Implementing prospective budgeting for Dutch sickness funds

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Most if not all social policies entail redistribution of scarce public resources from central government to regional and local authorities, to individual citizens or non-government agencies. Governments use a wide variety of instruments to allocate public funds, including direct state provision of subsidies and goods and services, setting budgets at different levels, and regulation of social insurance schemes. Most industrialised countries have developed budget models based on implicit or explicit allocation criteria. Governments usually start by determining global budgets for an entire category of public spending and then specifying the amounts allocated for categories of spending, and next, the budgets for individual agencies. Within such a ‘cascading’ model, the lower level budgets may be more controversial than the global budgets, as they directly affect the amounts available to individual actors in the system, e.g. hospitals or health insurance agencies. Setting budgets not only shifts decision-making authority but also financial risks from the central government to decentralised actors. The introduction of the prospective budgeting model for the Dutch sickness funds illustrates why determining budgets is not merely a matter of choosing objective allocation criteria, but also, of interaction between state and stakeholders. In the typical Dutch neo-corporatist policy arena, where organised interests share responsibilities with government for the shaping and implementation of social policies, the health insurance agencies actively participated in the development of the budget model.

Keywords: allocation criteria, ‘cascading’ budget models, prospective budgets, state and stakeholders

The prospective budget model for Dutch sickness funds is a funding model which aims to shift decision-making power over the contracting of health care services as well as financial risks from a central health insurance fund to individual sickness funds. The funds, legally independent, act as competing purchasing agents on behalf of their members. As part of the health reforms based on the recommendations of the 1987 Dekker Commission, the Dutch government decided to introduce prospective budgets for sickness funds in 1988.1,2

DEVELOPING A CAPITATION-BASED APPROACH

The Dekker reforms contained several measures to increase the negotiating power of the sickness funds in contracting health care services. The elimination of legal boundaries on regional sickness funds allowed them to expand their activities. By the end of the 1990s, all funds had extended their activities to the entire country. This means that eligible citizens can choose which fund they want to join, and they may change funds once a year. In the early 1980s, there were 60 independent sickness funds; following a process of mergers and takeovers, this number went down to 20 in 1991, but in the following years, some new funds entered the market. In 1999, there were 30 funds. Deregulation of existing planning and tariff legislation increased the funds’ influence over capital investments, and introduced the possibility of contracting lower fees than the ongoing maximum rates. Further, the abolition of mandatory contracting of self-employed health professionals meant that sickness funds no longer must contract with all eligible physicians in their working area. Another step replaced part of the income-related contributions with flat rate premiums. While the income-related contribution rates are uniform for all insured, the flat rate premiums are set by the individual funds, reflecting differences in contracting outcomes and administrative efficiencies (but they are not allowed to set risk-rated premiums). In a sense, the flat rate premiums serve as a ‘safety valve’ for the budget model.

The first step in implementing a prospective budget model based on a capitation formula for Dutch sickness funds took place in 1990.3 The formula was based on studies commissioned by the Ministry of Health to an independent research institution, the Institute for Research on Public Spending (Instituut voor Onderzoek naar Overheidsuitgaven, IOO). The first IOO report concluded that age, gender and regional cost differences are important determinants of costs differences, but that they needed to be complemented by other criteria in order to reflect cost variations that cannot be influenced directly by the insurer.4,5 The IOO also formulated guidelines for the choice of adjusters. It rejected the idea that only refined models, with many variables reflecting...
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the health status of all insured, can prevent cream skimming by insurers, arguing that the model needed to be robust and administratively feasible. Moreover, criteria needed to be objective, and not vulnerable to manipulation by providers, insurance agents or government. The report rejected health status as a capitation variable, because, at that time, there were no objective health measures available. It did not exclude the possibility that, at some future date, measures might be developed for certain types of chronic diseases, very expensive diseases or terminal illness. But for the time being, it recommended that the capitation model be based on age, sex, and region, while testing the availability and use of criteria reflecting socio-economic status (e.g. disability, income, education level, chronic disease, and high consumption levels in the past).

The proposal to introduce prospective budgets raised concerns about the behaviour of the sickness funds once they had full power to contract health care providers. Some critics argued that the funds would have ample opportunity for risk selection (focusing on selecting healthier insured and avoiding sicker population groups) and to reduce the quality of care by contracting below-standard services. Others advocated extension of the number of adjusters by including health-related criteria. At the same time, there is reason to argue that the budget model needs to be robust, simple and administratively feasible. Generally speaking, the larger the number of adjusters, the more accurate the estimation of future health costs is likely to be. But reliable data are scarce, and while adding variables may improve the model outcome, it also greatly increases costs and administrative complexity. Clearly, ill health affects the level of health care consumption. But there are few if any direct measures of (ill) health readily available on a population base. A recent report by the American Institute of Medicine (IOM) discusses different measures for assessing the health of populations: health-adjusted life expectancy, health adjusted life years (HALYs), quality-adjusted life years (QUALYs); disability-adjusted life years (DALYs), quality of well-being scale (QWB), health utilities index; and the EQ-5D scale. The IOM concludes that in principle, such measures may be helpful to assess the cost-effectiveness of interventions, to illuminate the impact of disability, to serve for international comparisons, to monitor trends in population health, and to guide resource allocation. However, IOM adds, the measures are best suited for descriptive comparison of populations. There is no agreement on the role such measures can play in the actual resource allocation. In the end, the Dutch Health Ministry decided to start with a capitation formula based on the age, sex, region and disability of each insured.

The Ministry installed a working group which included both experts and stakeholders: civil servants, employees of the Sickness Fund Council and representatives of the insurance industry. After some years, disagreement over the capitation model resurfaced. In a peacemaking effort in 1992, the Health Minister and sickness fund representatives signed a Memorandum slowing down but not rejecting further implementation of the model. The sickness funds agreed to share responsibility for the results. Further, the parties agreed to seek the advice of an independent expert committee, the Bruins Slot Committee. In its 1993 report, the committee sharply rejected the current policy of gradually expanding the existing long-term care insurance AWBZ as the carrier for the future health insurance. It proposed another model which would merge private and public health insurance, with a high proportion of flat rate premium funding to be paid by each individual subscriber directly to the sickness fund. A parliamentary working group concluded that The Bruins Slot report was one of the factors leading to the ultimate demise of the Dekker proposals, even though it did not stop the implementation of the sickness funds budget model. A new working group of experts chaired by the Health Ministry but excluding representatives of the peak organisation of the health insurance industry, continued the preparations and commissioned more technical studies.

Meanwhile, the sickness funds effectively slowed down the pace of implementation. On the one hand, its representatives supported the underlying principles of the new capitation model, but on the other hand they raised many objections and issues which, they argued, needed to be addressed before any next step could be taken. In some cases they threatened to take the Health Ministry to court. This often led to adjustments in the capitation formula and a further slowdown in implementation. In the first two years, sickness fund payments were based on historical costs but, gradually demographic and social criteria were phased in. As a first step in 1993, the historical base was adjusted by age and sex. Next, in 1995, a regional variable was added as well as a disability component. In 1999 employment and disability-status replaced the disability component. This new variable distinguishes five categories of insured: persons receiving disability benefits; employed and early retired persons; welfare recipients; unemployed; and old age pension beneficiaries. As a consequence, the model has 680 risk-groups (19 age groups, 2 sexes, 5 region factors, and 5 employment status). A sickness fund currently receives a specific amount for each individual insured, based on age, gender, region, employment and disability status. In 1994, another working group addressed the 'dual budgeting issue', the problem caused by the fact that the implementation of the prospective budgeting did not keep pace with the deregulation of existing planning and tariff regulation of hospitals. The sickness funds felt that they had not received enough room to negotiate with providers of care. The new working group consisted of ministerial experts and representatives of sickness funds and hospitals. The recommendation of the group led to another adjustment of the model, differentiating four cost components (the so-called 'splitting model' or 'splittingsoort'): capital investments, variable hospital costs, care by medical specialists, and 'other care' (mostly non-hospital services). This distinction is based on the
fact that the funds cannot directly influence capital investments by hospitals. Hospitals thus receive separate reimbursement for these costs. Other adjustment mechanisms enable a gradual phasing in of the actual financial risk borne by sickness funds. These (temporary) adjustments include the pooling and reimbursement of excess costs; ex post reallocation of funding between the funds, and compensation for the difference between model prediction and actual outcomes. The pooling of excess cost started in 1997.14 Sickness funds face only limited risks of certain insured with very high health care costs. If the health expenditures of such a person exceed Dfl 7,500 or Euro 3,400 per year (in 1999), 90% of the excess costs are reimbursed. Secondly, at the end of the budget year, the funds receive (or pay) partial compensation for the differences between their allocated budgets and actual costs. When expenditure of a fund surpasses its prospective budget, it receives partial compensation for this shortfall out of the General Fund administered by the College for Health Insurance (College voor Zorgverzekeringen). When actual costs are lower than the budget, the fund pays part of the difference to the General Fund. Thirdly, at the end of each year, the funds receive compensation for shortfalls in the distributive accuracy of the budget model up to a certain level ('equalisation percentage'). In the process, there is a general reallocation of resources from 'gaining' to 'losing' sickness funds. These temporary mechanisms serve as a financial buffer for the funds, as they still have limited possibilities to influence the level of their actual expenditure (by selective contracting and by negotiating with health care providers over their tariffs and budgets). It is expected that over time, the capitation model will be simplified by differentiating only between investment costs of health facilities and all other expenditure. The temporary compensation mechanisms will be phased out. Since 1984, the sickness funds have received a separate budget to cover the costs of administration. In 1998, the total amount was Dfl 870 million (Euro 400 mln), or about Dfl 88 or Euro 40 per insured. There is no ex post adjustment for this payment. If a sickness fund spends less than this amount, it must add the money to its general reserve. If it overspends, it has to recover the loss out of its reserve, or out of its flat-rate premium income.

FURTHER DEVELOPMENT OF THE BUDGET MODEL

Several issues remain under discussion regarding the further development of the capitation-based budget model for Dutch sickness funds. The first crucial topic is the speed with which the ex post compensation arrangements will be phased out and replaced by ex ante normative budgets, increasing the insurance risk for the sickness funds. Secondly, there is pressure to extend the number of variables in order to improve the predictive accuracy of the model, for example by including previous levels of pharmaceutical consumption. Third, there is the contentious question whether allocation criteria should directly reflect the health status of populations.

There are also diverging views about the role of government in health care. Critics argue that delegating budgetary authority to an actor outside government may encourage risk selection ('cream skimming') by rejecting or excluding certain categories of high cost insured, and attracting healthier groups instead. To date, there have been only relatively minor instances of Dutch sickness funds having actively engaged in selecting healthy insured (or rejecting high risk ones) even when faced with increased insurance risk (but by law, they have to accept everyone eligible for social health insurance). New sickness funds are targeting special populations, e.g. the employees of large companies, but their capitation payments compensate for this bias. This illustrates the importance of the legislative context of the capitation and budget model.

There is clear need to simplify the current payment structure to Dutch sickness funds. Some of the current adjustments and budget sub-divisions are seen as temporary measures, which will be phased out. In the end, the Ministry of Health aims at integrating the different sub-budgets so that the model will differentiate only fixed investment costs and all other expenditures. It is not yet clear when such simplification will take place.

The debate about the design and implement prospective budgets for social services is not unique to The Netherlands. The working group for the development of the budget model for regional health authorities in the Canadian province of Alberta followed similar arguments as their Dutch counterpart. In selecting budget criteria, both groups started with age and gender, then added region (in the Alberta case, in particular for compensating the high costs of transportation in the sparsely populated areas in the north). Next, both groups considered but rejected health-related criteria such as morbidity or mortality or prior utilization of health services. As a proxy for socioeconomic status, both working groups ended with employment related insurance status. In the UK, fundholding general practitioners receive budgets based on the age and sex of their patients, as well as on regional 'deprivation criteria'. GPs in rural areas receive additional amounts.

In Israel, the budget model for the main four sickness funds are targeting special populations, e.g. the employees of large companies, but their capitation payments compensate for this bias. This illustrates the importance of the legislative context of the capitation and budget model.
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