Perspective of Health

20/20*

Report by the Council for Public Health and Health Care
to the Minister of Health, Welfare and Sport

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Crux of this report

The government's role is to createa perspective and the conditions for good, sustainable care properspective, which matches changing care requirements of a changing client population. Efforts to manage costs within the care sector will reflect the government's vision for the sector.

What problems does this care agenda address?

A new lperspective of care is needed if care provision is to remain sustainable under the increasing pressure that will develop over the next ten years. The strategic care agenda set out in this report provides a basis for such a new perspective.

What are the implications for consumers?

The availability, quality and accessibility of appropriate care will remain assured. However, consumers will be expected to do more themselves, to accept more responsibility for their health and lifestyles and, when ill, their treatment. Consumers will be helped to take on responsibility by, for example, providing walk-in centres, ICT facilities and support from their insurers.

What are the implications for care providers?

Care providers will be expected to deliver greater quality, efficiency and transparency. Investments will be expected to yield a better social return, in terms of health and participation. Providers who deliver will be appropriately rewarded, however. Restructuring will create an environment that is more competitive, but also affords greater freedom and more opportunity. After all, the demand for care will continue to grow strongly in the years ahead.

What will it cost?

This report sets out a vision of care that is sustainable and affordable. Sustainable and affordable care implies less rapid growth in care expenditure. At least as important, it implies an environment in which support for collective care and public health can flourish.

What's new?

A shift in emphasis from treating illness to promoting health. An integrated set of tools for restructuring over the next ten years.

Contents

Summary

Dutch Health care is facing huge challenges: increasing and changing demand for care, the growing capabilities of medical science, and major shortages of financial and human resources.

The sector is not currently equal to these challenges, because it is neither directed nor incentivized accordingly.

This report endeavours to translate the challenges facing the sector into a perspective the quality of care defined as a contribution to health and participation, and all actors behaving accordingly. A perspective based on clear and honest transactions. The citizen receives care and in return accepts responsibility for his or her own health. The provider has access to a larger market, but has to deliver quality and efficiency. The government assures solidarity and demand-side purchasing power, while laying down social return criteria. The insurer acts in the public interest as a broker and coach to both the consumer and the provider.

Realization of this perspective implies a busy agenda, easily spanning the lifetime of two administrations. Parameters have to be put in place, then progress monitored and adjustments made as necessary. Parameters for the citizen/care consumer, for the care professional, for the system and for the directional model, always with a view to promoting quality, as expressed in results.

First, however, collaboration has to be organized. Without the collaboration of the sector, consumers and providers, the government will not achieve the restructuring that is required. The creation of a Care Foundation might provide an appropriate forum for discussion.

The agenda referred to in this report requires sufficient substance to get restructuring off the ground. Both on the demand side, i.e. in the attitude of the care

consumer, and on the supply side, i.e. in the day-to-day care provided close to home for minor ailments and the chronic conditions, in hospital care and in long-term care. The main points on the agenda are as follows:

- Pursue health and participation systematically. Invest in health: add prevention to the basic Health Insurance Act entitlement package, require the citizen to be a good patient, get more out of the collective contracts, implement a smoking prevention action plan (adult and youth smoking rates are higher in the Netherlands than almost anywhere else).
- Standardize quality; define quality as an outcome and oblige producers and consumers to commit themselves to its achievement in the shortest possible term. Look to other countries for examples of good practice. Only care that conforms to applicable quality standards should be included in the entitlement package. Supply contracts should never be awarded for nonconforming care, and such should never be provided.
- Efficiency is particularly important in fields affected by personnel shortages. This implies pursuing process improvements and labour-saving innovations and technologies.
- Ensure that restructuring actually occurs. Remove all financial guarantees from the system. Wonderful work is done in the care sector, but there is insufficient incentive for people to work together in the interest of public efficiency. Efficiency incentives are the cornerstones of regulated market mechanisms. Debureaucratization is also important.

In this report, the points outlined above are developed into twenty recommendations; a timetable for action spanning the lifetime of two administrations is also presented. The government can act upon its duty to reorganize immediately: creative economization implies, for example, higher personal contributions (insurance excesses). Priority should be given to quality

standardization. Quality standardization is inherently desirable and a prerequisite for the development of regulated market mechanisms and management of the entitlement package on the basis of substitution, which may be expected to encourage all actors – citizens, insurers and providers – to pursue efficiency.

Furthermore, the complex interrelationships between the various recommendations imply a process that will easily span two parliaments. First, parameters have to be put in place, then measures implemented, after which the rollout and fine-tuning can follow. A sequence that will take ten years.

1 The perspective

Increasing and changing demand for care is a major challenge …

Health care is facing huge challenges, which call into question the sustainability of the existing levels of provision. In the decades ahead, the disease burden and disabilities will increase sharply as a result of double-aging and the prevalence of chronic illness, thus changing the demand for care. People will utilize the growing scope for diagnosis and treatment. Moreover, the way that health care is currently directed and incentivized means that the sector is not equal to these challenges.

… the emphasis of care provision must shift from treating illness to promoting health …

At present, care provision focuses very much on treating illness. Much could be achieved by shifting the emphasis to health promotion. Such a shift does not imply any reduction in the importance attached to treating illness. On the contrary, the objective of realignment would be to assure the continued availability of necessary care on a collective, public basis.

… an effective and obligating vision.

This perspective depends on active citizenship, entailing an obligation to protect one's own health, and the existence of another kind of care provider, which thinks ahead and is involved in coaching self-management. It is up to the government to create the necessary environment.
Inaction is not an option; nor is clumsy intervention. The path from treating illness to promoting health is a long one, but one that must be followed. The characteristics of a sector focused on health promotion would be as follows:

- Quality is defined as contribution to *health and participation* (outcome).
- *All actors* pursue such quality. Government policy is *coherent and addresses all sectors*.
- The *citizen* recognizes and accepts *primary responsibility* for his/her health and behaviour.
- The government *assures solidarity* in the provision of care (access and purchasing power) and formulates *clear entitlements and outcome indicators*.

- The supply side takes a *broad view of health*.

- The insurer acts as *broker and health & participation coach* to secure value for both the client and the supplier.

Agenda items for the new government …

Because of its size, weight and complexity, a strategic care agenda capable of realizing this perspective would require the support of the whole government. For the period ahead, the focus should be on at least the following:

1. *Systematic pursuit of health and participation.*
2. *A set of outcome-oriented quality and transparency standards.*
3. *A push for role redefinition and occupational productivity.*
4. *Getting restructuring under way.*

… to be discussed with the field: joint public-private project

The first step is for the government to discuss its perspective with the care sector and relevant representative organizations. The creation of a Care Foundation could provide a forum for such discussion. The government is soon to make arrangements with the sector regarding the realization of its perspective and agenda. These arrangements are also to address the organization and implementation of this major restructuring exercise. The government is to present the exercise as a joint public-private project, based on mutual interests:

- The government assures the accessibility of care and thus the funding of care provision (purchasing power).
- Quality and efficiency, transparency and accountability are expected of providers. The sector accepts that coherent service provision is inconsistent with seeking to maintain individual providers.
- The citizen remains assured of necessary care, but accepts responsibility for his/her own health and efficient care demand.

Review of health insurers' public role

The health insurer has a pivotal role in the directional model. This role requires review. In the context of the Health Insurance Act and the Healthcare Market Regulation Act, the insurer's role needs to be

more public than it presently is. In other words, in the public interest, insurers should focus more on quality and affordability. Review of the system is neither desirable nor necessary.
The ultimate goal of this government-wide project is improved health and participation. Such a project requires a funding and investment plan.

Detailing

The proposed policy programme is described in more detail in subsequent sections of this report. First, however, we take a brief look into the future (section 2) and into the past (section 3). What challenges lie ahead? What developments have brought us to where we are today? What can we learn from a problem analysis? Thereafter, in sections 4 to 7, we define the agenda that the *20/20 Perspective** should realize in four domains (those of the citizen/care consumer, the care professional, the care delivery system and sectoral direction).

Finally, we outline the route to our defined objective (section 8). To that end, we draw upon feedback received in connection with our discussion document *Zorg voor je gezondheid!* (*Take care of your health!*; April 2010). The latter document has been discussed at length with the care field (care consumers, care providers, their representative organizations and other stakeholders, totalling approximately a thousand people). In that context, considerable approval and enthusiasm was expressed for our ideas, plus some criticism of aspects such as the proposed walk-in facilities and the possibility of premium differentiation on the basis of health and behaviour, which has been taken into account in this report.
In the final section of the report, we outline a possible timetable spanning the lifetime of two administrations: where to begin, when follow-up steps can be taken, what can be done in the lifetime of the current administration and what will need to be done in the period 2015-2020.

* 20/20, originally an expression of visual acuity, has taken on a wider significance in the English-speaking world, where it now implies ‘clear-sighted’ or ‘comprehensive’.

2 The challenge

Four challenges

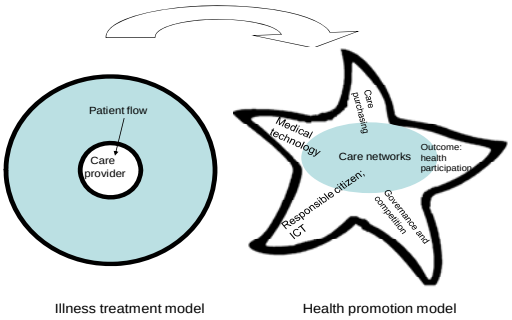
In the years ahead, the care sector will feel the combined force of four challenges:

1. The impact of the economic crisis and sluggish economic growth, which will limit the scope for increasing healthcare expenditure
2. Increasing and, crucially, changing demand for care, which care provision will need to match
3. Rapidly increasing diagnostic, treatment and care capabilities, to which people consider themselves entitled
4. A substantial shortage of care practitioners

Changing drivers and inhibitors

It is the combination of these four challenges and their interaction that are significant. There are two drivers (demand for care and medical capability) and two inhibitors (the crisis and staff shortages). Hence, *growth* and *contraction* will be significant processes, but ultimately the crucial process will be *change.* Medical technology and ICT are influential, autonomous forces within a globalizing, knowledge-driven setting. In that setting, the supply and utilization of information via the internet will be defining mechanisms. In its appearance, the care sector of the period 2010 to 2020 will consequently differ considerably from the sector of 1990 or even 2000. Once an island, health care will increasingly take the form of a peninsula. Social developments will pervade; immunity and specificity will decrease, with major implications for regulation and supervision.

Figure 2.1



Source: RVZ, 2010.

Opportunities ...

However, there will be opportunities as well. We are not only obliged, but also able to anticipate the combined force of the four challenges. We will have the chance not only to prevent worse things happening, but also to take advantage of the changes that are occurring. The agenda for 2010-2020 must not therefore be purely defensive (cost-cutting). While it has to provide a framework for the sizable budgetary task facing the incoming government, it must additionally utilize the opportunities that exist.

... and the need for change

One conclusion is unavoidable: both the demand side and the supply side must change. And that change should take the form of restructuring. Demand has to be redirected, while supply (provision) has to be reorganized, and there must be interaction between the two. Restructuring is required in four domains:

1. The domain of personal health, risk groups and consumer demand for care
2. The domain of the professional care practitioner
3. The domain of the care delivery system (and its context)
4. The domain of health sector direction and management

Being responsible for the system, the government is also responsible for restructuring.

3 Retrospective

Difficulties for long-term care

Long-term care has experienced difficulties over the last ten years. Costs have risen excessively and the executive organization has stagnated. Various reports have indicated that there is considerable scope for improving efficiency, yet efficiency stimuli are largely absent. The care offices, which should play a role in that regard, have insufficient capacity and lack power, due to the application of maximum prices and compulsory contracting. On the other hand, accessibility is good. The fact that, for example, care for the elderly is consequently much more expensive in the Netherlands than in most other European countries should not come as a surprise. In the past, futile attempts have been made to reduce expenditure by extending the range of available care forms to include new, less intensive options; welcome though such options (e.g. personal care budgets) have proved, their availability has not led to lower expenditure on expensive direct care. Despite their modest size, the care offices are characterized by excessive and costly bureaucracy. The procedures for applying for care are so complex that the subsidized MEE organizations provide personalized support for many applicants. An application should lead to a care indication from the independent Centre for Care Indication (CIZ), but the latter organization's countervailing power is very limited. The Central Administration Office (CAK), which defines care consumers' personal contributions and undertakes the budget funding, has also become unduly large because of the complexity of the regulations. Continuing with the AWBZ modernization policy adopted in the 1990s no longer appears to be an option.

Curative care: expenditure growth, control difficult, affordability not assured

In curative care, all analyses indicate that the new system brought in by the 2006 Health Insurance Act has generally had a positive effect on access. Controlling expenditure is very difficult, however. The Council has highlighted this issue before, describing healthcare expenditure as a baby cuckoo in the nest of collective provision. Affordability and sustainability in the public

interest are not apparently adequately assured. One significant causal factor is that the introduction of regulated market mechanisms to curative care has fallen between the two stools of the market and the state. Moreover, political decision-makers have not set out a clear roadmap for the coming years. Does the road ahead lead back to state control and funding? Or further into the world of regulated market mechanisms? Which direction should we take? We have recently seen cautious steps towards allowing the market a freer hand, but the supply continues to be highly regulated and there have even been backward steps when certain forms of healthcare expenditure have exploded due to system errors. In itself, this is understandable, but it provides no forward vision. The belief that the traditional regulation of the care supply should be replaced by open demand-side management is now widely held, both in the Netherlands and internationally.

Outcome and quality not clear, threatening support

There is also insufficient transparency with regard to outcomes and quality. Moreover, management focuses too much on input and supply-determined production. Consequently, we do not know what benefit the growth in collective healthcare expenditure is bringing for society in terms of improved health. This creates a legitimization problem: sooner or later, public support for continued state funding of the ever spiralling healthcare expenditure will inevitably weaken.

Lack of incentives …

Because there is no clarity regarding the course to be followed, parties active in the field pursue their own strategies. And, with the old budgetary guarantees and safety nets still in place, there is no incentive for such parties to take responsibility for affordability. Hence, the assurance of a good price-quality ratio is always left to someone else.

… and lack of clarity regarding the role of the state and the public goal

Nor is the government sending a clear message regarding its own role. What does it stand for? What does it want to achieve? Is the objective care or health? What means are to be used and to what purpose? Section 22 of the Health Act requires the government to promote public health. We know that much avoidable ill-health is related to

lifestyle (smoking, obesity). Nevertheless, the government is failing to communicate an unambiguous message about smoking – by, for example, setting a target of bringing smoking levels in the Netherlands down to or below the OECD average by 2020. Similar statements of intent are needed where alcohol consumption and exercise are concerned. First health, then care; health promotion should replace the treatment of illness as the primary focus. To be effective, management of the sector must be based upon a social objective (Section 22 of the Health Act).

Departmental policy is not sufficiently coherent

Similarly, the government is failing to communicate effectively with the public regarding the four pillars of policy within the remit of the Ministry of Health, Welfare and Sport, namely public health, curative care, social support and long-term care. There is a serious lack of cohesion between these pillars. The government accuses the care sector of insufficient transparency. Yet it is itself not transparent either with regard to the way the four pillars relate to each other. This has implications not only for the government's ability to manage the sector, but also – and more importantly – for its authority.

4 The agenda: citizen and care consumer

The citizen must take more responsibility …

Growing healthcare expenditure. The lingering effects of the economic crisis. The need to reduce public expenditure. Across the political spectrum, it is generally acknowledged that the state's financial burden must be reduced by the partial transference of responsibility to the individual citizen. There are many ways of effecting such a transfer, but it is desirable that the adopted policies should encourage people to take more responsibility for their own health and should promote lifestyle changes. Examples of such policies include care savings schemes, personal contribution arrangements and reduction of the entitlement package provided by insurance policies. Crucially, conditions should be attached to the provision of insured care: healthy lifestyles, good 'patientship', following medical advice, no-show penalties, and participation in sensible (cost-effective) screening programmes for physical and mental conditions.

… sensible screening….

It is also legitimate to question the extent to which collective insurance should fund care for and support with the consequences of often predictable chronic conditions that affect (very) large population groups. Because such services tend to be widely used and providable at a relatively low cost, their inclusion in the collective insurance entitlement package leads to the circulation of money within the system, unnecessary bureaucracy, inefficient demand patterns and a culture of dependency. It would also help if health insurance covered certain costs associated with staying healthy. Within the sector, collective contracts could be structured to promote health and participation more effectively. Health is, of course, influenced by environmental factors at school, home and work, by the food available to us and so forth. However, good health begins with the individual, not the employer, the educator, the insurer or the state.

… health insurance should be about health…

Moreover, good health doesn't 'just happen'; it depends on commitment. Clearly, people sometimes need help, but that does not diminish the need to put this new philosophy into practice. It is therefore vital to define the scope of the collective health insurance system more

… define scope of insurance system more precisely …

ICT support

precisely. Developments in ICT, especially those involving the internet, can be valuable in this context and must be utilized.

… a variety of preventive policies …

Putting the new philosophy into practice also implies taking account of preventive policies aimed at young people (smoking, alcohol, exercise) and at older people (fall prevention, isolation) and designed to address the discrepancy between prevention and care consumption (particularly by older people and those with chronic conditions).

The Council accordingly takes the view that, within the domain of the citizen and care consumer, the following items should be on the government's agenda:

recommendations regarding the citizen/care consumer

1. Good 'patientship'
Good 'patientship' should be a condition of insurance and of care provision (conditional solidarity; see also section 6). The insurer pays – subject to deduction of a substantially increased excess sum (personal contribution) – and encourages and supports the citizen in the use of appropriate resources: decision-support information, lifestyle information and the digital personal health record.

2. Personal liability for care
The government should identify the services that cost relatively little or are very widely used and may therefore be regarded as part of the normal cost of living; these services should then be removed from the basic entitlement package. So should forms of long-term care for which there is a predictable need. Steps will need to be taken to compensate for purchasing power effects.

3. GP registration fees
The government is looking at the pros and cons of requiring the individual citizen – rather than the insurer – to pay the fee for being registered with a GP, and at the conditions that would need to be applied in order to implement such a measure.

4. Investing in health
Health insurance policies should cover the costs associated not only with treatment and care, but also

with staying healthy. The entitlement package should be extended to include various preventive programmes, initially relating to exercise and the energy balance.

5. Group health contracts

The discounts that apply in the context of group contracts should be linked exclusively to the group's efforts to promote health and participation. Such contracts should be available only to employment and patient groups.

6. Promotion of intersectoral health policy

Much could be achieved by intersectoral policies. Intersectoral health policy requires a firmer central and local policy basis. Concrete objectives should be formulated and support improved. Various practical proposals concerning such policies are presented in the report *Buiten de gebaande paden* (*Off the beaten path*; 2009), published jointly by the ROB, the Education Council and the RVZ, and the report of the same name published by the SER.

5 The agenda: the care professional

Care professional in a public role

The care professional has a pivotal role to play in bringing about change. Good citizenship, good ‘patientship’ and especially more precise definition of the scope of collective health insurance imply changes in the way care professionals operate. Demand-side behavioural change has to be encouraged not only in the community and by the health insurance system, but also in the doctor’s surgery. The surgery is an appropriate setting for the discussion of personal responsibility for health and behaviour, self-management, the (medical) usefulness of professional care and the scope of the insured entitlement package. Hence, the professional is cast in a more public role – a role that he or she can perform effectively only by being transparent about his/her capabilities and performance. Furthermore, the care professional will have to work as part of a team made up not only of fellow practitioners, but also of people from other professions, and will have to share responsibilities with other team members.

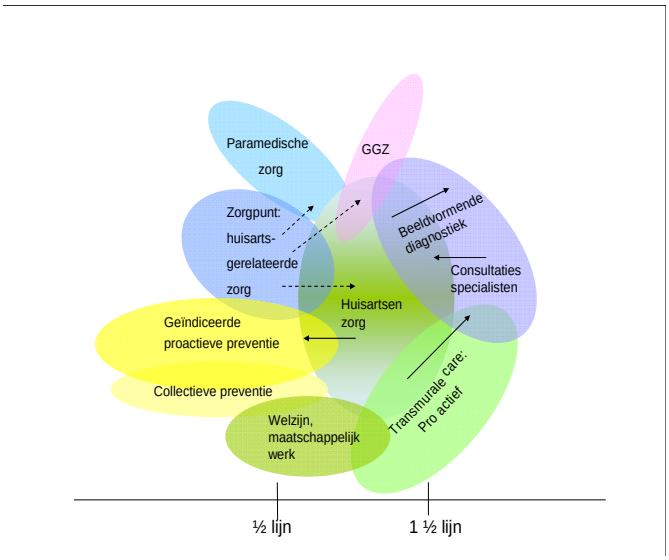
… supporting good citizenship

… operating transparently as part of a team …

An example

The Schiedam GP Centre serves as an example of such collaboration:

Figure 5.1 General practice network



Source: RVZ, 2010.

Teamwork in practice

The Schiedam GP Centre provides a complete range of GP and nurse care services. The provisions are coordinated on a service-centred basis, using a one-stop model that includes ultrasound examinations and does not require appointments for certain straightforward matters. Considerable emphasis is placed on prevention, at both the group and individual level, taking account of local demographic and epidemiological factors. The activities focus on medical matters, and on social issues such as isolation and financial problems. A network is taking shape: there is close cooperation with the home care sector and the hospital sector (transmural nursing; themed consultations with medical specialists from the hospital).

The care consumer is one of the team as well

Increasingly, the care consumer will be involved as one of the team. The consumer and the professional will in effect become co-producers. The internet will serve as their medium, also for the provision of coaching. Such developments will make it necessary to review the way professions and professional training are structured. Care professionals will need to adopt an active and positive attitude. Everything will revolve around investigation and around knowledge in an open society without boundaries.

Walk-in care services …

Professional cooperation in walk-in facilities, as outlined in the discussion document *Zorg voor je gezondheid!* (*Take care of your health!)*, can form a useful supplement in this context. The best format for such a centre still needs to be determined, but the basic idea is a low-threshold access point for people with health-related questions and straightforward care needs. Walk-in facilities would be cost-efficient because of smart task demarcation, and result-efficient because of the smart provision of support for healthy lifestyles and self-management.

… and municipal services

In addition, municipal services could be provided in fields such as social support, housing, debt management, work and benefits, and parenting. By coordinating these services, problem accumulation can be picked up early and assistance made available where appropriate. Moreover, people with problems can be directed to the most appropriate medical or other professionals. Thus, it will be possible to prevent people with socio-economic and health disadvantages, and other groups such as the elderly and people with chronic illnesses, slipping further behind. This is important, because the risk of people falling by the wayside is particularly great in the current dynamic environment, characterized by rapid advances in health and illness-related knowledge, digitization and computerization.

Walk-in facilities require operational and financial cooperation amongst municipalities and health insurers. The introduction of walk-in facilities must not be allowed to result in rigidity; these services should not become a new tier of provision or new institutions to which more and more tasks are assigned. For the time being, it will be sufficient for the government to make any necessary amendments to the Health Insurance Act, the Social Support Act and/or the Public Health Act, and to be actively involved in getting the idea off the ground, before leaving the parties active in the field to take the concept forward. Those parties may then opt for a digital implementation form or, in deprived areas for example, for a physical centre. Other components of this agenda will in due course create supplementary conditions.

Medical specialists working at hospitals should be integrated within the organization

Acting as researchers, treatment providers and organizers, medical specialists have considerable responsibilities and a major part to play in relation to innovation, quality and client orientation, efficiency and

productivity within the curative care sector. They will do so in institutional settings and increasingly in the context of adaptable, independent commercial practices, which invest in service provision and bear full responsibility and risk for turnover and costs. Commensurate rewards will be available.
The major changes in the care provision that we are advocating depend on entrepreneurship and adaptability. Where hospitals are concerned, those qualities must be provided by the management boards. Hence, specialists who work at hospitals, whether as employees or as practice partners, must be integrated within the hospital organization. The current fiscal position of practice partners is restrictive and inappropriate (being unjustified by the nature and size of the risk they bear).

External professional management?

Developments in the domain of the care professional are difficult to manage from outside. It is a long-winded process, that will be expedited most effectively by an urgent appeal and consistent communication of the government's vision. That implies that collective care should be based on agreement amongst and the acceptance of responsibility by all parties: the citizen, the government and the care professional. Other matters addressed by this report, such as good 'patientship' and the systemic and sectoral direction arrangements (quality indicators and financial stimuli) described below, will also be influential, but indirectly. In addition, the government will need to update the statutory framework (the Individual Health Care Professions Act).

The Council accordingly takes the view that, within the domain of the care professional, the following items should be on the government's agenda:

Recommendations regarding care professionals

7. The public role of the professional
Professionals need to increase their public accountability. That implies professionals being transparent about their expertise and the services they can offer, being open to cooperation and to a division of duties that promotes good-quality, efficient care provision. It also implies involving the care consumer in the new arrangements and working to protocols.

8. Obligatory transparency regarding care provision
The government should oblige care professionals to be open regarding the results they achieve and regarding patient satisfaction, so that care consumers may make informed decisions and insurers may take account of relevant data when contracting care services. Such performance data can also be of use to care professionals themselves for internal operational management and benchmarking.

9. Start with the introduction of walk-in facilities
As a first step, municipalities and health insurers should be given the statutory power to develop walk-in facilities together. Walk-in facilities could provide both care services and other municipal services (in fields such as housing, debt management, work and benefits), either through physical centres or through virtual portals (e.g. 'health-alert.nl'). The Council envisages municipalities and insurers sharing the cost of these facilities, and their use falling outside the personal contribution provisions of the Health Insurance Act. The initiative should be evaluated and possible follow-up measures considered after three years.

10. Position of the medical specialist
The formal relationship between medical specialists and hospitals should be reviewed, and new organizational forms should be encouraged. The fiscal status of independent medical specialists permanently attached to hospitals should be re-examined.

6 The agenda: the care delivery system (and its setting)

The government needs to spell out the purpose of the care delivery system in terms that command general support within the care sector. Efficiency is unattainable unless the system's purpose is clear. In the care sector, the purpose is necessarily a public one. The various parties must be given the greatest possible interest in the attainment of quality and efficiency. The public will accept partial transference of the cost burden to the citizen only if care provision becomes more efficient and more client-oriented. That implies effecting three major changes in the care delivery system.

Quality standards ...

First, a body of quality standards (including good 'patientship' standards) must be developed. The quality of care may then be expressed primarily as the social and economic return (in the form of, for example, improved health and increased participation, greater efficiency and reduced overproduction). Management of the sector should be based upon the pursuit of quality in the sense described. As an aspect of sectoral direction, supervision should have the same focus. Supervision is restrictive. Consequently, the government can and should substantially simplify its supervisory structure (the Health Care Inspectorate, the Dutch Healthcare Authority and the Netherlands Competition Authority). A word of caution is in order at this point. The new quality-oriented thinking must not degenerate into a modified form of supply regulation. To stop that happening, external quality calibration is required: an independent institute should set up the system, and the minister should authorize it.

… and the pursuit of health and participation …

… through the use of transparent indicators ...

… and criteria for the insured entitlement package.

To complement these arrangements, parties active in the sector should be obliged to publish transparent outcome indicators. Furthermore, the insured entitlement package should be restricted to protocol-compliant forms of care. Substitution is vital for quality and efficiency: forms of care that have been rendered obsolete by protocol

Management of the entitlement package means substitution.

development should no longer be insured or therefore suppliable or the subject of supply contracts. Much could be achieved in terms of quality and cost control by consistent application of the substitution principle in management of the entitlement package. To that end, tenacity is required from the entitlement package manager and effective enforcement from the inspectorate.

Pursuit of efficiency and labour-saving innovation

Second, the new government must do its utmost to create conditions under which efficiency and (labour-saving) innovation can flourish. Numerous studies have indicated that much could be achieved in those areas. Existing financial guarantees – ex-post settlement, macro post-calculation, division of insurers' premium income into nominal and income-dependent elements using fixed denominators, budget guarantees for hospitals and (some) long-term care, and direct linkage of (personal) income to production – act as obstacles to efficiency and innovation. There is scope for insurers to buy in services on more competitive terms and tighten up their supplier management arrangements. Insurers should be incentivized to help their clients exercise personal responsibility and control. They also need incentives to substantially upgrade their purchasing activities, which are critical in relation to quality and efficiency. Insurers may in principle purchase selectively, but do not do so for fear that their clients will suspect them of financial motivation and will be sceptical about the sincerity of their care-related intentions. Guidelines on quality and transparency could change this situation. However, even without selective purchasing, insurers could exercise more influence through their purchasing. They could, for example, develop their knowledge of clients, market developments and quality/efficiency matters and utilize it in negotiations with care providers. After all, through their activities, insurers have a great deal of information at their disposal, including health outcome information generated by service providers. The Council doubts whether the timetable envisaged in its report *Zorginkoop* (*Care purchasing*; (2007) is still realistic. Insurers do not appear to have fully acknowledged the added tactical and

The insurer as purchaser

strategic value of care purchasing. They will need to invest a great deal more in this activity before long.

Diagnosis-treatment combinations

The system of diagnosis-treatment combinations has not produced the anticipated results. There will come a time when the system has contributed all it can to the development of a negotiating language for curative care. When that time comes, it will no longer be desirable to retain the system as an obligatory vehicle for performance definition and claim submission. Research is required with a view to formulating an agenda for transition to new contracting and claiming models that maximize the parties' freedom of action. This is important, for example, in relation to the development of integrated care, redesign of the hospital landscape and rewarding health outcomes.

Organization of care to assure continuity for the consumer

Third, the care delivery system needs to be organized so as to assure the continuity of care and care services to the consumer. Because the regulatory context, funding arrangements and stimuli differ from one form of care to another, continuity is sometimes compromised. Causes of discontinuity include:

Causes of discontinuity

- Formal ranking
- The segmented organization of mental and somatic care
- The organization of specialist medical care in hospitals
- The separate organization of nursing in hospitals, nursing homes and home care
- The demarcation between public health, curative care, social support and long-term care
- The demarcation between occupational care and curative care, and between social security, occupational reintegration and care

Long-term care

Long-term care should be reorganized on the basis of a care-based transition agenda. The need and scope for change are greatest in the field of care for the elderly. This form of care can reduce functional disabilities and increases healthy life years through prevention and early diagnosis. Older people should have access to more aids and be more self-sufficient (income, accommodation). Organizational innovation is required; in the primary care

sector (walk-in facilities), a shift from hospital care to care at home; aids to support self-management and autonomy (domotics). Some of what are currently classed as exceptional medical expenses – such as the cost of guidance and support – will shortly be reclassified. This will have the effect of encouraging social networking and self-sufficiency. Consequently, where personal care is concerned, the norm regarding what a care consumer is able to do for him/herself can be raised, particularly if the need for care is unlikely to be prolonged. Such changes may nevertheless lead to increased expenditure within the Social Support Act system. Convalescent care should be made a component of curative care so that health insurers cannot pass on liability. However, for people with intensive care requirements, or who are really unable to look after themselves (people with advanced dementia, serious mental disabilities, chronic psychiatric illnesses, etc) the state will remain responsible.
Both quality and efficiency are important. In the provision of long-term care too, regardless of its organizational position, the use of quality indicators and adequate efficiency stimuli is essential. The long-term care purchaser has to develop into the counterbalance that is needed when care requirements are established.

Hospital restructuring

The restructuring of hospital care can increase efficiency and raise the quality of the available medical capacity. At present, too much of that capacity is used to maintain an unnecessarily wide range of emergency and acute care services (intake and acquisition activities of A&E). The restructuring and distribution of duties amongst hospitals would be in line with the trend within medical science with regard to super-specialization and knowledge of complex or rare conditions. There is often a need for scale at the super-specialist level, in order to ensure quality; this implies cooperation within hospitals and between hospitals (networking). With a view to promoting competition, it is important that a sufficient number of such networks exist across the country.

The Council accordingly takes the view that, within the domain of the system and its setting, the following items should be on the government's agenda:

11. Quality institute to formulate guidelines

An independent public institute (Quality Institute) with persevering qualities should formulate guidelines for insured curative and non-curative care and transparency indicators for ministerial approval. The functions of various bodies currently active in the management of quality and efficiency in the care sector should be incorporated into the new Quality Institute (so that the bodies in question cease to exist as independent organizations or shed their roles in the relevant fields). All elements of the insured care entitlement package must comply with the guidelines on quality, effectiveness and efficiency. No non-compliant care should be provided or paid for ('comply or explain' principle). The guidelines should be demand-oriented, integrated (curative and long-term care) and should provide for the treatment of multi-morbidity. Moreover, they should be formulated in terms of outcomes (solutions for health or participation problems). Wagner's chronic care model may serve as an example in this regard, and the experience gained by KaiserPermanente (USA) and the NHS (UK) should be utilized. An open approach to formulation of the guidelines must be adopted; they should not be tailored to existing professions or monopolies. What matters is the service, not the provider. The guidelines should utilize input from care professionals, patients' organizations and consumer organizations.

12. Continued migration to regulated market mechanisms

The migration to regulated market mechanisms referred to earlier should continue in the interest of efficiency. The introduction of such mechanisms implies (amongst other things):

Existing financial guarantees for insurers and providers should be withdrawn as soon as possible (2012). In future, these parties should be paid for health results (an RVZ report on this topic, entitled *Sturen op gezondheid* (*Managing for health*), is currently being prepared).

Ex-ante risk equalization should be supplemented by health indicators (2013); the possibility of doing this with the Municipal Fund should be investigated.

Progress towards regulated competition can be encouraged by concentration and by governmental contracting of provisions for which the state has a special responsibility, such as the availability of A&E. For the most specialized forms of care, further regulation within the framework of the Exceptional Medical Procedures Act is an option.

Considerable effort should be put into role redefinition. The withdrawal of financial guarantees for care providers can serve as a valuable motivator in this context.
The system of government assistance with increased employment costs should end. It distorts the labour market and is not conducive either to productivity improvement or to the acceptance of responsibility by care-sector employers and employees.

13. Reinforcement of the insurer's public role
When purchasing care, insurers should utilize their knowledge of their clients, the market and quality/efficiency. They should additionally play a role in the development of quality indicators and outcome indicators. Much more should be invested in care purchasing by the insurance industry.

14. Substitution in maintenance of the entitlement package
Maintenance of the entitlement package should be based upon the principle of substitution: new provisions replacing old ones. Forms of care rendered obsolete by guideline development should no longer be fundable through the system. Insured medical care must be defined in the Health Insurance Act as care that conforms to the relevant guidelines. Abandonment of the existing open definition will contribute to cost control. Health insurers and suppliers should be obliged to promptly inform clients about the insured entitlement package.

15. Care networks
The formal cooperation and division of responsibilities between the primary, secondary and tertiary care sectors should be superseded by more open relationships, which allow for the formation of horizontal and vertical networks. The role of gatekeeper to specialist medical care may be functionally assigned within such a network (and no longer exclusively to the GP). The new walk-in facilities could also be used for this purpose. At the gateway to the care system, we would then have teams made up of people with expertise in various fields (young people and families; employment; mental health care; care for the elderly). Where discrepancies between the regulations governing curative and long-term care inhibit such cooperation, they should be removed at the earliest opportunity.

16. Hospital care in networks

The definition of guidelines for hospital care and continued progress towards regulated competition will tend to foster the development of a small number of specialist medical networks, within which hospitals cooperate and divide responsibilities and specialisms. These open networks will promote quality and efficiency, without restraining competition or care consumers' freedom of choice. Treatment, rehabilitation and follow-up care will be viewed on an integrated basis and within a common financial context. The Council's programme of work for 2010-2011 includes the preparation of a report on this topic.

17. Reorganization of long-term care

Predictable care requirements should no longer be fundable through the collective system. This implies contraction of the entitlement package (e.g. through the removal of support services) with the aim of encouraging social networking and self-sufficiency. Under the Social Support Act, municipal authorities will have an interest in this field. Rehabilitation care should be transferred to the scope of the Health Insurance Act. The state should, however, remain responsible for people with intensive care requirements, or who are really unable to look after themselves. Distinction should be made between accommodation and care, with only the latter covered by health insurance. The possibility should be investigated of investing the executive organization for long-term care with sufficient countervailing power by transferring the formulation of care indications from the CIZ to the municipalities and insurers jointly.
Funding should follow the individual care consumer, with the Social Support Act retaining the status of a provisioning act that does not confer rights.

7 The agenda: direction and management of the care sector

Integrated vision of cohesion

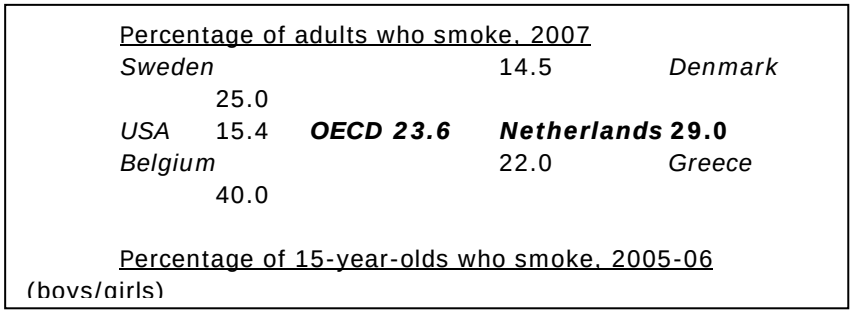
Effective management depends upon having a clear aim; this has to be defined by the government. As soon as possible after taking office, the government should discuss an integrated perspective of the supply of and demand for care with the sector. By 'integrated', we mean encompassing all four pillars of the health department's domain. It is important both that the perspective is integrated, and that the sectoral direction concept is similarly integrated. The government's perspective should be based upon a statement regarding health and participation. This statement should contain three messages:

- The citizen is called upon to accept personal responsibility for healthy behaviour (see 4A).
- Care properspective and health insurance should serve primarily to promote health, participation and self-sufficiency (see 4B).
- The government intends to lead the way by setting quantified objectives regarding matters such as smoking, alcohol consumption and exercise.

Concrete objectives for smoking and exercise

Smoking, alcohol consumption and exercise are the subjects of government policy. The government needs to commit itself to quantified targets for these issues and to pursue them using a balanced mix of tools capable of realizing tangible results (improved health) by 2020. In 2006, the RIVM estimated that tobacco use was directly responsible for 13 per cent of the nation's total disease burden. Excessive drinking causes 4.5 per cent of our disease burden, as well as a great deal of social damage. Obesity accounts for 9.7 per cent of the disease burden. In relation to these issues, it is important, particularly in the context of good 'patientship', that care providers take an active approach and offer support – in connection with stopping smoking, for example. The need for action is underlined by the statistics:

Figure 5.1 Smoking in the Netherlands: an above-average problem



Source: OECD Health at a glance 2009.

The Netherlands has substantially more adult smokers than the OECD average. Similarly, the level of smoking among 15-year-old girls is unusually high, at 21 per cent.

Government bodies

The introduction of outcome-based quality indicators, transparency and regulated competition implies a change in the role of certain government bodies. Both the nature and the volume of the work they undertake will need to change. Parallel changes will be necessary in the activities of care providers, who will need to account for what they do in a different way. Inevitably, the changes will bring new administrative burdens. However, these burdens can be kept to reasonable proportions by the collaboration of government bodies (single audit) and – if at all goes well – by ensuring that the required information is that which a care organization should be collecting anyway for internal management purposes. Ultimately, substantial debureaucratization should be achievable.

… debureaucratization

Two administrations

The government's vision should span the period 2010-2020, i.e. the lifetime of two administrations. The government needs to set targets for 2014-2015 and indicate what should be achieved in the years thereafter (see section 5). The whole undertaking needs to be presented as a joint public-private project, in which the various actors' responsibilities and duties are clearly defined; the national government must be transparent and predictable in its acceptance of ultimate responsibility for public interests. Against this background, it is important to invest in the prompt formulation of a research and development agenda. This agenda should be based on the just-in-time principle, i.e. structured to provide input just in time for the project as a whole to run smoothly and deliver results.

The Council accordingly takes the view that, within the domain of sectoral direction, the following items should be on the government's agenda:

Recommendations regarding sectoral direction

18. A government plan for the substantial reduction of smoking
The government's ambition must be to reduce the percentage of people in the Netherlands who smoke to the OECD average or below by 2020. To this end, tobacco duty should be raised (thus also underwriting the intensification of health promotion activities),

the regulations on smoking in publicly accessible places should be thoroughly reviewed and the social partners should be invited to seek agreement on the creation of smoke-free workplaces (i.e. workplaces without areas where smoking is allowed or smoking breaks). All school premises should be no-smoking zones. The possibility of including smoking in quality guidelines and as a compulsory component of basic group insurance contracts should be investigated. Furthermore, similar programmes of action should be considered for alcohol consumption and exercise.

19. The modification of government bodies
The Quality Institute should be given a prominent role; its creation can also help to reduce bureaucracy, since it will replace various existing organizations. The new quality guidelines need to provide a clear framework for management of the entitlement package and for quality monitoring. They should additionally promote transparency and thus progress towards the establishment of regulated market mechanisms. Hence, in due course, the application and enforcement of the Healthcare Market Regulation Act can be simplified and the relevant activities that remain necessary can be transferred to the Netherlands Competition Authority.

20. A research and development agenda
Various matters addressed in this report are complex and have far-reaching implications; they consequently require thorough research and a period of cautious, staged development. This approach needs to be applied to walk-in facilities, the indication of long-term care, the running of the Exceptional Medical Expenses Act system and tools for increasing citizens' personal responsibility. A research and development agenda should accordingly be defined in the short term.

8 Getting there

Setting this care agenda in motion depends firstly on the government presenting an inspiring perspective of care in 2020. A central component of this perspective must be the form that the government envisages for cooperation between the state and the care sector. The creation of a Care Foundation would provide a forum for relevant discussion. The Council accordingly advises the government to define its perspective and start discussions about the joint implementation of the agenda within six months.

Cooperation between the state and the care sector is *conditio sine qua non*. After all, the care sector does not belong to the government, but to the community. Hence, the government cannot dictate what happens. Only through cooperation can the culture shift from the treatment of illness to the promotion of health be effected and the new culture embedded in the care sector and wider society.

In its perspective for 2020, the government needs to address the following:

- The shape of the care sector in 2020. The RVZ's proposals in this regard are presented in *Zorg voor je gezondheid!* (*Take care of your health!*) and in this agenda. In the discussions that preceded publication of this document, the Council received considerable support for its perspective of the future.
- The public tasks: accessibility, quality and affordability. Attention must be given to the basic entitlement package, access-related services (A&E, complex care), quality standards, supervision, transparency, fundability and the expression of solidarity. In connection with these topics, the government needs to redefine the role of the health insurer.
- Integrated health and welfare policy, aimed at cohesion between the four pillars of departmental policy, i.e. public health, curative care, social

support and long-term care. The mission statement and the reference point for this policy should be rooted in the public health domain.

- Targets for 2015 and a description of what must be achieved by 2020. Broadly speaking, the theme of the new administration's period of office should be creation of the conditions in which a transition from treating illness to promoting health can be effected.

Budgetary task

This report is concerned primarily with the restructuring of the care sector and the realignment of demand. However, the Council is acutely aware of the sizeable budgetary reform task confronting the government. It is desirable that the government starts by adopting a clear position on the allocation of collective resources across the main areas of expenditure: education, social security and care. Thereafter, it is desirable that budgetary reforms within the care sector are, as far as possible, harmonized with the transition from treating illness to promoting health. That implies, amongst other things, balanced distribution between curative care delivered close to home and other fields of care: hospital care, medicines and medical devices, and mental health care (the latter being the fastest-growing field in recent years).

Table 8.1 Expenditure growth in the various fields of curative care

	Growth 2000-2008
Primary care	53%
Hospital care	73%
Medicines and medical devices	62%
Mental health care	95%
(General Exceptional Medical Expenses Fund 1999-2009; Statistics Netherlands	75%)

Source: Report on the general review of curative care, April 2010; Statistics Netherlands

Because this report seeks to present an agenda for the creation of a sustainable system by 2020, one of the central points is that the care sector's share of the savings that need to be achieved must be realizable. We have therefore considered the net effect on healthcare expenditure of each of our recommendations. In doing so, it has to a significant extent been possible to fall back on the calculations presented in the recent reviews of curative and long-term care. A summary of our calculations is appended.
Our proposals have many cost-saving features, including efficiency gains, higher insurance excesses (personal contributions) and the redesignation of some care forms as services that citizens must pay for themselves. Additional income will also be generated by higher tobacco duties.

Timetable
The agenda spans the lifetime of two administrations. Some of the recommended measures are fairly independent; others form part of a larger whole and should therefore be implemented in sequence.

a) Higher National Health Insurance Scheme excesses (personal contributions), higher tobacco duties and other anti-smoking measures can be realized in the short term, as can the proposed changes to the collective contracting arrangements.

b) The research and development agenda (including any related legislative measures) should be defined in 2011, addressing at least the following points: the transition from long-term care, care networks and decompartmentalization in curative care, walk-in facilities, intersectoral policy, the promotion of healthy behaviour and the insurance of preventive care, the fiscal position of medical specialists, the use of A&E and other public care services.

c) At the top of the research and development agenda, however, are quality guidelines and outcome indicators, since they are essential to the tangibility of subsequent aims. Rapid realization implies a pragmatic approach. Priority should be given to conditions associated with high levels of disease burden and cost. It is important to draw upon experience gained in other countries. By 2012, 90 per cent of healthcare expenditure should be covered by guidelines and indicators. Also necessary in this context are legislative provisions for the formal establishment of a Quality Institute by the merger of existing bodies (debureaucratization) with effect from 1 January 2014.

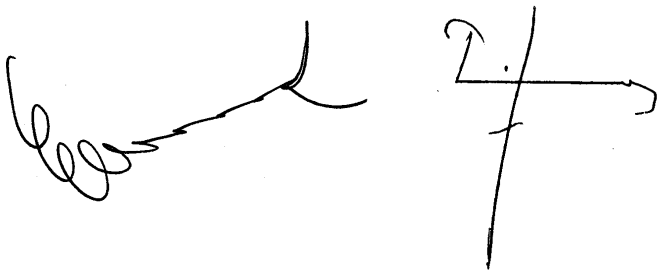
d) Quality and outcome indicators for curative and non-curative care are needed as the basis for a coherent reward structure for good 'patientship' and social outcomes. Using this basis, performance-related pay can be fully implemented within the curative care sector from 2014; financial safety nets for insurers and providers should then be removed and implementation of the Healthcare Market Regulation Act debureaucratized. Quality monitoring by the Health Care Inspectorate and substitution-based maintenance of the entitlement package can then be modified accordingly.

e) The other stimuli for restructuring can be introduced concurrently with the implementation of point d. (2012/2013). These include statement of the government's responsibility for A&E and other public services; redefinition of the formal relationship between medical specialists and hospitals and redefinition of medical specialists' fiscal position within hospitals. In addition, budgetary policy can be better aligned with the aim of effecting the culture shift from treating illness to promoting health.

f) In view of the complexity of the changes foreseen in long-term care (and the busy agenda for change in other fields of care), it may not be possible to bring forward the necessary legislation until the end of the new administration's term of office.

g) If adequately prioritized and supported, the measures outlined above can be put through by 2015. However, creation of the conditions necessary for change does not assure complete penetration and roll-out. That will take ten years. Consequently, in 2015 and beyond, the government will still have its hands full with implementation, operation and the encouragement of preferred lines of development in a setting that is bound to remain highly dynamic.

The Council for Public Health and Health Care



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