Dr. M. J. Boereboom
Speech by the director of the Curative Care Directorate, Ministry of Health, Welfare and Sports, 13 December 2004, 11.00-16.00 hrs.

The public hearing on the subject 'Priority Setting in health care in Austria, Denmark, Israel, the Netherlands, Sweden, Switzerland and the United Kingdom'.

I'm glad to be one of your guest speakers on this important topic. My introduction has three elements.

- First I'll tell you something about the expenditure growth we experienced and how we handled this,
- Second, I'll give an overview of the recent measures to curb this increasing growth,
- And I'll finish my introduction by looking ahead.

My main messages will be that the Netherlands moved from macro cost containment measures to more market oriented incentives. And that you can only release budget control after you implement new incentives to reach cost containment. In other words we first need to make *changes within* the system before we can commence a *change of* the system.

First, I want to say something about the expanding growth of the demand in health care.

All countries – and therefore also health care systems – are unique, some people might say. This is only partly true. Though western countries have different historical, cultural and political backgrounds, they share similar demographic, economic and technological trends. They also share a policy of pursuing accessible, high-quality and affordable care.

In all developed (OECD) countries there has been a growth in expenditure on health care over the last decades. The Netherlands are no exception in this.
As you all know, there are two main causes for increasing growth: advances in medical technology and an ageing population.

This growth contributes to the necessity to keep our healthcare systems feasible for new generations. The costs will increase rapidly if such a large proportion of the population demands a large amount of healthcare services. Furthermore: where shall we find all the people that are needed to provide these healthcare services?

The Dutch health care expenditure rose steadily to 8% of GDP in the early 90's and remained rather stable for some years. This is mainly due to our macro cost containment policy. Total health care expenditure and expenditure in specific sectors, for example in hospitals, was subject to global budgets and we used growth norms (1,3% from 1994-1998, 2,3% from 1998). Last but not least the Netherlands have price- and volume regulations.

Vraag 9

Since the "Right to receive care" was announced in November 2001, health care expenditure has been increasing rapidly. While real GDP rose 1.5% in total in 2001 and 2002, the growth in real health care expenditure was over 14% in that period.

This cost explosion was driven by several factors besides the "well-known" factors I mentioned earlier (technology, ageing).

Vraag 1 & 4

Then there was a growing political and public indignation about the existence of waiting lists. Therefore, since 1997 the government provided additional resources to increase the supply of elective surgery.
Both in curative care as in long-term care for the elderly and handicapped this led to extra budgetary claims.

Vraag 6 & 7 & 8

One last but important reason for our strong expenditure growth is the lack of incentives for consumers, insurers and suppliers to be efficient. And when you ease budget control without having new incentives in place, expenditure may easily rise in double digits.

Second, I'd like to come to where we stand today.

Vraag 3 & 6

Last two years, mainly due to international developments, economic growth collapsed. This made a renewed policy interest for cost control urgent, not to say acute. That's why our budget report includes several measures to offset new budget overruns. I'll give an overview of the most important measures we have implemented.

Vraag 2 & 5

1. We proposed general budget cuts with respect to health care providers. This way we assess providers to become more efficient.
2. Two other types of measures are directed towards consumers of health care. With our shift to an orientation on the demand side, it is necessary to underline there's a responsibility for patients as well. Therefore in 2006 we'll introduce €250 deductibles ("own risk") a year.
3. Besides that, the public health care package is limited. We believe that shaping the health care system in not something that the government does on its own. It is a task for the citizens themselves. It is similar to your health, which is not only the responsibility of your doctor, but first and foremost, your own. This changing attitude towards health is visible in the new package. For example: all children are insured for dental care, adults can decide themselves. Another example is simple medication. It's no longer in the standard package, so people can decide themselves want to buy it in a drugstore of they want an extra insurance for it.

vraag 10, 11 & 12

I'll finish my introduction by looking ahead into the near future.

At the moment essential curative care for about two-thirds of the population is financed through a mandatory social insurance scheme. People pay a percentage of wage income plus a nominal premium, up to certain income thresholds. Above these thresholds persons may purchase private health insurance. Private insurers don't have duty of acceptance, so they may apply risk selection. To ensure access to private insurance, a high-risk pool was created with regulated premiums and a standard benefits package.

During this cabinet period we intend to reform the healthcare sector. A change in the insurance system is an indispensable element of the healthcare reform. The reform will consolidate the public and the private health insurers into a single system by 2006. At that moment, there is to be a general insurance provision for essential curative care. This insurance will apply to all residents in the Netherlands. This way we'll establish a social insurance. The insurance will be executed by private entities.

An individual may take out supplementary insurance and may change insurers once a year. Incentives for competition are for example different premiums among insurers or different service levels. When consumers "vote with their feet" they stimulate competition.

For insurers there's a duty of acceptance, so the general insurance will stay accessible for everyone. The insurers are responsible for buying efficient, high quality care to be delivered timely. Furthermore, insurers will bear a greater financial risk in implementing the insurance. This will encourage them to compete with other insurers.

At the moment there are practically no possibilities for selective contracting by social insurers. In the future there will be more scope for new care providers. And an insurer will no longer have the obligation to contract every provider. Providers can compete by tailoring their care as closely as possible to clients' demands and by giving good value for money.

Besides this reform of our insurance system, which has been under debate for 15 years now, we are implementing several changes in the remuneration systems for hospitals and other providers (curative and long term care).
Similar to other countries that implemented Diagnoses Related Groups, the Netherlands move toward activity-based funding. We developed a system of Diagnosis-Treatment-Combinations to stimulate micro-efficiency. This is expected to encourage a higher production and a higher productivity. That way the budgetary challenges could remain limited.

When all these changes are implemented in 2006, the Dutch government can again guarantee more accessible, high-quality and affordable care. A healthcare system witch has less perverse incentives and with clear responsibilities for all parties.

Vraag 13

I hope my introduction gave a clear perception of our *changes within* the system and our *changes of* the system. And that this view trough the Dutch healthcare can contribute to the priority setting in the German healthcare in a way.

Thank you mister Chairman