Paying the medical specialist: the eternal puzzle : experiments in the Netherlands
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Appendix 4.1 Financial arrangements in the five different projects

Project 'Noord-Holland Noord'

Background of the project

The experiment with the payment system for specialists was initiated by the medical staff of the Medisch Centrum Alkmaar. The basis for the experiment was laid during the Lenzerheide-conference of March 1993. At the conference, specialists, the management of the hospital and health insurer Univé discussed ways to solve the problems with payment of specialists in the Netherlands. As a result of this conference the working party 'Verkenningen' (Explorations) was established. This working party produced two reports with essentially three concrete proposals:

- while awaiting a new payment system specialists would not be remunerated on a FFS basis, but on the basis of just three production parameters: first visits to the outpatient department, day surgery and admissions to the hospital;
- specialists would organise themselves better to cooperate more efficiently and to ensure their continued status as a contract party;
- a far-reaching integration between hospital and specialists would be created.

After a period of intensive discussion and consultation, the final framework agreement was signed by medical specialists, the management of the MCA and the Gemini ziekenhuis in Den Helder and health insurer Univé on 23 December 1994. This agreement was called 'Tijd voor Vernieuwing' (TVV, time for renewal). The agreement was valid for a period of three years starting 1 January 1995.

159 The Westfries Gasthuis in Hoorn later on joined these parties, but was not entitled to a subsidy from the Zfr (the supervisory body of Dutch Public Health Insurers).
Financial aspects

The base-year for the external financial framework was 1993. Determination of the internal starting budget of a partnership of specialists took place on the basis of 1992 revenues (expressed in tariffs of that year). In 1995, every partnership received the volume of specialist care of 1992, expressed in tariffs of 1992, as a fixed budget.\(^{160}\)

For later years, the (internal) budgets were adjusted to:

- the CBS consumer price-index;
- tariff-measures of the government from which the ESH-projects were not exempted;
- the FOZ growth-percentage;
- the production of the partnerships in as far as a certain threshold was crossed.

The budget of a partnership was changed when the production in a certain year had increased or decreased more than 10% compared with that in 1994. The budget in the following year was then adjusted by the percentage change, in as far as it exceeded 10% (in absolute terms). Thus, a notable element of this system was the comparison of production of all years to the 1994 level. The partnership budgets were fixed to a large degree, since only large increases or decreases in production were translated into changes in the budgets.

In the end, the system was only used to determine the budget for 1995. After that, it was decided to harmonise the incomes of medical specialists of different disciplines, and the above-described adjustment system was no longer needed.

Before the income harmonisation, it was felt that there were unfair income differences between specialties, and that these differences would hinder effective cooperation between different partnerships. It was expected that harmonisation would give more possibilities to refer patients from one partnership to another, and that harmonisation would make it possible to promote efficiency and innovation of care. It is interesting that it was felt that the abolition of the FFS system was not sufficient to promote efficiency, even though

\(^{160}\) Unless 1992 was clearly a special year. In that case the 'Trendbreukcommissie' adjusted the budget.
the determination of revenues within a partnership had changed drastically. It was the experience of the specialists in Alkmaar that only complete harmonisation between partnerships would make the desired cooperation possible.

The chosen production parameters (used before the income harmonisation) were in accordance with the FB-system of the hospital. For gate- and non-gate specialities there were somewhat different production parameters (see Table A4.1.1). The weights of the different parameters were based upon research into the amount of time each discipline spends on each of the production parameters. The weights for the different projects are given in appendix 4/2.

Table A4.1.1 Production parameters used

<table>
<thead>
<tr>
<th></th>
<th>gate spec.</th>
<th>non-gate spec.</th>
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<tbody>
<tr>
<td>number of admissions</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>number of day-treatments</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>number of first visits to the outpatient department</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>number of new clinical patients</td>
<td>-</td>
<td>x</td>
</tr>
</tbody>
</table>

x = used.
- = not used.

For the partnerships that had ‘vacancies’ at the start of the experiment, a slightly different adjustment system was used. From the moment the ‘vacancy’ was filled, the budget was increased by half the average fee of a full-time member of the partnership, taking into account the remaining part of the year.\(^{163}\)

\(^{161}\) According to the 1994 definitions of the COTG.
\(^{162}\) Following definitions determined by the Steering Committee of TVV.
\(^{163}\) The budget was further adjusted to the change in production under certain conditions. The growth of production in the year preceding the extension was compared with the production in the extension year. If the production in the extension year was larger than the increase of the budget by half of the average fee, the budget was adjusted. It was agreed that, after consultations between the three parties, these rules would be applied to partnerships who wanted an extension during the experiment.
Ziekenhuis Lievensberg in Bergen op Zoom

Background of the project

In 1993, the management and the staff of Ziekenhuis Lievensberg took the first steps to install a new payment system. Influenced by national developments – the termination of the ‘Vijf Partijen Accoord’ (VPA: the Five Parties Agreement) and the resulting problems with the payment system – the two parties and health insurer VGZ signed a declaration of intent. In this declaration, they expressed their wish to solve together their problems with the payment system for specialist care, the control of the volume and the improvement of efficiency and quality of specialist care.

Important elements of this declaration were the aspiration to develop a new payment system in which incomes of specialists would not be based upon an FFS system, while at the same time wishing to find a payment system that does justice to the efforts of specialists. After intensive and frequent consultations, this declaration was elaborated into a model for a new payment system. During this phase, health insurer OZ Breda, ZN and KPZ joined the talks about the proposal. In the middle of 1994, the proposal was accepted by the Zfr as part of the experiment concerning payment for specialist care.

At the beginning of 1995 the contracts were signed and the final approval of the Zfr and the COTG was received. The start of the project was backdated to 1 January 1995. It was also agreed that before 1 April 1998, the three parties would enter into consultations about the continuation of the agreement.

In the interest of the project, the medical specialists united in the ‘Coöperatieve Vereniging Vrij Gevestigde Medische Specialisten u.a. (CV: the Cooperative Society of Self-employed Medical Specialists). This society was established because some specialists were employees of the hospital. Moreover, in working out the details of the project the participants felt the need to have a separate legal entity.

Financial aspects

Besides agreements about the structure of the project, the three parties established a number of financial agreements, though they realised that: “it
Financial arrangements

concerns an experiment and, in a number of respects, difficult subject matter, so the present agreement does not offer an exhaustive settlement and so supplementing and/or changing this agreement may turn out to be necessary to which parties will give their cooperation considering the spirit in which parties enter into this agreement” (translation from ‘Overeenkomst Stichting Ziekenhuiszorg Lievensberg in een nieuw perspectief 1995’). The main points of agreement were the amount of the budget for 1995 and the way in which it would be adjusted in the following years.

The year 1992 was chosen as a base-year for the external budget. The starting budget per partnership was determined by sharing the total external budget for specialist care in 1995 over the partnerships on the basis of the 1994 revenues, with a division of the surplus per head. The surplus was the available budget for 1995 minus the revenues for 1994. The subsidy of the Zfr was part of the starting budget of the partnerships.

To determine the change in the budget of a partnership for the following years a parameter was defined, which was, in principle, based upon the number of new patients. The value of this parameter differed among partnerships. It was calculated at the start of the experiment by dividing the partnership budget for 1995 by the number of units of the parameter in 1994. The parameter was based upon the front-door principle: the remuneration of specialists was determined by the number of patients who came to the front door of the hospital and did not depend upon the intensity of treatment the patients received. The ‘first visit to the outpatient department’ was chosen as the relevant concept, since it was seen as the most pure expression of the demand of patients for specialist- and hospital care. Since the definition of the first visit to the outpatient department is ambiguous, it was agreed to define the number of first visits as the ‘number of short and year cards’ (for publicly-insured patients) and the ‘number of first visits to the outpatient department’ (for privately-insured patients) on the level of the partnership.
The value of the parameter for a partnership did not change during the experiment, except for a trend adjustment and a change in definition which was destined to be budgetary neutral.\textsuperscript{164}

For the budgets of radiology, microbiology and anaesthesia, separate arrangements were made. After all, these disciplines almost exclusively carry out the requests of other disciplines. Therefore there are hardly any patients who make first visits to specialists in these disciplines.\textsuperscript{165}

The budget in 1996 was the parameter-value times the production-agreement for the number of new patients. So, when the number of first visits to the outpatient department changed, the partnership budget changed but only within certain limits. The internal agreement was that each partnership budget could change no more than 5\% (increase or decrease, excluding the trend-adjustment of the parameter). This meant that the change of the total budget was also within the bandwidth of 5\%. An exception to this could only be made for important reasons and after consultation. The total budget for specialist care for 1996 (and the following years) was the sum of the individual partnership budgets.

So, in Bergen op Zoom, there was a direct relation between changes in production-agreements and changes in partnership budgets. Specialists were directly rewarded for helping more patients, as long as the increase did not exceed 5\%.

The CV played a role in implementing these agreements: it centrally administrated the services that were billed by the specialists. This was necessary since the specialists (as described above) continued to bill according to the

\textsuperscript{164} The trend adjustment was the annual adjustment to the development of wages and prices as used by the COTG for the tariffs of specialist care. The aforementioned change in definition of the parameter concerned the introduction of a ‘year card’ for privately-insured patients in order to be able to count private patients in the same unit as public patients.

\textsuperscript{165} For radiologists, the parameter was based upon the system of the ‘Nederlandse Vereniging voor Radiodiagnostiek (Dutch Society for Radiodiagnostics). For the microbiologists, the system used in this discipline was chosen. For anaesthetists, the parameter was based upon the part of their activities that concerns pain relief and intensive care- and operating-room- activities. For this discipline there was also a safety-net: if the parameter of the surgical disciplines were to remain unchanged or increase and the parameter of anaesthesia to decrease, the budget of the anaesthetists would be adjusted.
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existing FFS system. Apart from that the administration of the CV was the basis for calculating the partnership budgets and the total budget in the years after the start-year.

**Scheperziekenhuis Emmen**

**Background of the project**

At the beginning of 1993, the medical staff of the Scheperziekenhuis Emmen took the initiative to explore the possibilities of an alternative payment system. Health insurer OLM/Het Groene Land and the management of the hospital also saw advantages in a regional approach and solution for the national problems with the payment system.

Moreover, the reduction in the number of beds caused an increasing shortage of hospital beds in the Scheperziekenhuis according to the management. Assuming that the FFS system does not stimulate efficiency, the hospital wanted to introduce an alternative system that would encourage a more efficient use of the available capacity. The medical specialists and the health insurer also felt that the payment system in use hindered the desired developments. On 20 October 1993, the ‘Stichting (Foundation) het Scheperziekenhuis in Emmen’, the Medical Staff of the Scheperziekenhuis on behalf of all self-employed specialists, the health insurers OLM/ Het Groene Land and KLOZ and KPZ signed a declaration of intent to realise a local initiative. Their mutual interest in a local initiative was described as keeping in balance the quality, the volume and the cost of patient care in the region.

In April 1994, the Ministry made financial support available for the ‘Experiment Emmen’. In the end, the initiative started on 1 January 1995, and was meant to last for a period of three years. All self-employed specialists participated in the experiment. In an agreement among the three parties it was stated that they aimed at cooperation with primary care and the patient-platform.

The essence of the experiment in Emmen was an alternative payment structure that would fit in better with hospital budgeting and in which changes in medical treatment would have no negative consequences for the budget of partnerships or of the hospital. The hospital aimed to be able to treat and admit more patients from the area that was dependent upon the care of the Scheperziekenhuis.
The consequences of changes in treatment for the hospital budget depend upon the FB-system, and the compensation for different elements within this system. Generally speaking, hospitals see the financial consequences of substitution of clinical admission of patients by day-treatment for their budget as unfavourable, since they are of the opinion that the compensation for day-treatment is relatively low in the FB-system. In the case of Emmen, one respondent stated that the hospital and the insurer had come to an agreement about a favourable tariff for the hospital for day-treatment. Such an arrangement was called a ‘grey’ production agreement between the management of the hospital and the insurer. On the one hand, the FB-system was used in a way that was not intended by its designers. On the other hand, it was clear that the FB-system could hinder the experiment, if it could not be used in a somewhat flexible way. So, more efficient treatment of patients by specialists did not automatically ensure that the hospital would have a favourable outcome for its budget, but the hospital could negotiate with the health insurer about this point.

The goal of the experiment in Emmen was to see whether the alternative payment system would have a favourable influence on the efficiency of care (with constant quality) and on the costs of the hospital and the costs of specialist care. Apart from that, the initiative would possibly give rise to a better alignment of the interests of the hospital and the specialists, the transparency and stability of the payment of specialists would be improved, and the shared responsibility of the three parties for the provision of care in the region would increase.

**Financial aspects**

The Experiment Emmen chose 1993 as a base-year for the external budget. The point of departure for the determination of the internal starting budgets were the revenues per partnership in 1989. These revenues were adjusted to: the development in revenues 1989-1992; the tariff-adjustment of 1 April 1993 of -12%; the number of extra specialists that was formally agreed; and possibly to the specific circumstances of a partnership.

To determine to change in the budget of a partnership in the years after the start-year, the budget was divided into three elements:

- a fixed element based upon the formally approved number of specialists (40%);
- a half-fixed element based upon the adherence of (i.e. number of patients served by) the hospital (30%);
- a variable element based upon production (30%).

The fixed element was adjusted to the wage-index of the FOZ, and to the approved number of specialists.

The variable element for the gate-disciplines was determined by the number of patient-units (see Table A4.1.2). The chosen parameters largely corresponded to the parameters in the FB-system of the hospital.

Table A4.1.2 Definition of production in the Scheperziekenhuis for gate-disciplines

<table>
<thead>
<tr>
<th>production parameters</th>
<th>internists.</th>
<th>other gate spec.</th>
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<tbody>
<tr>
<td>number of admissions</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>number of day-treatments</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>number of first visits to the outpatient department</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>number of repeat visits to the outpatient department</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>number of consultations for colleagues</td>
<td>x</td>
<td>-</td>
</tr>
</tbody>
</table>

x = used.
- = not used.

The number of first visits to the outpatient department was defined by adding up the number of short cards and year cards and the number of first visits of private patients. For every discipline, weights that expressed the workload were determined for these patient-units. In this way the production of a partnership was expressed in workload-units. In October of each year, arrangements were made with each partnership about the production for the next year. These arrangements determined the variable component of the budget in the next year. The workload-unit was indexed yearly.

For radio diagnostics and anaesthesiology (non-gate disciplines), changes in the production of gate-disciplines were included in the calculation of their budgets, using weights.

In summary, the agreed payment system, on the one hand, took into account changes in the volume of care (through the production-agreements), but, on the other hand, made the revenues of specialists less variable than in the old system.
For situations in which the external budget together with the subsidy of the Zfr would not be sufficient to cover the sum of the internal partnership budgets, the agreement was that the three parties would jointly try to find a solution.

**Regional project Rijnmond**

**Background of the project**

The expiration of the VPA and the following stalemate motivated the concerned parties (hospital, medical staff and health insurers) in the Rijnmond region to enter into consultations on a regional level, about, among other things cost containment, the quality and the volume of care. In mid-1993, the regional consultations resulted at first in a joint declaration of intent, a ‘memorandum’, between the former regional sickness fund in Rotterdam\(^{166}\) and the specialists in the region Rijnmond. Following that, the hospitals and other insurers joined in the talks. The participating parties were:

- stichting Samenwerkende Rijnmond Ziekenhuizen (SRZ: Foundation of Hospitals Working together in the Rijnmond);
- vereniging Specialistenbureau Rijnmond (VSR: Association Bureau of Medical Specialists Rijnmond);
- the health insurers Zilveren Kruis Rijnmond, Onderlinge Zorgverzekeringen, Zorgverzekeraar DSW, Zorgverzekeraar Trias and the ZN.

A Steering Committee was established for the implementation of the memorandum, consisting of representatives of the three parties. In the end, this resulted in the ‘Tripartiete Perspectief Rijnmond’ (TPR: Tripartite Perspective Rijnmond). A framework-agreement was formulated, which was signed at the end of February 1995 by representatives of the three parties, as well as by the individual boards of directors, specialists and insurers.

The initiative started on 1 April 1995, retrospective from 1 January 1995, and ran for a period of three years.

With the TPR, the parties initially intended to develop a fundamentally different payment system that would offer medical specialists a guaranteed income and

\(^{166}\) Before the sickness funds competed, each fund could only operate in its own region.
that could end discussions about specialist incomes. Also, it was meant to contribute to a lasting promotion of efficiency and of cost containment of specialist care and hospital care, and to harmonisation of targets (so that the incentives for hospital and specialists would be the same), and to a better cooperation of specialists with the hospital and the health insurer.

Secondly, the TPR was meant to give an important extra impulse on a regional level to innovation of the contents of care and to quality-improvement. These goals were meant to be reached by (among other things) participation of specialists in the management of the hospital, by developing care that transcends the walls of the hospital (transmural care), by offering support to the primary care sector, by developing new relationships for cooperation among different care providers, by drawing up protocols for research and treatment and by reaching an agreement about quality. Before the start of the experiment, it was explicitly the intention to engage GPs and patient-organisations in the initiative. During the preparation for the experiment, there had been informal contact with the regional patient-platform a number of times. These goals (participation of GPs and patient-organisations) were planned to be introduced in stages.

Financial aspects

The COTG determined the external budget for the experiment at the level of individual hospitals. But the project was working with one external regional experiment-lump sum that was based on the sum of the (by the COTG determined) budgets of the partnerships, supplemented with the subsidy of the Zfr. The base-year was 1994.

The TPR calculated an internal regional lump sum for the experiment. This internal sum consisted of the calculated budgets of the partnerships based upon the volume of 1992, expressed in tariffs of 1 April 1994. When the COTG had determined the final partnership budgets for 1994, it turned out that the internal lumpsum exceeded the total external lumpsum. Adding the subsidy of the Zfr was not sufficient to cover the shortfall. Therefore, all partnership budgets were reduced.

In some cases, the choice of the base-year 1992 (for determining the partnership budget in the start-year) was unfavourable for a partnership. If this was based upon developments that could not be influenced by the partnership or the
hospital, the partnership could appeal to a hardship clause. After consultation with, and permission of, the Steering Committee, the revenues of 1994 could be chosen as a basis.

The following system was used for adjusting the partnership budgets in the second and third year of the experiment. The budget of a year consisted of three components:

- a fixed component (25%);
- a partly-fixed component based upon adherence (the number of people served by the hospital) (25%);
- a variable component based upon annual production-agreements (50%).

To realise harmonisation of targets between specialists and hospital, the definition of the variable component was geared to the FB-system of the hospital. The parameters determining this component were:

- the number of first visits to the outpatient department;
- the number of day-treatments;
- the number of admissions;
- the number of patient-days.

The Steering Committee added weight factors, which expressed the workload, to the parameters, as suggested by the specialists. For example, the weights for a visit to the outpatient department differed among the disciplines in the Rijnmond. But for all physicians of the same discipline, there was a uniform weight for the whole region. The weights were valid for the entire period of the experiment. Later on, it turned out that the intended harmonisation between specialists and hospital was not realised, because of differences in the weights between the hospital and the specialists, especially for day-treatment.

The adjustment of the partnership budget to the variable component (the development of production) took place on the basis of agreed production-growth. So, the production-agreement for a coming year was compared with the production-agreement of the present or an earlier year, and not compared with realised production. It was, however, possible to use realised production-changes as an argument in determining the new production-agreements during the annual consultations.
The 50% share of the variable component meant that the production of a partnership could at the most grow by twice the FOZ-growth rate as long as it had to stay within the external constraints. After all, only half of the growth of production (-agreements) was translated into growth of the partnership budget. Furthermore, the partnership budgets were adjusted annually on the basis of the wage- and price-index that the COTG used for specialist care.

The variable production-component of the non-gate disciplines was linked to the production-components of the most relevant gate-disciplines in the hospital. For top-clinical functions, like dialysis or heart surgery, the government determined separate growth percentages. Therefore separate production-agreements were made for these functions.

The regional element was of special importance to the project in the Rijnmond. A hospital could agree to a production-growth rate that made the growth of the partnership budgets together exceed the FOZ-norm. In such cases, arrangements had to be made with the specialists on the level of the hospital to pay for this ‘extra’ growth by creating efficiency-gains within the hospital budget.

There was an ‘escape-clause’ from the experiment for the participants if national measures had to be enforced or if extreme unforeseen developments were to arise in the volume or the budget for the region. This concerned ‘major infringements from the outside’. Arrangements for income harmonisation between specialities were not among the accepted reasons to leave the experiment. The project offered the possibility to adjust the indexing of the budgets of the different disciplines in order to decrease income-differences. This possibility was not used, however.

As mentioned, it was intended that specialists would make an active contribution to not directly patient-related activities, and they would receive payment for these activities. The money would be raised tripartite and deposited in an efficiency and innovation fund. It was considered essential for a lasting participation in the initiative that any savings resulting from the initiative would benefit the participants.
Regional project ‘Ziekenhuizen Noord-Limburg’

Background of the project

In 1989/1990 a new Board of Directors began work in the hospitals in Venlo/Venray. They initiated a process of change. It was recognised that closer cooperation between medical specialists and the hospital-organisation was a condition for satisfactorily reacting to the developments in health care. In order to realise such closer cooperation, projects were launched to promote the management-participation of specialists. The developments concerning the alternative payment system fitted in well with these ideas. In 1992 the first tripartite consultations took place in Noord-Limburg. These resulted in the ‘Experiment Zorgvernieuwing’ (Experiment innovation of care).

The parties in this initiative were the ‘Stichting Ziekenhuizen Noord-Limburg’, the health insurer VGZ, (the former) KLOZ and KPZ, and the management of the medical staff of the ‘Stichting Ziekenhuizen Noord-Limburg’.

In March 1995, the specialists, the hospital and the insurers agreed on the broad outlines and conditions of an agreement. The alternative payment system for specialists was introduced retroactively on 1 January 1995. The initiative was supposed to run for four years; after three years the effects of the project would be evaluated and a decision would be made about continuation of the project.

The essence of the ‘Experiment innovation of care’ consisted of a number of measures that gave the specialists peace of mind about their income and therefore created more leeway for innovation of care. The experiment encouraged the development of an integrated medical organisation. The parties expected that a number of goals could be realised by the introduction of the new payment system. These goals were controlling the cost development in health care, offering optimal care to patients, reducing existing waiting lists, and developing an optimal quality and efficiency of care. The removal of the conflict of interest between the hospital budget and the payment of specialists was another target of the ‘Experiment innovation of care’.

An organisation in which the management and the specialists no longer operated independently. The Dutch Minister of Health Care compared this to a good marriage: both partners are working together harmoniously and neither party is dominant.
Financial aspects

The base-year for the external budget (as determined by the COTG) was 1992. The revenues of 1989 were the basis for determining the internal budget per partnership. These revenues were updated to the year 1994 by applying a 12% increase and a number of other adjustments (among other things, adjustment to an increase in the approved number of specialists). To calculate the level for the start-year 1995, the wage- and price-rises for that year were applied. As mentioned before, there was a deficit in the first year that was later cleared. For the period as a whole, the partnership budgets had to fit within the external financial framework of COTG-budgets and subsidy from the Zfr. It was arranged that partnership budgets would only increase under exceptional circumstances (through adjustment during the budget year, see below), and that the FOZ-norm growth would be used to close the deficit.

The production was exclusively defined in terms of new patients, despite the fact that harmonisation between the hospital budget and the payment of specialists was one of the goals. However, the project had found another way to safeguard the financial position of the hospital. It was agreed with the health insurer that changes in specialist treatment would not influence the hospital budget. This was another case of a ‘grey’ production agreement between the management of the hospital and the insurer (as was the case in Emmen).

A tariff per new patient was calculated to adjust the partnership budgets in the years after the start of the experiment. The concept of a ‘new patient’ was operationalised by adding up short cards, year cards, repeat-year cards, first visits of private patients and clinical cards, with some corrections. The price for a new patient was calculated by dividing the starting budget of a partnership by the production of 1994, expressed as the number of ‘new patient units’. This calculation was carried out for every partnership separately. Therefore the tariff per new patient differed between partnerships.

In the years after the start of the experiment, this tariff was adjusted to the development of wages and prices (as used by the COTG). In principle, the tariff

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168 Partnerships who found this to be unreasonable could appeal to a fairness clause. Decisions about this were taken in tripartite consultation.
was supposed to be adjusted to an increase in the intensity of care by a maximum of 2%. In practice, however, the latter adjustment did not take place.

Towards the end of the year, production-agreements about the number of new patients for the next year were made by the partnerships. However, a higher agreed number of new patients did not automatically mean a higher budget for a partnership. As stated above, at the level of the hospital, the aim was to keep the sum of the budgets constant in order to compensate for the deficit that arose at the start of the experiment. Therefore, the growth of production agreements with the specialists was limited. Therefore, the project did indeed succeed in keeping the total internal budget constant.

The project ‘Experiment innovation of care’ was the only project in which, in principle, adjustment to the budgets during the year was possible. It was agreed that this would only take place when the number of new patients changed by more than 5% (plus or minus). This system was chosen to avoid a discussion about an unlimited obligation of physicians to care for patients. In practice, no use was made of this system. During the year, the developments in production were watched attentively to spot at an early stage discrepancies between the production and the production-agreement.

The adjustment-system described above was used for gate-disciplines. For non-gate-disciplines the existing system was used in the first year.