difficult to make a considerable change in the way things are done, since it is probable that there is at least one party that suffers from such changes and therefore tries to stop them.

The following organisations at the national level had an interest in specialist health care in the Netherlands at the start of the 1990s. The health insurers,

41 At the start of the experiment, this was called the Ministry of WVC (Ministry of Welfare, Public health and Culture). During the experiment, the Ministry was reorganised and at the moment it is called the Ministry of VWS (Public health, Welfare and Sport).
public and private, were organised in ZN (Zorgverzekeraars Nederland: at the start of the experiment the organisation of private health insurers was called KLOZ\textsuperscript{42} and there was a separate organisation for sickness funds, called VNZ\textsuperscript{43}). There is also an organisation for the insurers of civil servants who carry out the special arrangements: KPZ (Kontactcommissie Publiekrechtelijke Ziektekostenverzekeringen). The organisation of the hospitals was called NVZ (Nederlandse Vereniging van Ziekenhuizen). For medical specialists, there were several organisations with somewhat different viewpoints at the time; the LSV (Landelijke Specialisten Vereniging) was the biggest. Later on, the different organisations were united in one organisation, the OMS (Orde van Medisch Specialisten). The national organisation of GPs was called LHV (Landelijke Huisartsen Vereniging). For patients, there was also a national organisation, the NPCF (Nederlandse Patiënten Consumenten Federatie).

Role of the government

In the period before the experiment, apart from control of the volume and quality of supply, one of the goals of Dutch health policy (and not the least important one) was cost control. This had to do with the fact that a large part of health care costs was financed from social insurance premiums and taxes. An increase in health care costs would also mean an increase in the difference between labour costs and net income, possibly leading to higher labour costs and negative effects on employment. So there were macro-economic considerations for cost control. The government had devised a system to control the real growth (in volume terms) of health care. This system concerned not just the publicly but also the privately-financed part of health care. Every year, the permitted volume growth of health care was announced. The government tried to limit growth to this figure by the use of budgeting systems, for example for hospitals. The hospital budget system will be described below. Some parts of health care were not budgeted but were essentially open-ended, such as the costs of pharmaceuticals and the costs of specialist care. For these elements, cost control turned out to be very difficult.

\textsuperscript{42} Kontortogaan Landelijke Organisaties van Ziektekostenverzekeraars (Contact Agency for National Organisations of Health Insurers).

\textsuperscript{43} Vereniging van Nederlandse Ziekenfondsen (Association of Dutch Sickness Funds).
Specialist health care

In the Dutch health care system, the GP serves as a gatekeeper for specialist care. Generally speaking, patients are supposed to visit their GP first with their complaints. Referral to a medical specialist takes place when the GP considers this necessary. Most patients of a medical specialist are referred by the GP. The patient surveys, that we organised at the start of the experiment and after approximately two and a half years, indicated that 79% of patients were referred to the specialist by their GP. The rest of the patients were referred by other health care workers or came through emergency care or on their own initiative.

Medical specialists in general hospitals as well as GPs were, in most cases, self-employed at the start of the experiment. Physicians sharing a speciality most commonly had formed partnerships within the hospital in which total revenues are shared equally over the participants. At the start of his career, a medical specialist had to buy himself into such a partnership by paying goodwill. This means that young specialists started with large debts. In many cases, there were large differences in average earnings between specialities. In a minority of the hospitals, i.e. in academic hospitals, specialists were, and are, usually employees of the hospital. In general hospitals, there was a special and sometimes problematic relationship between the hospital management and the medical specialists. The management had no direct authority over the specialists but the specialists' decisions did have important consequences for the functioning of the hospital, financial and otherwise. After all, the specialists were the persons who decided how many tests should be performed, how many patients should be admitted, etc. On the other hand, the specialists need the facilities and infrastructure of the hospital to do their work. So there is a mutual dependence. The problematic relationship between specialists and hospital management was one of the reasons why the experiment with the payment system for medical specialists was initiated.

44 See SEO and Ipso Facto (1998).
In the period before the experiment, there were important differences in physician payment systems between the public and private insurance systems. For specialist care, these differences were abolished during the experiment. For the GP, these differences still exist (in 2002). Before the experiment, the payment systems were as follows. General practitioners (GPs) were working on an FFS basis in the case of privately insured patients (payment for each visit), while they received a capitation fee for each publicly-insured patient. For visits to medical specialists at the outpatient clinic, private patients had to pay per visit.\(^{45}\) For sickness fund patients, the specialist received a ‘short card’ (for one or two months of treatment) or a ‘year card’ (for a year treatment). The number of visits during that period made no difference to the fee. For a large number of specifically-listed diagnostic and therapeutic activities (‘verrichtingen’ in Dutch), there was an FFS system for both public and private insurance. In many cases, the fee for the same service was higher for privately-insured patients than for publicly-insured patients. There was no fee for medical specialists for admission of patients to the hospital, but there might be a fee for every day that the patient had to stay in hospital. This depended upon whether separate services were performed. If that was the case, the fee for the services formed the remuneration for the specialist. If no services were performed, the specialist got a fee for each day the patient was in hospital. This system was used for public and private

\(^{45}\) These costs were reimbursed by the insurance company in as far as they exceeded the deductible.
insurance alike, but the tariffs per service and per patient day differed. For publicly-insured patients, a tariff for day-treatment existed. For privately-insured patients, there was no tariff for day-treatment as such, though, naturally, when a specialist performed services during day-treatment, these services were paid for.

Before the experiment, there was a budget system for hospitals which was maintained during and after the experiment. This was very relevant for analysing the effect of changes in the payment system for specialists, because the different incentives for specialists also had consequences for the hospital budget. The hospital budget consists of location costs, fixed costs, semi-fixed costs and variable costs (see Table 3.2). Location costs are infrastructure costs. The fixed costs can be considered costs of availability, i.e. the hospital has to be there just like the fire brigade. These depend on the number of inhabitants in the region served by the hospital and do not vary with the volume of production. Semi-fixed costs depend not upon actual production of the hospital but upon capacity (e.g. the number of beds). The variable part depends upon production-arrangements with the health insurer. The production of the hospital is measured in first visits of patients with a new complaint to the outpatient department, clinical admissions, day-treatments, patient-days and top clinical services. The arrangements that are made with the insurer about the number of visits, admissions etc. are for a large part influenced by the production in the preceding year. So, while there is a budget for the hospital, this is influenced by the actual production over time.

During the experiment, in a number of cases, specialists were stimulated to substitute day-treatment for clinical admission in order to increase economical use. This meant a decrease for the hospital budget since the day-treatment fee was lower than the admission fee for the hospital. This was disagreeable to the hospital management, since the decrease of the budget was according to them larger than the decrease of the costs, at least in the short run.

46 The latter are, for example, dialysis and open-heart-surgery. Special arrangements were made about these special services.
Table 3.2 Hospital budgeting system before and during the experiment

<table>
<thead>
<tr>
<th>cost categories</th>
<th>cost basis</th>
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<tbody>
<tr>
<td>location costs</td>
<td>infrastructure</td>
</tr>
<tr>
<td>fixed costs</td>
<td>availability (number of people served by the hospital)</td>
</tr>
<tr>
<td>semi-fixed costs</td>
<td>capacity</td>
</tr>
<tr>
<td>variable costs</td>
<td>production-arrangements (first visits, clinical admissions, day-treatments, patient-days, top clinical services)</td>
</tr>
</tbody>
</table>

The sickness funds that administered the public health insurance scheme ZFW, and had to finance the specialist and hospital costs for their enrolees, were budgeted as well. The budget for the health insurer was based upon the number of insured persons and some of their characteristics, like age and sex. However, at the start of the experiment, the role of the budgeting system was still small, since the financial risk for individual sickness funds was low. It was kept low by largely redistributing differences between the budget and actual expenditures over sickness funds and by adjusting the total budget afterwards. It was the intention to gradually increase the risks for the sickness funds as the budgeting system became more refined. So, at the start of the experiment, the sickness funds could expect that their financial interest in cost containment would increase. At the end of the experiment, in 1997, the financial risk for insurers for the variable part of hospital costs had increased.\(^{47}\)

### 3.2 Problems of the organisation before the experiment

As described in the former section, the government was striving for cost control in health care from the second half of the 1980s onwards. This also concerned the costs of specialist care, over which there had been disagreement for many years by the start of the experiment. However, the government did not have a mechanism at its disposal to control these costs. The development of the costs depended upon patient demand and the reaction of specialists to this demand. The specialists had professional autonomy to decide on the treatment of patients and on the number of services they were going to perform. This number of

\(^{47}\) The percentages for redistribution and adjustment had been decreased from 95 and 90, respectively, at the start of the budgeting system in 1991, to 30 and 25 in 1997 for the variable hospital costs. See Jaaroverzicht Zorg 1998.
services largely determined their income on the micro-level. At the macro-level, all individual decisions together determined the total cost of specialist care. As described in Chapter 2, utility maximising specialists can be expected to base their decisions on the effect on both their patient’s interest and their own income and leisure, and possible other personal goals. Macroeconomic considerations did not really play a role in the decision-making process.

In 1989, the parties tried to solve the problem with the cost of specialist care by entering into an arrangement. This was between five relevant parties (the Vijf partijen Akkoord: VPA) and concerned, amongst other things, the introduction of a macro-budget for specialist care. However, this arrangement did not offer the hoped-for solution. Costs turned out to be higher than the budget, which led to fee reductions in the following year (as arranged), which in turn led to an increase in the number of services and costs in excess of the budget again. None of the parties were content with this situation. The relation between the medical specialists and the government was steadily getting worse and the specialists were becoming more and more fed up with being accused (or so they felt in any case) of being too money-conscious. After the failure of the VPA in 1993, a committee was installed to consider possible solutions for specialist care. This was the Committee for the Modernisation of Curative Care ('commissie Biesheuvel', which saw the solution in a closer relationship between specialist and hospital: for example, by making the specialists employees of the hospital.

3.3 Origin of the experiment

In the light of the developments described above, there was a feeling in several places in the Netherlands that something new would have to tried in specialist health care and that it was best to discuss this locally or regionally and not at the national level. Early in 1993, local consultations were started in several regions between specialists, the health insurer(s) and the hospital management. The intention was to find a new solution for the volume and price of specialist care. The specialists hoped that this would put a stop to the financial discussions and disagreements, that an acceptable consensus could be reached about their income, and that they would then be able to concentrate upon the medical side of

48 The five parties were organisations of the medical specialists (LSV), hospitals (NZr, Nationale Ziekenhuisraad) and health insurers (VNZ, KLOZ and KPZ).
their work. For the hospital management, it was important that the incentives for specialists would become more coordinated with the interest of the hospital. Under the hospital budgeting system, the financial considerations for the hospital were quite different from those of the specialists. The health insurers were interested in efficiency, cost containment and the accessibility of specialist health care.

The content of the local consultations differed between the regions, but a common element was that everywhere the parties wanted to end the dependence of the specialists’ income on the number of performed services. Many felt that the FFS system was a disincentive to efficiency, since more efficient treatment could decrease the income of the specialist. For example, specialists felt that some of the services they performed could be more appropriately performed in the primary care sector. However, in the old system this would mean a decrease of the income of the specialist. In the regions that eventually took part in the experiment, the self-employed status of the specialists was not under discussion. Another common element was that there would still have to be some relationship between the income of the specialists and their effort. But this effort should no longer be measured in terms of the services performed. In regions where coordination of interests between the hospital and the specialists was considered important, the proposal was to use the production parameters of the hospital budgeting system to measure the production of the specialists. This meant that their production would be expressed in first visits of patients with a new complaint to the outpatient department, clinical admissions and day-treatments. In other regions, it was considered important that production should be expressed in parameters that could not be directly influenced by the specialist. In those cases, the proposal was to use only the number of first visits of patients with a new complaint to the outpatient department as the production parameter. It was believed that the specialists could only influence this parameter by delivering high quality care. That would be an incentive for the GP to send them patients. In all regions, the plan was to make production agreements for the upcoming year. That would determine the specialist budget which would not be adjusted during the year.49 The realised production could, however, influence the

49 In one region, the possibility of adjustment during the year was kept open, see Chapter 4.
budget for the following year. The details of the agreements in the experimenting regions are described in Chapter 4 next.

The Ministry of Health was in favour of these local initiatives and wanted to stimulate as well as study them. It asked the Zfr to create a platform that would supervise and facilitate a number of local initiatives in the form of an experiment. Local projects that fulfilled a number of conditions could take part in this experiment which would be the subject of an evaluation study. The conditions were the following:

1. the initiative had to include incentives for suitable use of care;
2. there should be safeguards against referring patients to a private clinic or a non-experimenting hospital purely for financial reasons;
3. the old FFS payment system should keep functioning even though specialist incomes were no longer determined by it;
4. the initiative should be realised within the ‘acceptable financial level 1994’.

To make sure that there would be no financially-motivated referrals of patients, all gate-specialities in the hospital had to take part in the experiment and the experiment had to concern all patients of the participating hospitals. There were several reasons to maintain the FFS system in sending out the bills. First, this would make it possible to return to the old system after the experiment. Second, no laws would have to be changed to carry out the experiment. And third, it was important to have some insight into the number of services performed during the experiment for the evaluation of the experiment.

In October 1993, local initiatives who wanted to take part in the experiment were asked to come forward. Originally, eleven projects showed an interest; ultimately, five of these participated in the experiment. These remaining projects did, however, have a problem with the condition that they should stay within the acceptable financial level of 1994. This was because the acceptable level included the tariff cuts that took place in 1993 and in April 1994. The specialists in the local projects did have two advantages over non-experimenting specialists: they would not be faced with future tariff cuts if the costs of specialist

50 The others did not meet the requirements or decided not to take part in the experiment.
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care exceeded the macro-budget again, and they would be exempted from the remaining financial repercussions of the 1992 budget-excess. However, the five projects were not satisfied with the financial level. The Ministry of Health offered the five projects a subsidy, of 15 million guilders in total, to take part in the project. This brought the total budget for specialist care to 266.5 million guilders. Though this was still less than the projects had asked for, in the end they accepted this offer.

The five local projects that took part in the experiment all participated in the evaluation study. This does not mean that all hospitals in the five projects were studied. Within the projects, in a number of cases, there was a further selection of hospitals to include in the study. This process is described in Section 4.2.2. The Project ‘Noord-Holland Noord’ (Tijd voor Vernieuwing (Time for renewal), TVV agreement) was a project in the region to the north of Amsterdam that consisted of two hospitals at the start of the experiment. One of the two was included in the study: Medisch Centrum Alkmaar (MCA) in Alkmaar. The project ‘Ziekenhuis Lievensberg’ is a project revolving around one hospital located in Bergen op Zoom (in the south of the Netherlands, not far from Antwerp). The project ‘Schepenziekenhuis Emmen’ also includes one hospital that is located in the north (near the German border). The Regionaal project Rijnmond (TPR agreement) consists of 13 hospitals in Rotterdam and its environs, two of which were included in the study: the St. Clara Ziekenhuis in Rotterdam and the IJssellandziekenhuis in Capelle aan den IJssel. The Regional project ‘Ziekenhuizen Noord-Limburg’ ('Experiment Care renewal') concerns one hospital on two locations in the most southern part of the Netherlands. One of these locations participated in the study: the st. Maartens Gasthuis in Venlo.

51 The reason why the spelling of st. Maartens begins with a small ‘s’ and that of St. Clara with a capital ‘S’ is because these are the official forms of these hospitals’ names.
Figure 3.2, Hospitals in the experiment