Health care purchasing

Summary

What exactly is ‘health care purchasing’?

In addition to setting out a standard health insurance package for health care costs, the provisions of the Health Insurance Act (Zvw) also regulate health care purchasing. Health care purchasing is the process that leads to a contract between a health insurer and a health care provider. That contract incorporates agreements about the health care that the provider is required to supply to the health insurer's policyholders for the duration of the contract. That may involve agreements about the amount, type, price and quality of health care. The health insurer offers this package of contracted health care to its policyholders. The insurer does not need to do this, it could instead simply pay the costs detailed on the claims forms submitted by its policyholders and invest no time or effort in the contracting of health care. If it opts for the former course of action, then it is focusing on "sales" (of policies). If it opts for the latter, then its objective is "purchasing" (of health care). This represents a strategic choice for health insurers.

This is an advisory report on purchasing, not sales. Why is the purchasing of health care important? The health service is beset by problems. The quality of health care is inadequate, and the costs of health care are skyrocketing so rapidly that affordability is becoming a problem. These two seemingly separate problems are actually one and the same: the gains (the quality) on the enormous investments being made in the health service are too small. So says the government, so says parliament, and so says the man in the street. If this problem is not quickly resolved, then society's support for such an expensive collective amenity will crumble away.

The concept behind the Health Insurance Act is that competition between health care providers and between health insurers will reduce the scale of this problem. One factor behind this competition is health care purchasing, in particular selective health care purchasing. It would not be overstating the case to

say that selective health care purchasing is an indispensible precondition for the Health Insurance Act. Nor would it be stretching a point to describe selective health care purchasing as a vital mechanism which safeguards three public interests in the health service: quality, accessibility, affordability.

An indispensible precondition? Vital mechanism? On what is this based? On the idea that selective purchasing allows health insurers to compel health care providers to deliver the quality that clients need and demand. At the same time, we assume that policyholders will compel health insurers to purchase that same quality. More to the point, the purchasing process allows health insurers in turn to force (or guide) policyholders in a given direction. It is assumed that quality stands for responsible, safe, customer-friendly, and efficient health care. There is evidence to support this assumption. Health insurers who use selective purchasing do not contract all of the health care that a given health care provider has available, nor do they have contracts with all health care providers. They only sign contracts for that health care provision and with those health care providers for which there is a real need. They make their selections on the basis of quality and efficiency. The idea (and this is also the main concept underpinning the Health Insurance Act) is that purchasers (health insurers) are the representatives of all their policyholders, healthy or otherwise.

Health care purchasing is special yet complex because it involves private parties - health insurers and health care providers, with the patients as prominent spectators - while at the same time having to serve the public interest within the health service. A private procedure in a public arena. Health care purchasing represents an alternative to both market regulation and government intervention.

Why is there a need for an advisory report about health care purchasing?

This Council for Public Health and Health Care advisory report addresses these questions:

1. **What impediments are there?**
2. **How can these be lifted?**
3. **Whose should do it, and how?**

The focus here is on Quality, Integrated Care, and the Client.

The Council's advisory report is intended for the Minister of Health, Welfare and Sport and for the parties in the sector

The Health Insurance Act has now been in effect for two years. It can be concluded that this standard health insurance package works fairly well but that health care purchasing can and must improve. Health insurers do not yet employ genuine selective purchasing. However, there are some hopeful initiatives.

This advisory report is underpinned by two main principles.

1. Health care purchasing can only work if the government and others in the political arena allow the contracting parties sufficient latitude, and if they accept the associated risks. Selective purchasing demands room for manoeuvre at the local level. Yet selective purchasing will have enormous (and essential!) implications for existing health care provision. The authorities in the Hague must be reticent in their responses to the resulting commotion. We must accept that previously sacrosanct rights, such as the right to choose one's own physician, will be abrogated as a result of selective health care purchasing.
2. However attractive a direct exchange relationship between health care consumers and health care producers may be, this is simply not always possible. In a number of situations it is necessary, both in the public interest and in the interest of the individual, to place a third party between consumers and producers. This is the health care purchaser, the health insurer.

Health care purchasing by a third party is necessary if:

- **the health care in question is complex and scarce**
- **and if integrated health care needs to be involved**
- **and if quality and efficiency are inadequate**
- **and if there is substantial variation in the charges for diagnosis/treatment combinations.**

The need for health care purchasing and for a third party is not carved in stone. Successful (read: selective) health care purchasing could eliminate this need entirely. This could make the direct exchange relationship a possibility. But we are not there yet!

Let's take a closer look at the purchasing partners: the contract-

ing parties, health insurers and health care providers, and the patients themselves.

Health insurers: from sale to purchase

Health insurers have two types of policyholders, health care consumers who are healthy, and those who are not. They sell insurance policies to healthy (potential) policyholders at the lowest possible premiums. They purchase care on behalf of care consumers who are their policyholders. These two types of clients have very different interests. One wants low prices, while the other wants good health care. Is it possible for health insurers to satisfy both requirements? Indeed it is, by purchasing health care that is both efficient and of good quality. And it is selective health care purchasing which makes that possible. Selective, that is, for efficiency and quality. Good health care with a low price tag. Everyone's happy.

Selective health care purchasing is dependent on:

1. **The insurance market**
2. **Legislation**
3. **The coalition of health insurers and patients**

But will health insurers actually do this? That is dependent on three factors.

1. Developments in the insurance market

It is reasonable to assume that, in the coming struggle to attract customers, health insurers will mainly have to rely on the exclusivity of the health care that they purchase to distinguish themselves from the competition. They will no longer be able to do so on the basis of price and service alone.

2. Legislation: preconditions and operational latitude

It is already possible for health insurers to employ selective health care purchasing, and to guide their policyholders in a particular direction. Yet the impediments inherent in current legislation act as a brake on this process, and there is too little operational latitude for "genuine" selective health care purchasing, especially with regard to quality and integrated health care.

Impediments to selective health care purchasing:

1. **Partitioning of funding (Health Insurance Act, General Act on Exceptional Medical Expenses, Social Support Act)**

2. **Insufficient quality transparency**
3. **Inadequate diagnosis/treatment combination structure**
4. **"Floating" policy holders**
5. **Central pricing**
6. **Payment and accountability cycle**
7. **Ex post balancing (actual costing)**

3. The coalition of health insurers and patients

A partnership between health insurers and patients (and patient organizations) is an absolute precondition for selective health care purchasing (and for the ability to guide policyholders in a particular direction). The very fact that health insurers have to purchase on behalf of patients means that they are compelled to consult patient organizations in advance. The selective purchasing of efficiency and quality must serve the interests of patients. A failure to do so will result in the evaporation of social acceptance and tenability.

Selective health care purchasing demands major investments on the part of health insurers. Those investments must result in a strategic shift from sales to purchasing. This has a number of implications for the purchasing function. These include professionalization and expansion, placement close to the Board of Directors, leaning to a greater extent in the direction of quality, integration and the clients, as well as a regional orientation. This transition can be assisted by the fact that:

1. guiding policyholders in a given direction is certainly feasible, provided that there is a clear profit involved, and
2. the vertical integration of health insurers and health care providers is certainly a viable way forward.

Health care providers: efficiency and quality

Health care providers will also have to make major investments in the health care purchasing process. They will have to correctly identify the ideal combination of quality and efficiency. If they can do this successfully then they will become an attractive proposition for both patients and health insurers.

Does this ideal combination really exist? Indeed it does, if you assume that quality consists of three specific components:

Quality of health care can be broken down into:

1. **Medical technology and professional aspects**
2. **responsiveness and functionality (for patients)**

3. **The organization: logistics, communication etc. (efficiency)**

Quality therefore equates to organization and efficiency, and it is surprising how often a relationship is found to exist between these two sides of the coin. This is why quality is the central issue behind selective health care purchasing. Selective health care purchasing should incorporate incentives for quality improvements.

Measures to achieve quality transparency:

1. **The Netherlands Health Care Inspectorate draws up minimum quality standards.**
2. **Authorization (content, process, communication) by an independent institute.**
3. **Health insurers and patients formulate a purchasing policy.**
4. **The Netherlands Health Care Inspectorate publishes details of the top and bottom x% of health care providers prior to the start of a purchasing cycle.**
5. **Health insurers do not contract (completely) beneath the minimum quality level (in association with stricter monitoring by the Netherlands Health Care Inspectorate).**

Selective purchasing can have enormous implications for existing health care provision. This could lead to the following situations:

1. The end of the hospital as an integrated, specialist medical company. Many new types of care will develop. Functions and integrated care system will soon be more important than institutions.
2. The combination of selective health care purchasing, quality transparency, and integrated performance pricing results in an accumulation of business risks for intramural care. Providers will replace intramural care with extramural, clinical and outpatient care. In general: a trends towards decentralization.

3 This will result in the creation of genuinely novel opportunities for innovative, wide ranging primary care as a substitute for secondary care.

4 All of which will benefit health care professionals. They will have more opportunities to do justice to their professional responsibilities.

Accordingly, the selective health care purchasing scenario could well result in major improvements to the health service. We should not lose sight of the fact that this will have radical repercussions in terms of the way in which health care is often organized at the moment: in institutions, centralized, intramural, and in echelons. Whatever the outcome, the situation for patients will improve.

Health care consumers: put-upon or principal?
Much has already been said about health care consumers. The heart of the matter: health care purchasing is something that is always done for, on behalf of, or even by consumers. This means that those involved must maintain a clear demarcation of roles:

- Policyholders want low premiums.
- Patients want quality (in the three-pronged sense of the word described above), tailored health care, and value for money.
- The man in the street wants gains, results, and the safeguarding of public interests.

Of these three, patients at the very least should have a say in the purchasing process. Remarkably, in the current situation, patients have the least influence of all those involved in the purchasing market. They have a limited influence on the insurance market and the health care provision market. There are certainly ways and means of influencing health care purchasing. This may involve a policyholders' council, use of the Consumer Quality Index, agreements between health insurers and patients' organizations, and even the partial delegation of purchasing authority. The client-linked budget (CLB) represents an alternative to such health care purchasing models. A CLB gives patients direct purchasing authority. It results in a direct exchange relationship between consumers and producers. In the case of health care purchasing, a third party is involved. Between these two extremes - CLB and health care purchasing - there are all manner of hybrid forms. It is anticipated that a wide range of purchasing formulas will develop within the health service. New intermediaries and third parties will probably also get involved, via the Internet, mediation agencies, case managers, integrated health care directors, the primary health care system, and novel forms of insurance.

All of this, like the above-mentioned developments in care provision, is to the benefit of the health care consumer.

The government: the advisory report

Health care purchasing is the regulation of market forces. It involves contracting, which means that it is governed by private law. Does the government have a part to play in this, and if so, what is it? What recommendations have been made to the Minister of Health, Welfare and Sport?

In short, the advice of the Council for Public Health and Health Care to the Minister was that:

- **Health care purchasing is a private matter. Keep your distance. Allow the contracting parties as much latitude as possible. Otherwise it will be impossible for selective health care purchasing to develop. Latitude and selective health care purchasing will undoubtedly have significant repercussions for care provision. Have faith, and accept the occasional incidents that are part and parcel of a process of this kind.**
- **Specifically: remove existing legal impediments in the areas referred to in this advisory report. Priority: quality transparency.**
- **Be clear when discussing the purpose of the Health Insurance Act, the desirability of selective health care purchasing, and any repercussions that might be involved.**
- **Make use of existing instruments to enhance differentiation and competition in care provision, by fostering substitution, for example. Allow professionals greater latitude to be health care providers.**
- **Agree a schedule for the further expansion of selective health care purchasing with the health insurers, in combination with a programme of deregulation (pricing, expenditure management, capital costs). If required, provide a fast track to the B-segment for those health care providers and their diagnosis/treatment combinations that are ready for the move.**
- **Launch pilot projects at regional level, as a way of experimenting with health care purchasing modalities.**
- **Initiate a parliamentary debate on the repercussions of selective health care purchasing and on dealing with the associated risks. Put forward "The Hague axioms", such as the right to choose one's own physician, as a subject of debate.**