Case study

Netherlands

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Abstract

The Netherlands has a long tradition of public long-term care provision. The Dutch system is known for its broad access to a wide range of long-term care services, which not only includes good quality nursing home care, but also extensive home care and social assistance. At the same time, this long tradition has led to a complicated mix of three financing schemes – social long-term care insurance, social health insurance, and tax-financed social support – each of which pays for other types of long-term care. In all three schemes, the national government has delegated the contracting of private care providers to a different party (regional purchasing offices, health insurers, municipalities). The extent and kind of (price) regulation, the way of contracting and pricing, and the distribution of financial risk between the national government, the contractor, and the private providers differ across schemes.

In this report, we describe the pricing and contracting in these three financing schemes. We identify two common best practices. First, care is highly accessible, and the distribution is equitable. Second, integrated prices, which play a role in all schemes, give room to providers to tailor care to the specific needs of a patient. We also identify three challenges: ensuring the coordination and sharing of responsibilities *within* each financing scheme, improving the coordination of care provision *across* the three financing schemes, and modifying price setting and contracting to improve quality, efficiency, innovation and prevention.

Lessons learnt

If the incentives to achieve system goals and financial risk and decision-making power are delegated, this is best done in tandem and to the same organization or organizations.

Financing long-term care through multiple schemes means coordination problems. Even if incentives of all agents are aligned within one scheme, this may not need to be the case across schemes.

Integrated prices give providers opportunities to provide long-term care that is tailored to the needs of their patients, yet it does not provide them with the incentives to actually do so.

Ensuring universal access requires that there is ample budget and that providers are paid a price that ensures that they can at least recover their costs. Ensuring efficiency and quality requires several additional preconditions.

Contents

1 Introduction

The Dutch health care system aims to provide affordable care of good quality to all its citizens. Universal health coverage has existed in the Netherlands for decades and has included long-term care as early as 1968 (Schut and van den Berg 2010). Currently, this universal health coverage is achieved through three complementary public financing schemes that each pay for specific types of care. Social long-term care insurance pays for care in nursing homes (about 217 000 users in 2019), social health insurance pays for nursing and personal care provided at home (about 222 000 users in 2019), and the Social Support Act makes municipalities responsible for organizing and financing assistance and social support for elderly living in the community (1.1 million users in 2019). Each of these public schemes pays for care for the full population, and enrolment in the social insurance schemes is mandatory. The two social insurance schemes are primarily funded through earmarked insurance premiums[1], and the Social Support Act is fully financed through general taxation. In addition, co-payments amount to 8% of the social long-term care insurance spending, and a deductible pays for 4.3%[2] of the expenditures paid for through the Social Support Act, but there is no cost sharing for home care paid for through social health insurance (Staat van Volksgezondheid en Zorg 2019; Statistics Netherlands 2019a, 2019b).

This universal and comprehensive coverage of long-term care expenditures comes at a cost, however. According to the most recent estimates (OECD 2020), the Netherlands spends 3.7% of its Gross Domestic Product on long-term care, which is more than any other country. Because the share of the oldest-old in the Dutch population will grow fast over the next two decades and the government strongly increased long-term care spending in recent years, growing health care expenditures – long-term care expenditures, in particular – are a major threat to the sustainability of public finance in the long run (Adema and Van Tilburg 2019). Reforming the organization and financing of long-term care, including the price setting, may be part of the effort to deal with growth in demand for (high-quality) long-term care and increased budgetary pressures.

While virtually all long-term care is publicly funded, all providers are private organizations. Therefore, prices are not merely for administrative reasons but are used to pay these private providers. Prices for most types of long-term care are regulated, but this regulation offers room for price negotiations

1 16% of social long-term care insurance revenues come from general taxation; 6.6% of the social health insurance revenue comes from general taxation: primarily for health insurance for children (5.6%), and the remaining 1% is for home care expenditures (Staat van Volksgezondheid en Zorg 2019). These revenues are not earmarked, however.

2 This estimate is for 2018. In 2019, the co-payment schedule was reformed. Preliminary estimates for the first 9 months suggest that the revenue from co-payments was about 27% lower in 2019 than in 2018 (Statistics Netherlands 2019a).

between payers and providers. The regulation of prices, among other things, differs strongly between the three financing schemes. This has implications for the incentives and the financial risks that payers and providers face, and hence for the outcomes of the negotiations, not only in terms of prices and volumes but possibly also for other outcomes, including the quality of life of the elderly who need care and relatives who are potential caregivers.

The outline of the remainder of this report is as follows. Section 2 describes the structure of the long-term care sector in more detail and argues how this structure determines the incentives for providers and payers. Section 3 discusses how the prices are determined. We distinguish two steps in this process: (i) the administrative process that sets the boundaries for the negotiations between payers and providers ,and (ii) the negotiations themselves. In the conclusion (Section 4), we review the evidence on the contribution of price setting and price regulation on the system objectives and describe the best practices for other countries.

2
Background on the Dutch long-term care system

2.1 Historical perspective and recent reforms

In 1968, the Netherlands was the first country to implement a universal social long-term care insurance scheme (AWBZ) alongside a social health insurance scheme for curative health services (e.g. hospital care, primary health care, prescription drugs). Initially, social long-term care insurance covered primarily nursing home care and institutionalized care for the mentally handicapped, but in due course coverage was expanded to home care (1980), ambulatory mental health care (1982), social assistance in case of frailty and psychosocial problems and assistance after childbirth (1989) and elderly homes (1997) (Schut and van den Berg 2010). In comparison to other European countries, the resulting public financing scheme for long-term care was very generous and comprehensive. Provider contracts were negotiated by 32 regional procurement offices within a regional budget constraint set by the government. In almost all 32 regions, the health insurer with the largest market share has been designated as the regional procurement office[3]. The central government was the single risk-bearing entity, implying that regional procurement offices were not at risk for long-term care expenses covered by the social long-term care insurance scheme.

3 Hence, although the social long-term care insurance and the social health insurance schemes were separate, the functioning of social long-term care insurance relied on insurers operating in the health insurance system. In contrast to the social health insurance scheme, however, in the context of social long-term care insurance, health insurers were – and are – not at risk and not competing for customers.

The comprehensive and generous social long-term care insurance scheme has resulted in a high share of older people receiving formal care within long-term care institutions relative to most other OECD countries (Colombo et al. 2011). From 2000 to 2013, the average annual growth of public expenditure on long-term care was 4.3% in real terms (Ministry of Health, Welfare and Sport 2013). The broad entitlements, heavy reliance on formal (institutionalized) care, and limited incentives for efficiency resulted in increasing political concerns about the financial sustainability of the system. However, the large role of public financing of professional home care and institutional care has created strong vested interests in maintaining this way of long-term care provision, which made it difficult to reform the system. Nevertheless, after years of discussion and several minor reforms to curb the growing public long-term care expenditure, in 2015, the growing concerns about the sustainability of the long-term care system resulted in a radical reform. The former comprehensive social long-term care insurance scheme was split up, and its benefits were allocated to three different financing regimes: (i) a new social long-term care insurance scheme replacing the previous one (Long-term Care Act - WLZ)) covers institutional care and substitute care at home or in other assisted-living facilities (hereafter, we simply refer to this as institutional care, since most people covered under this scheme use this type of care); (ii) the existing social health insurance scheme (Health Insurance Act - ZVW) now covers nursing and personal care provided at home; and (iii) the existing Social Support Act (WMO) covers assistance and social support for elderly living in the community and assistance for people with chronic psychic or psychosocial problems.

The reform had three interrelated goals: (i) improve the quality of long-term care provision by encouraging 'tailor made' care and facilitating self-reliance; (ii) increase the role of the person's social network in providing informal care; and (iii) improve the financial sustainability of the public long-term care system (Alders and Schut 2019). The idea behind the split-up of the former comprehensive social long-term care insurance scheme was two-fold. First, its aim was to improve the coordination between the provision of nursing and personal care on one hand and medical care (e.g. primary care and hospital care) on the other hand by financing all this care through social health insurance. Second, it was expected to foster coordination between all types of social care (e.g. social care, domestic help, social welfare and housing) by financing them all through the Social Support Act. Moreover, the aim was to make people more self-reliant and less dependent on formal care by explicitly making their social network responsible for providing social assistance and support and only providing publicly-funded care if this social network is not capable of providing all the care that an individual needs. Finally, by making risk-bearing health insurers and municipalities responsible for procurement, the reform aimed to reinforce incentives for an efficient provision of care.

2.2 Main features of current long-term care financing

The main features of the organization and financing of long-term care for the three different financing schemes are discussed below. Key figures about the various types of long-term care covered by these finance schemes are summarized in Table 1.

Table 1
Type of long-term care by source of finance, number of users and total expenditures in 2018.

Financing source	Type of long-term care	Number of users (in thousands)	Expenditure (in million EUR)
Long-term Care Act (WLZ)	Nursing home care[a]	217	10 720[b]
Health Insurance Act (ZVW)	Nursing and personal care	222	3637
Social Support Act (WMO)	Assistance in daily living	1106[c]	4918

Notes: [a] Including intensive (around the clock) care in other settings; [b] Excluding cash benefits; [c] Users of tailor-made services only. **Sources:** Ministry of Health, Welfare and Sport (2019a, 2019f, 2019g), Statistics Netherlands (2019d, 2019e).

2.2.1 Long-term Care Act

The Long-Term Care Act covers around the clock intensive care for vulnerable elderly and individuals with severe disabilities in the full Dutch population: enrolment is automatic and mandatory[4]. The long-term care insurance scheme is financed by earmarked, income-dependent insurance premiums and has a standardized benefits package (including care for elderly people in an institutional setting, care for people with mental and physical and sensory limitations, and care for people with long-term severe psychiatric conditions). The benefits people are eligible for depend on the type and severity of an individual's disability. Individuals apply for eligibility at the independent central assessment agency (CIZ), where an assessor determines whether an individual meets the set of eligible criteria, and, if so, which amount of care is appropriate. Because the Long-Term Care Act is a social insurance scheme, access to care is a legal right: eligibility should solely be based on formal criteria regarding someone's health status and disabilities. That is, the availability of care (e.g. concerns about waiting lists and the regional care budgets) does not play a role in the eligibility decision.

Most care for the elderly that is financed through this scheme is provided in-kind in a nursing home. The basic costs of living, such as housing, are also covered by this scheme. Instead of an in-kind provision of nursing home care, beneficiaries can also choose to receive in-kind care in another setting, such as their own home, an assisted-living facility or a partly privately

4 From 2021 onwards, care for adults with chronic psychiatric conditions will also be covered by the Long-Term Care Act.

funded nursing home[5] – in which cases only the care components are covered – or they can choose to receive cash benefits. When people opt for cash benefits, they organize the provision of care themselves[6]. Individuals are free to go to a nursing home or provider of their choice, as long as the providers has been contracted and the capacity of the provider permits.

Procurement of in-kind services is carried out by 32 regional procurement offices, each within a separate geographic region. Typically, the role of the regional purchasing office is entrusted to the largest health insurer in the region, though this task is carried out by a separate legal entity. The regional purchasing offices are not at risk, because it is believed that the financial responsibility for the provision of care for the most vulnerable people, requiring very intensive care is best borne by the central government. However, the regional offices must comply with a regional budget constraint – set by the national government – when contracting care.

2.2.2. Health Insurance Act

The Dutch social health insurance scheme is carried out by competing private health insurers. The benefits package is defined by law and includes hospital and medical specialist care, primary care, prescription drugs and – since 2015 – nursing and personal care. Health insurers are at risk for the medical expenses of their enrolees and no selection of applicants is allowed. People have an annual free choice of health plans offered by the insurers at community-rated premiums (i.e. insurers are not allowed to differentiate health plan premiums based on personal characteristics), yet signing up for health insurance is mandatory.

Benefits are financed from three sources: (i) an income-related contribution that is set by the government (which has to cover 50% of total expenditure), (ii) a community-rated premium that is set by the insurer, and (iii) mandatory and voluntary deductibles paid directly by the consumers. Because premiums are community-rated, insurers are compensated for differences in the expected costs of their insured population by risk-adjusted capitation payments. These payments come from a national health insurance fund that is financed by the income-related contributions. General practitioner (GP) care, maternity care and nursing and personal care are free for users, because these benefits are exempted from the deductibles.

Health insurers may selectively contract with health care providers, which may be for-profit or non-profit entities. Moreover, in line with common practice in medical care, the

5 All nursing homes are private entities. Fully publicly funded nursing homes (i.e. in which case total costs are reimbursed by social long-term care insurance) are not allowed to be for-profit (i.e. not allowed to distribute profits to owners or stockholders). By contrast, partly privately funded nursing homes (i.e. where the costs of room and board are privately paid) are allowed to be for-profit.

6 In 2018, there were 216 780 eligible persons for nursing care covered by the Long-Term Care Act, of which 12 975 (6%) opted for cash-benefits (sometimes in combination with in-kind services) (Ministry of Health, Welfare and Sport 2019fe).

need for nursing and personal care is assessed by providers themselves. Instead of care that is provided in kind, elderly may opt for a cash benefit and may contract and organize the care that they need by themselves[7].

2.2.3. Social Support Act

In 2015, the Social Support Act[8] was revised to expand the responsibility of municipalities for assisting citizens who need support in performing activities of daily living (ADL) from domestic help to assistance and social support. The Social Support Act is not a social insurance scheme and hence individuals do not have a formal right to care. Instead, municipalities have to provide assistance and social support that is tailored to the individual's needs, but only when someone's social network is not capable of arranging sufficient support. Municipalities have considerable freedom in setting the eligibility criteria and the way in which individual cases are assessed and how the care is provided, but they are required to specify this. Eligibility decisions are formal government decisions that may be appealed.

Municipalities receive a non-earmarked block grant from the national government to provide care, which is financed from general taxation[9]. This block grant means that municipalities bear the full financial risk for organizing this home care. Until 2019, they were allowed to charge co-payments that depended on the amount of care that was used and the user's income and means (up to a legal maximum amount), but, since 2019, municipalities have to charge a fixed deductible for providing individual-specific ('tailor-made') social support and assistance (maximum €19 per month in 2020).

Like health insurers, municipalities may selectively contract with providers, which are for-profit or non-profit private entities. Instead of care that is provided in kind, elderly may opt for a cash benefit and contract and organize the care that they need by themselves[10].

2.3 Incentives for ensuring financial sustainability

Since health insurers are at risk for nursing and personal care and compete for customers, they are expected to have incentives to contract good quality care at the lowest possible price. In addition, since health insurers are also responsible for

7 In 2018, 222 435 persons used nursing and personal care covered by the Health Insurance Act, of which 15 725 persons (7%) opted for cash benefits instead of in-kind benefits (Ministry of Health, Welfare and Sport 2019g).

8 The Social Support Act regulates the responsibilities of municipalities for providing support to two groups: (i) citizens who need assistance in daily living and (ii) informal caregivers. A distinction is made between general support available to all citizens (e.g. meals on wheels, activities in community centres) and tailor-made support for specific persons (e.g. house cleaning, support in administrative tasks, home adjustments, providing mobility scooters).

9 Dutch municipalities have a limited ability to raise their own taxes and are mostly dependent on grants from the national government.

10 In 2018 about 1.11 million people made use of tailor-made care services provided by municipalities, of which 313 880 (28%) used support at home and 51 220 (5%) opted for cash benefits (Statistics Netherlands 2019c, 2019d).

covering the cost of hospital care and primary care, they have an incentive to coordinate care provided by different providers, for instance by organizing good home health care or rehabilitation care for frail elderly after hospitalization to prevent unnecessarily long hospital admissions. Similarly, since municipalities are fully at risk for the expenses of providing social support and assistance, they are expected to put pressure on providers to offer care at competitive prices. In addition, municipalities are expected to put pressure on people's social network to provide informal care and to foster an efficient coordination of the provision of social support and assistance and social welfare.

However, the system also creates a number of potentially important incentive problems that are resulting from: (i) the way long-term care benefits are allocated to the three financing regimes; (ii) the way the various third-party purchasers are financially compensated; and (iii) the way co-payments for the beneficiaries are designed (Alders and Schut 2019). As will be explained below, these incentive problems may result in cost shifting, a lack of coordination between various long-term care providers, and inefficient use or provision of long-term care.

Cost shifting

The distribution of long-term care benefits across three different financing schemes creates opportunities for cost shifting from one scheme to another. The boundaries between social support and assistance provided by municipalities, personal care and nursing covered by social health insurance, and nursing home care covered by the Long-Term Care Act are not clear-cut and frail elderly sometimes may be simultaneously meet the eligibility criteria for all of these services.

Municipalities have particularly strong incentives for cost shifting, since they are fully at risk for providing care, while the block grant they receive does not depend on whether someone uses social support services from the municipality or care from home healthcare agencies or nursing homes covered by health insurers or the public long-term care scheme. Therefore, municipalities have few financial incentives to prevent frail elderly from being institutionalized by investing in social support and assistance, home adaptations and other facilities that enable people to stay at home if possible. Moreover, if the municipality suspects that someone is eligible for nursing home care financed through the Long-Term Care Act, it may urge this person to request eligibility at the independent assessment agency. If someone is considered to be eligible for this care or does not cooperate with this assessment, the municipality can deny paying for social support and assistance.

Although health insurers also are at risk for the cost of personal care and nursing, their incentives for cost-shifting are much weaker than for municipalities. This is because their financial risk is substantially reduced by the system of risk equalization. Due to a lack of data on exogenous risk adjusters for predicting

individual expenses on community nursing, the risk equalization is currently based on the individual's prior cost of community nursing. People with the highest expenses on nursing and personal care in the preceding three years are classified in 8 categories, and the risk-adjusted capitation payment to the health insurer is increased by the mean spending in this category up to a maximum (about €31 000 per adult per year in 2020). This provides health insurers with incentives for shifting costs to the Long-Term Care Act for only the subgroup of enrolees with expected costs exceeding €30 000 a year (i.e. those needing on average more than 13 hours of community nursing per week), e.g. by urging advanced care planning and an application for admission to a nursing home or substitute care covered by the Long-Term Care Act.

Hence, municipalities and health insurers financially benefit from nudging independently living people to apply for care financed through the Long-Term Care Act. These incentives are opposite to the reform goal of financial sustainability, because they may result in avoidable use of home care and nursing home care.

Coordination problems

The separate financing of institutional care, nursing and personal care and social support and assistance also generates coordination problems, because these services are now purchased by different entities serving different populations and having different incentives. Cooperation and coordination between regional purchasing offices, health insurers and municipalities are very difficult to organize, which is perceived as a major problem (Kromhout, Kornalijnslijper and de Klerk 2018), especially because incentives for cooperation are not well-aligned. Furthermore, none of these entities are clearly responsible for the coordination of medical and social care, there is no financial reward for coordination tasks with uncertain outcomes, and there is no mechanism for sharing savings.

Efficiency problems

A first problem is that both the purchasers of institutional care (i.e. regional purchasing offices) and of personal and nursing care (i.e. health insurers) have limited financial incentives for the procurement of efficient care (i.e. good quality care at the lowest possible price). This is because regional purchasing offices are not at risk for the cost of institutional care, and health insurers are largely compensated by the risk equalization scheme for the cost of nursing and personal care.

A second efficiency problem is caused by the way co-payments of the three financing schemes are structured. Because these are not aligned, the cheapest way to obtain appropriate care for the user may not be the most efficient way to provide this care for society. Co-payments in the Long-Term Care Act are related to the user's income and wealth and may be up to a maximum of about €2300 per month for nursing home care for users with a high income. By contrast, there are no co-payments for

nursing and personal care. This makes these types of care financially more attractive for users and may encourage people to age-in-place rather than enter a nursing home. However, the lack of any incentive for cost-conscious use of nursing and personal may result in moral hazard. This incentive may be reinforced by the fact that the needs assessment for these services is no longer entrusted to an independent agency (as in the former AWBZ scheme) but to the providers themselves, who may also have incentives for overprovision if they are paid a fee-for-service. For social care and assistance, the new deductible introduced in 2019 may provide similar incentives: the deductible (€19 per month) is very low and means that the marginal cost of using an additional hour of care is zero for existing users. This may encourage people to age-in-place but may also result in moral hazard (Onstenk et al. 2019). The replacement of income-related co-payment by a small deductible in 2019 has resulted in a relatively strong growth of the use of municipal housekeeping assistance, particularly among middle- and high-income groups (De Koster 2019). Hence, the introduction of the deductible in 2019 may be at odds with the goals of increasing self-reliance and improving financial sustainability.

3 Price Setting

The process for price setting differs across the three schemes that pay for long-term care. Hence, this section will be divided into three subsections, one for each of the financing schemes: social long-term care insurance, social health insurance and the Social Support Act. In each of these subsections, we discuss how prices (and volume and quality) are determined through a combination of (i) administrative processes that set the boundaries for the negotiations and (ii) the negotiations between payers and providers.

3.1 Social long-term care insurance

The contracting of care providers is delegated by the national government to the regional purchasing offices. Three important boundaries limit the room for negotiations between the regional purchasing offices and providers. First, purchasing offices have to comply with a regional budget constraint set by the national government. Second, the Dutch Health Care Authority (NZa) sets maximum prices. Third, the purchasing offices and providers have only limited control over the total amount of care required within their region. In addition, the Dutch Health Care Institute puts legally binding requirements for the quality of nursing home care (ZIN 2017) into place. These requirements directly impact the price setting and delivery of nursing home care.

3.1.1 The regional budget

The national government sets a macro budget for all care financed through social long-term care insurance for the coming year based on forecasts by the NZa (NZa 2018c). These forecasts try to take wages and price changes, demographic changes, and policy changes into account. The macro budget is then divided across the regional purchasing offices. The allocation of funds across regions is based on historical grounds, although a model based on indicators of care demand is being developed. The regional purchasing offices are responsible for the procurement of care within their region. In doing so, they have to comply with the lump-sum regional budget set by the government. A part of the budget is specifically earmarked for quality improvements in nursing homes.

Because the regional purchasing offices are not allowed to exceed the assigned budget, unexpected budgetary setbacks (e.g. caused by additional volume growth) should be financed by adjustments within the region in which they occur. The financial risks of exceeding the budget thus lie in principal with the providers. However, there are two ways to increase the budget. First, the purchasing offices can redistribute funds from one region to another. Second, the national government can increase the macro budget during the year based on updates of the expenditure forecasts by the NZa. In the past few years, upward adjustments of the forecast have been a reason for the government to increase the macro-level budget. This has made the financing system somewhat open-ended in practice, shifting the financial risk of excess volume growth from the providers to the national government.

3.1.2 Maximum prices

The care an individual is entitled to is determined by his or her care profile, which is assigned by the independent assessment agency. For elderly care, there are 10 care profiles (see Table 2). These care profiles give a broad description of the health problems, limitations and the care category to which clients with that profile are legally entitled to. The exact type of care and the number of hours are not specified in detail. Care providers are required to make a care plan together with each client and are responsible for maintaining good quality care and provide enough hours of care.

Each year, the NZa sets maximum prices for each care package, which are based on the care profiles (NZa 2019c, 2019d). The maximum prices are shown in Table 2. As the care profiles do not describe the exact type and hours of care required, these prices are integrated: there is one (per diem) price for a care package that should cover all the care needed for a certain health profile. The maximum prices for each package are differentiated based on whether treatment is provided by the nursing home or outside a nursing home. Moreover, the NZa sets separate maximum prices for a substantial number of additional activities, including additional care for patients with

specific diseases, such as Huntington's, or additional services like transport. On top of the payment for care, the price of a care package contains payments for two types of capital: housing and inventory.

The maximum prices are based on empirical costing research on the actual costs related to each care package across providers (KPMG 2018). A survey among all providers delivering care financed by social long-term care insurance was conducted in 2017[11]. Based on this data, costs for each care package per provider were estimated. The care package-specific average price is used as the main input for the regulated maximum price. Depending on the statistical validity and plausibility of the estimates or policy changes that might impact costs, the maximum set by the NZa can deviate from the estimated prices (NZa 2018a). Empirical cost calculations are only conducted occasionally, but the NZa does update the regulated prices each year.

Table 2
Care packages, number of users, regulated maximum price.

Care package	Description	Users[a] (in-kind)	Users[a] (cash benefit)	Price per day in EUR[b]
1	Assisted living with some support	350[c]	0	100
2	Assisted living with support or personal care	1015[c]	0	128
3	Assisted living with intensive support and extensive nursing	2110[c]	0	183
4	Assisted living with intensive support and extensive nursing	26 445	2235	197
5	Nursing home care with extensive dementia care	60 290	5400	250
6	Nursing home care with extensive personal care and nursing	27 885	1750	251
7	Nursing home care with intensive care, with focus on supervision (often behavioural problems)	10 635	290	293
8	Nursing home care with intensive care, with focus on personal care / nursing (problems with ADL and cognitive)	2150	355	331
9b[d]	Rehabilitative treatment	825	55	300
10	Protected living and palliative care	255	25	354

Notes: [a] Number of users on reference date (2018, 2nd Friday of November). [b] Regulated maximum price for 2019. Prices for intramural care packages including day care and treatment. **Source:** NZA (2019c). [c] Access to care packages 1-3 was abolished in 2012; only cases prior to 2012 remain. [d] Rehabilitative treatment for individuals already living in a nursing home. Rehabilitative treatment for community dwelling elderly (ZZP 9a) was transferred to the social health insurance in 2013. **Source:** NZa (2019c).

11 In the end, data from 56% of all providers were used in the analysis (KPMG 2018).

There are two recently introduced exceptions to the idea that the NZa only sets maximum integrated prices. The first is an additional payout to compensate care providers in relatively expensive regions (for instance, because of high turnover in personnel in urban regions). To ensure a fair price compensation for these providers, the NZa sets a bandwidth: the negotiated price between the regional purchasing office and the provider for this component should stay between the minimum and maximum price set by the NZa.

The second is additional funding for quality improvements of nursing homes to fulfil the quality requirements introduced in 2017. Based on a cost impact assessment of the quality framework by the NZa, the macro-level budget for nursing home care was increased substantially (€2.1 billion per year, or about 10% of the total budget). In 2021, this extra budget will be added to the regular prices for care activities. Until then, the distribution of the quality budget is based on lump-sum funding. The regional purchasing offices have to distribute the quality funds across care providers. The providers are required to make a quality plan. The regional purchasing offices and providers then have to agree on the additional budget for quality improvements based on this plan, while the NZa ensures that the negotiated budgets stay within the macro-level budget. Although the regional purchasing offices and providers have considerable freedom on how to spend these funds, agreements and expectations at the national level are that 85% of these funds are spent on additional nursing staff.

3.1.3 The demand for care

Because eligibility for care is determined by the independent central assessment agency and not by the regional purchasing offices themselves, the purchasing offices have no influence on the overall amount of care demanded in their region. Because demand for care has increased relatively strongly during the last few years, the supply of care has become tight: between 2017 and 2019, the waiting list for nursing homes increased from 9000 to 18 000 people[12] (Ministry of Health, Welfare and Sport 2019d). The number of individuals that apply for eligibility for nursing home care may be affected by the availability and the quality of home care and social support. As these types of care are provided by health insurers and municipalities, the purchasing offices cannot directly influence the demand for care financed through the Long-Term Care Act through this channel either. Purchasing offices do try to cooperate and align care provision with health insurers and municipalities within their region, but they are, for example, not (yet) allowed to use financing through the Long-Term Care Act to pay for social support that may help elderly postpone a nursing home admission.

12 The majority of these persons (16 000 in 2019) are individuals for whom a place is available but who are waiting for a place at their preferred provider.

3.1.4 Contract negotiations

The regional purchasing offices negotiate the volumes and prices with each individual provider on an annual basis. The negotiated prices are generally lower than the maximum prices set by the NZa, in part so that the regional purchasing offices are able to adhere to the regional budget. The regional purchasing offices often apply the same rebate (a few percentage points) to the maximum prices to all providers. The regional purchasing offices have to comply with procurement rules regarding transparency and non-discrimination (VGN 2018), which might restrict their ability to negotiate different prices for each provider. In addition to negotiating prices, regional purchasing offices and providers negotiate budgets. One way such a negotiated agreement can look is as a fixed ex-ante budget (for instance, 90% of a provider's revenue), with a smaller flexible part based on the number of clients the nursing home is able to attract.

The contract also contains agreements on the quality of care. These agreements seem to be mostly enforced through the informal power of the purchasing offices, as they only have limited formal means to enforce quality agreements within the contracts. The information on the quality of the care that is provided by providers to the purchasing offices is limited. Purchasing offices use the report by the Health Care Inspectorate (who is responsible for enforcing basic levels of quality of care), client satisfaction data, data on employees' sick leave, and the quality of the administrative and management processes. In some instances, the purchasing offices carry out file examinations. The providers gather quality information themselves, but there is no uniform quality measurement system, making it difficult to compare this information across providers. Specific agreements are made for the budget that is earmarked for quality improvements.

3.1.5 Conclusion

The price setting and contracting of care in social long-term care insurance is based on shared responsibilities. The budget is set by the national government, which also bears the financial risk. The maximum prices are set by the NZa, and the eligibility for care is determined by the independent central assessment agency. Within these boundaries of regulated prices and a regulated budget, the regional purchasing offices are responsible for ensuring access to good quality care by contracting providers and containing costs by negotiating prices below the maximum and staying within the budget.

There are two main challenges. The first is ensuring the quality of care. A public debate about the quality of Dutch nursing homes has been ongoing for some years now. The additional, legally binding quality framework that has been put into place in 2017 (ZIN 2017) suggests that the limited requirements about quality of care in the care profiles and individual care plans are no longer considered to ensure that the quality of care is sufficient. To fulfil the additional requirements that

follow from this quality framework, substantial additional funds have been made available. Currently, these quality improvements are financed through a separate budget. In 2021, they will become an integral part of a new system to set the regulated prices being developed by the NZa. Policy efforts and funding are now mostly directed at increasing staffing ratios, but whether this will also result in improvements in other quality dimensions is unclear, in part because the ability of the regional purchasing offices to incentivize providers to increase the quality of care is limited by the lack of uniformly measured quality indicators.

The second challenge is to ensure enough supply of nursing home care for an ageing population. Waiting lists for nursing homes are increasing in all regions, and waiting times are particularly long for individuals who want to go to the nursing home of their first choice (e.g. a home in their own neighbourhood). These capacity constraints can decrease the incentives for providers to deliver good quality care, as they limit consumer choice. In light of the ageing of the population, both acquiring enough personnel and building enough nursing home beds is a challenge. Organizing price setting and the contracting of care such that they stimulate capacity growth, e.g. by facilitating the entrance of new providers, is an important challenge.

Apart from these two specific challenges, there seems to be a tension between the desire for a tailor-made approach to care, which means that decisions are delegated to the regional level or even the level of the individual provider and client, and a desire to control spending and quality of care at the national level, which means that the room for lower-level decision making is limited. One example of this tension is the new benchmark-based system to regulate prices that is currently being developed (Ministry of Health, Welfare and Sport 2019c). In this new system, which is planned for 2022, the regulated maximum prices of the care packages will be replaced by a specific bandwidth for each nursing home. This nursing-home specific bandwidth is based on a costing method that takes circumstances out of the control of the nursing home into account. The additional payments to nursing homes in relatively expensive regions are an example of this move towards price regulation at the level of the individual providers. The idea is that the bandwidth set by the NZa will be wide enough for the regional purchasing offices to still be able to engage in meaningful price negotiations with the providers, but how much room will be left for them to do so is still unclear.

3.2 Social health insurance

Nursing and personal care are covered by the social health insurance scheme. The contracting of care providers is delegated by the national government to competing risk-bearing health insurers. Three regulatory boundaries restrict the room for negotiations between the health insurers and providers: (i) health insurers and care providers have to comply

with an overall budget constraint set by the national government; (ii) prices are partly regulated by the Dutch Health Care Authority (NZa); and (iii) insurers have to reimburse part of the prices charged by non-contracted providers.

3.2.1 The overall budget constraint

Within the social health insurance scheme, health insurers are responsible for the procurement or reimbursement of nursing and personal care. To that end, health insurers conclude contracts with providers of care about the conditions of care delivery or reimburse (part of) the cost of non-contracted providers. The government sets an overall budget for nursing and personal care based on a national agreement with the representative associations of providers and insurers.

For the period 2019-2022, the agreed-upon growth of the overall budget has been 2.4% per year in real terms. Typically, health insurers and care providers take this overall growth limit into account when negotiating contracts. Still, this does not guarantee that total expenditures satisfy the ex-ante overall budget constraint. When total expenditures exceed the overall budget, the government will consult the representative stakeholders to investigate and discuss the reasons for the budget overrun. The government has the legal power (known as the "macro control instrument") to recoup the budget overrun by requiring providers to pay back a share of the excess expenditure in proportion to their market share.

3.2.2 Maximum prices and freely negotiable prices

Prices for nursing and personal care are set in two different ways.

Regulated maximum prices
First, regulated maximum prices for legally defined types of activities have been traditionally set by the NZa based on calculated average costs per activity (Table 3).

Table 3
Regulated maximum prices per hour (in EUR) for legally specified care activities in 2019.

Care activity	Regulated maximum price per hour (in EUR)
Personal care	55.56
Nursing	72.25
Personal care (on call 24 hours)	59.51
Nursing (on call 24 hours)	77.40
Specialized nursing	90.63
Advice, instruction and counseling	88.71

Source: NZa (2018a).

Since 2019, maximum prices have been based on a detailed cost analysis by PricewaterhouseCoopers (PwC 2017) using data from 2015 and 2016 of a representative sample of 80 home care organizations and 40 self-employed providers (together, these account for 51.8% of total spending on nursing and personal care)[13]. According to PwC (2017), 95% of the total number of hours of care activities consists of personal care (68%) and nursing care (27%). In consultation with the associations of care providers and health insurers, the cost calculation model developed by PwC was supplemented by the Dutch Healthcare Authority with several normative elements about skills mix, job rating, and productivity to safeguard sufficient quality of care (NZa 2018a, 2018b).

Health insurers and care providers negotiate prices for these activities up to the regulated maximum price. If they sign a contract, the negotiated prices are fully reimbursed by the insurer. If no contract is concluded, care providers may charge a price up to the regulated maximum level directly to consumers. Depending on the insurance contract between the health insurer and the consumer, health insurers then reimburse 70-100% of the average price paid to contracted providers.

Freely negotiable prices

Second, instead of paying regulated maximum prices or negotiating lower prices for legally defined types of activities, providers and insurers may also opt for negotiating a single integrated price for a bundle of agreed-upon activities. In this case, a contract between the provider and insurer is required. The option of integrated prices was introduced in 2016 as an experiment for a period of 5 years (i.e. until 2021).

Despite being officially still an experiment, insurer-provider negotiations about integrated prices for nursing and personal care have rapidly become the standard way of price setting. Since 2016, the share of contracted providers opting for integrated prices steadily increased to nearly 100% in 2019. Hence, the regulated price per type of activity is now only used by non-contracted providers, which in 2018 accounted for about 9% of public expenditures on nursing and personal care (Ministry of Health, Welfare and Sport 2019b). The experiment on integrated prices was recently evaluated by the Dutch Healthcare Authority (NZa 2019b). According to the evaluation, the main reason for the increasing popularity of integrated pricing was the substantial reduction of the administrative burden[14] and the larger room and stronger incentives for providing tailor-made care, innovation and prevention. Providers and insurers also mentioned a number of downsides: the providers and insurers commented on a lack of relevant

13 From 2002 to 2019, maximum prices were based on a detailed cost analysis that was performed in the year 2000. During this period, prices were annually adjusted for changes in personal, material and capital costs.

14 About half of the providers switched from a 5-minute registration of activities to only registering a "care plan" including the planned activities for the specific patient, from which the number of hours is derived (based on the supposition that realized activities are equal to planned activities, unless there are reasons why this is not likely to be the case). In 2020, all providers should be switched to this new way of registration (NZa 2019a).

information for about which specific care activities were performed, on incentives for underprovision and risk selection, and on less comprehensible prices for clients. Nevertheless, based on the overall positive assessment of the experiment, the Dutch Healthcare Authority recommended to retain the system of integrated pricing as the standard way of price setting for nursing and personal care (NZa 2019b).

Integrated prices are typically set per hour, although an increasing number of providers and insurers switched to monthly prices[15]. As shown in Table 4, in 2019, the average price per hour was about €54, but prices varied considerably across providers from about €46-84.

Table 4
Integrated prices for a bundle of care activities per hour in 2019.

	Average	Lowest	Highest
Negotiated price per hour (in EUR)	54.42	46.20	83.88

Source: NZa (2019a).

The substantial variation in prices can at least partly be explained by differences in the type and mix of activities performed by the provider. As shown in Table 5, almost all providers in the sample (97%) provide regular personal and nursing care, about two-thirds (64%) also provide nursing palliative care, about half (48%) provides specialized nursing care, 39% provides case management of dementia care, whereas (regional) coordination of unplannable care and complex wound care is typically provided by a minority of large home care organizations[16]. Other potential sources of price variation are differences in the type and mix of personnel and differences in productivity.

Large providers (i.e. with an annual turnover exceeding €10 million) charge substantially higher prices than smaller ones (NZa 2019a). This is presumably because they perform a broader range and more complex activities (e.g. providing unplannable acute care and complex wound care) to a group of patients with more severe and complex needs. Small providers often restrict themselves to a niche of less severe patients, but some small providers focus on very specialized care activities. Large providers may also be able to negotiate higher prices because of more market power. To date, however, empirical research is lacking about the sources of provider price variation.

15 In 2019, monthly prices were negotiated by 7 care providers with most health insurers (at an average price of €808), accounting for about 5% of total expenditures on nursing and personal care (NZa 2019b). However, the actual number of providers and insurers using monthly prices is likely to be considerably higher, since several providers agree upon a monthly price but are still paid on an hourly basis, while at the end of the month the difference between the amount that is billed and the fixed monthly price is compensated. Next to monthly prices, a small minority of integrated prices are set on daily or weekly basis.

16 On top of this, providers of elderly care may also provide home care to children and the handicapped.

Table 5
Overview of the type of activities included in the bundle of care activities with integrated provider prices, by percentage of a sample[a] of providers in 2019 for which this activity is included in the bundle.

Activity included in integrated price	# of providers	% of providers for which this activity is included in the bundle
Personal care	206	97
Nursing	205	97
Personal care on call	154	73
Nursing on call	150	71
Palliative nursing	135	64
Advice, instruction and counseling	115	54
Specialized nursing	101	48
Case management of dementia care	82	39
Regional availability for unplannable care	33	16
Other activities	23	11
Pay for performance	20	9
Coordination of complex wound care	13	6
Personal and nursing care for children (< 18 years)	13	6
Daycare nursing for intensive childcare	3	1
Residential care for intensive childcare	1	0
Total response to survey	212	100

[a] The sample includes 212 providers, which is about 10% of all providers of personal and nursing care.

Source: NZa (2019a).

3.2.3 Budget ceilings, renegotiations and waiting times

In most cases, health insurers and care providers do not only negotiate an integrated price (per hour, day, week or month) but also a budget ceiling (or expenditure cap) per provider. According to the Dutch Healthcare Authority (NZa 2019a), most insurer-provider contracts include a clause that providers have a "duty to deliver care" in case the budget ceiling has been reached, which delegates all responsibilities for limiting use and the financial risk from the health insurer to the provider. However, in practice this responsibility and this risk are shared: in 2018, about one-third of the providers who reached the budget ceiling during the year were able to renegotiate a higher budget during the year. Another 19% announced a temporary "patient stop" when reaching the budget ceiling (NZa 2019a), which means that the consumer or the health insurer has to find another provider (as the health insurer has a legal responsibility to ensure timely access to care)[17]. Despite these temporary patient stops, research shows that most people were able to receive care within reasonable time: in 2018 the average waiting time was 2.6 days after providers were notified that care is needed, and 37% of patients received care the same day as the notification (Meijer, van

17 In addition, 14% of providers announced a patient stop because of a shortage of personnel.

Plaggenhoef and Reitsma 2019)[18]. For only 1% of patients, waiting times exceeded 6 weeks, which is considered the maximum acceptable waiting time by the Dutch Healthcare Authority[19]. Due to the growing shortage of personnel and ageing of the population, however, timely access is expected to become under increasing pressure in the near future (Meijer, van Plaggenhoef and Reitsma 2019; NZa 2019a).

3.2.4 Non-contracted care

Care providers and insurers are not obliged to conclude a contract. Non-contracted providers directly charge consumers a price for their services. As explained in section 3.2.2, the maximum price they can charge for a specified set of activities is determined by the NZa. Health insurers may reimburse users for the full or part of the price. Legally, it is stipulated that in the case of incomplete reimbursement, this should not hinder people from consulting a non-contracted provider. Court decisions do not provide a clear-cut minimum level for the reimbursement of non-contracted providers, but in practice the minimum reimbursement level used by insurers is set at 70% of the average price paid to contracted providers (NZa 2019a).

A growing number of care providers does not have a contract with a health insurer, either because they do not agree with the contract conditions offered by the insurer, or because the insurer does not want to conclude a contract with the provider[20]. The share of non-contracted care in total public expenditure on nursing and personal care increased from 4.3% in 2016 to 9.0% in 2018 (Ministry of Health, Welfare and Sport 2019b). The increase in non-contracted care is primarily due to the unrestricted entry of new providers[21].

As mentioned above, if no contract is concluded, care providers may charge a price up to the regulated maximum level directly to the consumers. Since insurers often reimburse only 70-80% of non-contracted care, this may create financial barriers to the use of non-contracted care. Frequently, however, non-contracted providers do not require patients to pay the non-reimbursed part of the price. Instead, they claim reimbursement from insurers for substantially more hours per patient than contracted providers. In 2018, non-contracted providers offered on average 2.7 more hours per patient than contracted providers, despite their patients being younger and not having more chronic conditions (Ministry of Health Welfare and Sport 2019a). Although health insurers increasingly use preauthorization requirements to counteract excessive provision of care by non-contracted providers, the ratio of the average

18 There is regional variation in waiting times of 0.8 and 6.1 days. Health insurers offer waiting list mediation services, which are frequently used (Meijer, van Plaggenhoef and Reitsma 2019).

19 An exception is case management of dementia care, for which waiting times in several regions are substantial (NZa 2019a).

20 For instance, in 2016 the largest health insurer (Zilveren Kruis) started a pilot to grant contracts through a tendering process to only four preferred providers in the city of Utrecht.

21 Some insurers only contract new providers when their turnover exceeds a certain threshold (e.g. the largest health insurer requires a minimal annual turnover of €100 000).

number of hours of care per patient offered (or claimed) by non-contracted providers to the average for contracted providers increased from 1.9 in 2016 to 2.7 in 2018. To curb the growth in non-contracted care, the Ministry of Health is considering introducing a legal notification and licensing requirement for providers of nursing and personal care.

3.2.5 Quality and other performance targets

Both contracted and non-contracted providers have to comply with the legally required standards for quality and safety as specified by the Health Care Inspectorate (IGJ)[22]. In 2018 a quality framework for nursing and personal care was formally registered by the National Health Care Institute (ZIN 2018), which was developed by the associations of patients, providers and insurers. This framework describes the professional and organizational requirements for providers of nursing and personal care. In addition, about half of providers make specific contractual agreements about performance with the largest insurer in their region (NZa 2019a). Typically, these agreements are about realizing a certain (maximum) number of hours of care per patient and a certain level of average cost per patient in return for extra payment or a higher budget ceiling. In a recent evaluation of the provider-insurer contracts, the Dutch Healthcare Authority concluded that there are hardly any specific agreements about quality, innovation, or prevention (NZa 2019b). One reason for this is that health insurers do not gather data on these topics and do not possess a set of relevant, reliable and comparable quality indicators about nursing and personal care. In the recently adopted quality framework for nursing and personal care, however, providers and insurers have committed themselves to developing, measuring and implementing indicators for patient experiences[23] and other indicators for quality, which should be used to provide patients and insurers with relevant quality information and providers with relevant feedback information (ZIN 2018).

3.2.6 Towards case-mix adjusted monthly payments per patient

In its evaluation of the experiment with integrated prices, the Dutch Healthcare Authority argues that most of the insurer-provider contracts are based on integrated prices per hour, which provides incentives for overprovision and disincentives for prevention and adopting labor- and cost-saving innovations such as e-health (NZa 2019b). For this reason, the Dutch Healthcare Authority is in favor of integrated payments per month instead of per hour. In 2019 only seven care providers agreed upon an integrated monthly payment per patient with most health insurers, accounting for about 5% of total expenditures on nursing and personal care. Fixed monthly

22 In addition, contracted providers also need a legal licence to operate, which implies that they have to meet requirements about governance and financial administration, as specified in the Act on Admission of Health Care Providers.

23 In 2019, providers started to measure a Patient Reported Experience Measure (PREM) for nursing and personal care based on a standardized questionnaire among patients.

payments per patient offer incentives for prevention and cost-saving innovations. However, they may also provide incentives for underprovision and risk selection and may obscure which care activities are actually performed. Hence, the Dutch Healthcare Authority stipulates a number of preconditions – including appropriate case mix adjustment, transparent registration of activities and adequation patient information – that should be fulfilled before expanding the role of monthly payments per patient (NZa 2019b).

3.3 Social Support Act

3.3.1 Boundaries for contract negotiations

The Social Support Act states that the 355 Dutch municipalities are responsible for organizing and financing assistance that enables residents who live in the community to live independently and participate in society. To this end, municipalities contract providers[24]. There are two main sets of rules that set the boundaries for the negotiations about these contracts.

The first set is about the process of awarding contracts. As the value of these contracts usually exceeds the threshold set by the European Union (EU) above which EU regulation applies, the process through which the contracts are awarded needs to be public and transparent. The vast majority of the contracts are awarded either through public procurement or through a so-called open house procedure. Public procurement means that the municipality sets evaluation criteria and awards a pre-specified contract to the bidding organization or organizations who score highest on these criteria. The open house procedure means that the municipality sets criteria for reimbursement and that all providers who meet these criteria are reimbursed for the care that they provide[25]. These criteria may include, but are not limited to, criteria about the price and about meeting quality standards. Both public procurement and the open house procedure are governed by EU regulation.

The second set of rules governs how prices are determined. Municipalities are required to ensure that the price they pay is sufficiently high for providers to cover their costs (Rijksoverheid 2017). The national government has set rules that state the types of costs that municipalities need to account for when calculating the price. The types of costs that the municipality must include are at least: (i) the salary and related costs for the workers providing the care (including non-billable hours because of paid time off, illness, education, and work meetings), (ii) reasonable overhead costs, (iii) travel costs, (iv) training costs, (v) inflation, and (vi) costs for the provider resulting from requirements that the municipality sets for providers (e.g. about reporting and administration). These rules were set in 2017 as

24 Municipalities may choose to hire health care workers themselves to provide this care, but currently none of them does this (PPRC 2018).

25 In addition, some support services may be provided by organizations who receive subsidies for this. In 2018, this occurred for 4% of the services (PPRC 2018).

decreasing prices were causing concern about the quality of care, service disruptions and poor working conditions. The rules were set after consulting representatives of all stakeholders: municipalities, providers, labour unions and patients.

In addition to rules about the process of awarding contracts and about price setting, there are additional boundaries that have an influence on the contract negotiations. First, the Social Support Act requires that municipalities set rules to (i) determine which citizens are eligible for care[26] and (ii) how high the deductible is. Second, municipalities need to ensure that the quality of care that is provided is monitored in a transparent and independent manner (Health Care Inspectorate 2019). Unlike in the case of social long-term care insurance and social health insurance, there are no rules for providers about public reporting of quality measures. Third, while municipalities receive a block grant for financing social support and assistance (section 2), they may increase expenditures by re-allocating budget from other expenditure categories towards assistance and social support. In practice, however, changes in the block grant have a large effect on expenditures on these types of care (Kattenberg and Vermeulen 2018). This finding suggests that municipalities are generally reluctant to re-allocate money away from other expenditure categories to increase spending on assistance and social support.

3.3.2 Contract negotiations

From subsection 3.3.1, it follows that municipalities have freedom regarding the prices that they set and several other aspects of the contracts.

Regarding prices, municipalities may decide how they define the product that providers are being paid for. Most municipalities pay per hour of care that is delivered. In these cases, a very limited number of contracts contains a reimbursement cap (0-17% of the new contracts in 2018 and 2019, respectively; PPRC 2020), unlike in social health insurance, where such caps are very common when contracting providers.

Some municipalities choose alternative ways to remunerate providers. The most commonly used alternative is to define the desired results or intermediate results, e.g. that the house of the recipient of assistance is always clean (PPRC 2020). This may take the form of longer-term care trajectories. Contracts about these care trajectories may contain expectations about achieving certain outcomes at the end of the trajectory, e.g. about functional limitations or the ability of the care recipients to care for themselves, but achieving these targets is generally not rewarded financially (PPRC 2020). Two other alternative ways of defining the product are (i) care bundles, which mean that care recipients receive all types of assistance from the same provider in order to ensure the continuity of care and to

26 A recent court ruling limits the freedom that municipalities have when specifying the care that a person is eligible for. Specifically, it rules that decisions in which the aim of the care is specified without specifying the amount of care that someone should receive to achieve this goal are not providing patients with a sufficient level of safeguards against arbitrariness in the allocation of means (Ministry of Health 2019h).

limit transaction costs, and (ii) prospective payments, which mean that providers are being paid a fixed sum for providing all assistance that a specified subpopulation (e.g. by neighbourhood) is entitled to[27]. There are currently no studies that document the differences in outcomes between these ways of remunerating providers.

Moreover, municipalities have the freedom to decide how much weight they place on the quality of care versus other goals such as access or cost containment and how they define and measure the quality of care. Generally, the role of quality of care in price setting and contracting is limited. If quality plays any role, then this is usually limited to setting minimum criteria regarding the quality of inputs (e.g. the level of qualification of employees) or the process (e.g. by requiring ISO certification) when awarding the contracts (Berenschot 2019). Prices are generally not directly adjusted for quality[28].

Regarding other aspects of the contracts, municipalities have freedom regarding which services are contracted out. All municipalities contract out the delivery of care; some municipalities also outsource the eligibility assessments that determine which citizens are eligible for assistance. Alternatively, they do these assessments together with providers in multidisciplinary teams consisting of providers of assistance and civil servants (Van Eijkel 2018)[29].

Moreover, municipalities are free to decide whether to limit the number of providers or to contract all providers that are interested in providing care. It is unclear what the optimal number of providers is. On one hand, contracting many providers has the advantage that it may stimulate competition for clients. If quality is observed by care recipients, contracting many provides may mean that recipients can choose their provider based on quality and hence that providers have incentives to provide high-quality care (Van Eijkel 2018)[30]. On the other hand, a smaller number of providers might facilitate better relationships between the municipality and providers and hence discussions about longer-term goals such as cost reduction and improvements in the quality of care.

27 In addition, municipalities have the freedom to offer services as general provisions or as tailor-made services. The rules, such as awarding contracts and setting co-payments, are less strict in the former case, which means more room to manoeuvre for municipalities. However, general provisions are by definition available to all residents whereas tailor-made services are only provided to residents who are eligible for this specific service. This means that if municipalities offer a service as a general provision, they give up one important way to target services to those individuals who need them most and limit the demand for care.

28 Indirectly, higher quality of inputs, e.g. higher-educated staff, may influence prices, because higher-quality input may be more expensive, which means that the costs for the provider are higher. In turn, municipalities need to set prices such that providers may cover reasonable costs.

29 In some municipalities, a provider who is contracted by health insurers to provide personal care or nursing that is paid for through social health insurance is also part of such a team. Many elderly who require personal care and nursing paid for through social health insurance also need assistance paid through the Social Support Act. This means that these care recipients receive care from multiple long-term care providers (Van Eijkel 2018). In these cases, the full need for home care and support may be assessed at the same time.

30 The open house procedure rules out that municipalities engage in favouring some contracted providers over others. This includes steering care recipients towards providers who provide higher-quality care (Pianoo 2020).

Both public procurement and the open house procedure provide opportunities for municipalities to influence the number of providers, as in both cases municipalities may set standards that limit the number of providers that are able to meet these standards. Municipalities that use public procurement may also explicitly limit the number of providers that they contract. The open house procedure was used to award 90% of the contracts that municipalities had in 2018 (PPRC 2018). Whether public procurement or open house in practice achieves superior results is unclear, nor is there direct evidence regarding the relationship between the number of providers that is contracted and the choice between open house and public procurement[31,32]. While the process of awarding contracts through public procurement is administratively much more complex than the open house process, the administrative burden *after the contracts* have been awarded depends on the number of providers that is contracted.

3.3.3 Conclusion

The Social Support Act and other relevant legislation leave municipalities with ample freedom to determine how prices are set and providers are contracted. Most municipalities opt for an open house procedure, which means that all providers who meet some set of criteria may provide care and get reimbursed. In most cases, providers are paid per hour, although a minority of the municipalities opts for prospective payments or for partly tying payments to achieving outcomes or intermediate outcomes. Unlike contracts for nursing and personal care between health insurers and providers (section 3.2), municipalities usually do not cap total payments in these fee-for-service contracts.

These contracts mean that the incentives of providers are often not fully in line with the goals of municipalities: the contracts give providers incentives to deliver more services, which helps to ensure access but also increases expenditures. Moreover, since the deductible is low and not related to the amount of care that is used, potential care users do not have strong incentives for efficient care use either.

The contract design and the limited ability to increase revenues together mean that many municipalities face substantial financial risks. The risk that a municipality exceeds its budget is particularly important because the block grant from the national government is fixed and municipalities have very limited room to increase revenues.

31 In general, it is not known if there is a relationship between characteristics of the municipalities (e.g. with respect to their budget situation or population composition) and whether they choose public procurement or the open house procedure. However, municipalities that choose to pay providers through prospective payments must opt for public procurement.

32 KPMG (2020) states that in adolescent care, which is also organized and financed by municipalities, the number of providers is higher in municipalities that use the open house procedure, yet it does not reveal the magnitude of this difference.

Hence, the main way to limit this financial risk is to contain the expenditures, by either limiting prices or limiting the quantity of care that is provided. Municipalities have some room to set prices low, yet this room is limited by the requirement to ensure that the prices are sufficiently high such that providers can at least recover their production costs (Rijksoverheid 2017). Municipalities may keep the quantity of care in check in two ways. First, by tightening the criteria that determine which citizens are eligible for assistance. Second, if municipalities pay providers for achieving an intermediate outcome (e.g. a clean house) rather than per hour, municipalities may reduce spending by reducing the estimate of the number of hours that is used to calculate how much providers are being paid for this outcome[33].

Generally, it is unclear whether the system-level goals – access, high-quality care and efficient provision – are achieved for social support and assistance, because there is limited information on how municipalities spend the budget, on waiting lists, and on outcomes such as care-related quality of life of the care recipients and other dimensions of quality of care.

4 Conclusion

4.1 Key characteristics of the Dutch system

The Netherlands has a long tradition of public long-term care provision. The Dutch system is known for its broad access to a wide range of long-term care services, which not only includes good quality nursing home care, but also extensive home care and social assistance. At the same time, this long tradition has led to a complicated mix of three financing schemes. Within each of these three schemes the responsibilities and incentives for achieving the system goals are with different parties. The three financing schemes have different pricing schemes for the different types of long-term care.

A key characteristic of the Dutch system is the partial delegation of responsibilities: in the three financing schemes, the procurement of care and, to some extent, the financial risk, are delegated by the national government to regional purchasing offices, health insurers, and municipalities, while the budget for each type of care is determined at the national level. This delegation to the decentral level can enable tailor-made solutions that take personal and regional circumstances into account. At the same time, this delegation of responsibilities is only partial. In practice, a substantial share of the (perceived) political responsibility, decision-making power and financial risk remains centralized because the national government issues

33 In addition, municipalities may limit the information that is available to residents about the possibilities to apply for tailor-made care, or they may nudge people to apply for nursing and personal care covered by health insurers or to apply for nursing home care (see also chapter 2).

regulations that set important boundaries to what the contracting organization negotiates with providers. This partial delegation results in a system where no single party bears sole responsibility for ensuring that the goals of the health and long-term care systems are achieved.

4.2 Best practices

Across the three main financing schemes we have discussed, two common best practices can be identified. First, care is highly accessible, and the distribution is equitable. Second, integrated prices, which play a role in all schemes, give room to providers to tailor care to the specific needs of a patient.

Equitable access

Equitable access to care is supported by separating the price setting and contracting from eligibility decisions and from the way co-payments are set. The social long-term care insurance is the strongest example of a completely separated eligibility decision: the entitlement to care is based on national rules, and eligibility is determined by an independent assessment agency. Hence, although the regional purchasing offices are bound to a budget and negotiate on volumes with providers, this should not affect the access to care for individuals. In the Social Support Act, the eligibility decision is made by the municipality and not by the providers. The requirement for municipalities to specify eligibility rules and regulate the assessment procedure means that access is likely to be equitable within each municipality. However, municipalities may set different eligibility rules, for reasons such as different political preferences and different budget constraints, and hence there may be differences in access between municipalities. In social health insurance, eligibility decisions and contracting are less separated, as providers are responsible for determining eligibility and their contracts with the health insurers tend to include volume caps. In practice, however, access to nursing and personal care is not an issue, possibly in part because of the lack of incentives and ability of the health insurers to actually control volume that we describe below. Moreover, volume caps are set at the provider level rather than on the patient level, which leaves providers with enough room to tailor the amount of care to patients' needs[34].

In all three schemes, co-payments are determined at the national level and are considerably lower than the real price of care. This way, low-income people are protected against the financial risk of substantial out-of-pocket costs and are ensured access to care. For nursing home care co-payments are income-related, for nursing and personal care, co-payments are zero, and for social assistance, the deductible is very low (€19 per month).

34 Although volume caps can also induce risk-selection, there is no evidence that this happens in practice.

Integrated pricing

Integrated pricing plays an important and increasing role in the price setting of long-term care in the Netherlands. Instead of specifying and pricing the exact hours and types of care that must be provided, one price is set for an integrated, broadly defined package of care that suits a particular type of patient. Integrated pricing can reduce the administrative burden for providers and gives more room for providing tailor-made care. However, without appropriate risk adjustment and appropriate publicly available information about the quality of care providers, integrated pricing may also incentivize providers to engage in risk selection, underprovision of care and quality skimping (NZa 2019b).

The price setting in social long-term care insurance is almost fully based on integrated pricing. The eligibility is based on care profiles that describe the nature of the health problems and the type of limitations, clients with certain health profile, and the type of care needed (e.g. around the clock supervision and intensive nursing). Maximum prices for the care packages are set at the national level, and providers and regional purchasing offices negotiate the actual price. These integrated prices seem to function well and are generally accepted. However, the fact that new requirements about the quality of nursing home care have been introduced in 2017 (along with additional, earmarked funding to fulfil these requirements) seems to indicate that the integrated pricing mechanism, which leaves major decisions regarding the allocation of the care budget to nursing homes, did not lead to the quality of care that was desired by the general public. Moreover, these integrated prices might be less suitable to stimulate investments in more capacity or the entrance of new providers.

Integrated pricing has also been introduced for nursing and personal care activities. These prices can be freely negotiated between health insurers and care providers. In most cases negotiated prices are set per hour, providing incentives for overprovision of care. However, several large providers and insurers have concluded monthly prices, which provide incentives for prevention, efficiency and innovation. Providers and insurers report that monthly prices are often accompanied with specific agreements about improving quality and innovation, and professionals report having more room for providing tailor-made care resulting in higher job satisfaction (NZa 2019b). For social support and assistance funded through the Social Support Act, integrated pricing is used by a minority of municipalities and may take the form of paying providers for achieving a pre-defined result or intermediate result.

4.3 Challenges

Based on our analysis, we identify three challenges: the coordination and sharing of responsibilities *within* each financing scheme, the coordination of care provision *across* the three financing schemes, and the use of pricing and contracting to improve quality, efficiency, innovation and prevention.

Appropriate incentives and tools for procurement of care within each financing scheme

In each financing scheme, the partial delegation of responsibilities from the national government to other entities has led to a situation in which not all parties have the right incentives to achieve the system-level policy goals of good access, high quality and efficiency. This is at least partly because decisions about pricing and overall budget constraints are often not made by the party that bears the financial risks.

In social long-term care insurance, regional purchasing offices are responsible for distributing the budget set by the national government by negotiating prices and volumes of care with providers. The purchasing offices are not allowed to spend more than the budget, but since they do not face any financial risk, they also have little incentive to spend less. In theory, the financial risk lies with the providers, who would be faced with budget cuts by the purchasing offices in order to stay within the budget. In practice, however, the macro-level budget has been adjusted upwards by the national government during the year whenever this was needed, essentially making the system become open-ended and shifting the financial risk from providers to the national government. Further, the negotiating room for the purchasing offices might be limited because of the fixed maximum prices and by the fact that they have no direct impact on the volume of care required.

Like regional purchasing offices in social long-term care insurance, health insurers have limited incentives for the procurement of efficient nursing and personal care (i.e. good quality care at the lowest possible price), because higher prior individual expenditures for nursing and personal care automatically result in higher risk-adjusted capitation payments in the next year. Hence, the way risk-adjusted capitation payments are calculated should be improved. However, improving the risk equalization method is far from easy, because there are no individual-level data on characteristics that can accurately predict someone's expenditures on nursing and personal care. Providing appropriate incentives for insurers to purchase efficient care is therefore a major challenge. In addition, health insurers have no instruments to counteract the provision of inefficient care by non-contracted providers (9% of all expenditures), because they are legally obliged to reimburse at least 70% of the prices charged by these providers. Municipalities are responsible for providing adequate social support and assistance and bear the financial risk for this. Their ability to contain the costs of care is in practice limited by national-level requirements on the level

of care that needs to be provided and by the nationally determined maximum on co-payments, which limits their potential effect on demand-side moral hazard. Moreover, their space to set prices is limited by recently introduced requirements that stipulate that prices should be set such that providers may recover their costs.

Lack of incentives and tools to coordinate care across financing schemes

The payers and providers in each of the three financing schemes of the long-term care system lack incentives to ensure that patients receive appropriate care in the appropriate setting, because each of the providers and payers is responsible for allocating only a subset of services. An optimal allocation is further hampered by the fact that incentives for patients (co-payments) are not set such that they choose the type and the amount of care that is optimal for them. This lack of coordination is most pressing for those elderly who are about to move from home (while receiving home care) to a nursing home: these individuals can face important changes in the amount of care they receive and how much they pay for it themselves. Also, the lack of coordination seems to hamper the ability to provide temporary institutional care for individuals who still live at home and the ability to provide and build residential care settings, because it is unclear through which financing scheme these types of care that are in between home care and nursing home care would have to be financed.

At the local level, several initiatives have been employed to streamline the provision of care within neighbourhoods. Some municipalities form neighbourhood teams, consisting of professionals financed through the Social Assistance Act as well as by social health insurance (e.g. nurses, GPs). At the national level, an effort is being made to enable the regional purchasing offices to use some of the budget for nursing home care to cooperate with health insurers and municipalities to stimulate living longer at home (Ministry of Health, Welfare and Sport 2019e).

Paying for quality and efficiency

Contracting of providers, including price setting, is currently mainly used as an instrument to ensure universal access to long-term care, which is one of the goals of the Dutch health care system was achieved. However, the contracting is currently used to a lesser extent to work towards achieving the two other health care system goals: efficiency and high-quality care. Instead, the national government aims to achieve the goal of high-quality care through a fully separate set of policy measures.

Quality of care and related outcomes currently do not play a role in contracting and paying for long-term care: while integrated prices are used in each of the three schemes, there are only a few cases in which payments are explicitly tied to achieving pre-defined outcomes such as care-related quality of life or preventing nursing home admissions or hospitalizations.

Until very recently, neither the regional purchasing offices nor the health insurers or the municipalities made efforts to collect good and uniform information on the quality of care and related outcomes. This may be due to the intrinsic difficulty to define good quality of long-term care and disagreement about the value of each of the dimensions of quality of care. However, in 2017 (nursing home care) and 2018 (nursing and personal care), the government and associations of patients, providers and insurers agreed upon the development and implementation of quality indicators based on patient reports and other quality measures. This information would help to not only understand if the policy goals of high-quality care and efficiency are currently achieved, but also to enable payers to use the contract negotiations as an instrument to incentivize providers to work towards achieving these goals.

To incentivize providers to provide high-quality care in an efficient way, payers do not only need information on outcomes, however. In addition, several other preconditions must be met, such as appropriate case-mix correction (or risk adjustment), an appropriate registration of activities, and an appropriate communication to users of care to prevent providers from engaging in risk selection, underprovision of care and quality skimping (NZa 2019b). Only when these preconditions can be fulfilled may prices provide appropriate incentives for efficiency, prevention and innovation.

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