



Tackling hospital waiting times: The impact of past and current policies in the Netherlands



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ABSTRACT

This paper reviews the impact of health policies on hospital waiting times in the Netherlands over the last two decades. During the 1990s hospital waiting times increased as a result of the introduction of fixed budgets and capacity constraints for specialists, in addition to the fixed global hospital budgets that were already in place since the 1980s. To tackle these increased waiting times over the years 2000–2011 several policies were implemented, including a change from fixed budgets to activity-based funding – for both hospitals and specialists – and increased competition among hospitals. All together these measures resulted in a strong reduction of waiting times. In 2011 mean expected waiting times for almost all surgical procedures varied from 2 to 6 weeks, well below the broadly accepted specified maximum waiting times. Hence, in the Netherlands hospital waiting times are currently not an important policy concern. Since the waiting time reduction was achieved at the expense of rapidly growing hospital costs, these have become now the primary policy concern. This has triggered the introduction of new powerful supply-side constraints in 2012, which may cause waiting times to increase for the coming years.

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1. Introduction

Over the past decade, many OECD countries introduced new policies to tackle excessive waiting times for elective surgery. These policies are critically evaluated in an OECD project carried out in 2012. After reviewing various policy tools that countries have used to tackle excessive waiting times in thirteen different countries,¹ Borowitz et al. [1] conclude that the most common policy is some form of maximum waiting time guarantee. From their findings it follows that such guarantees (i) are increasingly backed with targets set for providers and sanctions if these targets are not met and (ii) often go hand-in-hand with choice, competition and an increase in supply. They argue that

these policies have generally been successful in bringing down waiting times, while most attempts to increase supply temporarily in order to decrease waiting times have had only a limited effect. According to their review, the most promising approaches link waiting time guarantees to different categories of clinical need (i.e. waiting time prioritization).

In this paper we review the impact of successive Dutch policy measures to tackle hospital waiting times.² Though waiting times for hospital care in the Netherlands were the shortest among all countries included in the first comparative OECD study by Siciliani and Hurst [2], the issue was still high on the Dutch policy agenda in the late 1990s–early 2000s. This political pressure induced a major change in hospital financing that proved to be quite successful in bringing down waiting times. After the major

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¹ Australia, Canada, Denmark, Finland, Ireland, Italy, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden and the United Kingdom.

² This paper is based on a chapter by the same authors in Siciliani et al. [23].

health care reform in 2006 strengthening the competition among health insurers as purchasers of health care [3], hospital waiting times in the Netherlands were further reduced. In 2012, waiting times are therefore no longer an important policy concern. By contrast, Dutch policy makers are now primarily concerned about the rapid growth of health care expenditure caused by strong incentives for both hospitals and specialists to increase production and limited countervailing power by health insurers to counteract these incentives.

The remainder of the paper is organised as follows. First, we discuss the effectiveness and efficiency of past policies in reducing waiting times. Next, we provide an overview of the present mean waiting times for surgical procedures and the variation in waiting times across hospitals, and show how these waiting times relate to the specified norms for acceptable waiting times. Then current policies aimed at cost containment are discussed, including their potential impact on hospital waiting times for coming years.

2. Past policies (1995–2011)

2.1. Global budgeting system for hospitals and lump sum payments for specialists

Since the early 1980s Dutch hospitals' operating expenses were reimbursed under a global budgeting system to contain costs. At first, the budget for each hospital was fixed and based on the operating expenses of the hospital in the preceding year, but in 1985 part of the budget was made variable to reflect variations in hospital utilisation [4]. The fixed part of the hospital budget was based on the number of officially approved beds and specialist units. To determine the variable part of the budget, hospitals and health insurers had to reach an agreement about the number of expected inpatient days, admissions, day-treatment days and visits to the outpatient clinic per hospital per year. The precise hospital budget was then determined by using the 'agreed upon level of expected output' as an input into a nationwide applied legally established budget formula with fixed weights for each of the four types of output. Hence, the budget was prospectively determined and depended on the 'agreed upon expected output' rather than actual output [5]. If a hospital produced more than the agreed upon level, its per diem rates were subsequently proportionally reduced to redress the excess revenues. Because more production than originally agreed upon did not result in more revenue for the hospital, this budget system discouraged the hospital management to accommodate demand in excess of the negotiated output level [6].

Until 1995, however, the disincentives for the hospital management to raise output were to some extent counteracted by opposite incentives for self-employed medical specialists. While all specialists in university medical centres are salaried employees, most medical specialists in Dutch general hospitals were – and still are – self-employed entrepreneurs organized by specialty in partnerships. These specialists were paid on a fee-for-service basis. Hence, hospital management and self-employed medical specialists had diverging interests, which frequently

resulted in conflicts. Hospital management typically tried to curb production by indirect control measures, such as reductions in the number of personnel (e.g. nurses) and beds as well as lower investments in medical equipment. The first four years after the introduction of the global hospital budgeting system (1983–1987), the number of hospital personnel decreased by 0.5 percent per year and in several hospitals wards were (temporarily) closed [7]. Additionally, decision-making procedures for investments were no longer largely delegated to the medical staff. Nevertheless, hospitals frequently exceeded the agreed upon production limits. In the beginning of the 1990s, the government tried to align incentives by imposing an annual macro budget for the total revenues of all self-employed medical specialists. If this annual budget was exceeded because of an increase of the production by medical specialists, fees of all medical specialists were proportionally reduced to redress the excess total revenues. Individual medical specialists therefore faced a prisoners' dilemma, which induced them to raise rather than to mitigate production. This is because each individual specialist had an incentive to produce more to compensate a potential drop of income due to a general fee reduction as a result of an increasing production by other specialists. So, the conflict of interest between hospital management and medical specialists intensified rather than diminished. Moreover, medical specialists became caught in a spiral of increasing production and decreasing fees, resulting in increasing conflicts with the government. Urged by the need to reduce health care expenditure growth, in 1995 the government did a next attempt to align interests and to reduce incentives for extra production by giving self-employed medical specialists in each hospital the option to choose for a fixed budget (lump sum) in return for an exemption from fee reductions [8]. Except for two hospitals, medical specialists in all hospitals opted for the lump sum. In each hospital the self-employed medical specialists had to divide this lump sum payment among themselves, and in most cases the allocation was based on past production levels and fees. Since the lump sum payment was fixed, the production incentives for medical specialists were largely removed. Hence, by then the incentives of hospital management and medical specialists were effectively aligned, implying that both no longer had a stake in increasing production and in accommodating (or inducing) extra demand. In an empirical study about the effects of introducing lump sum payments in the first six hospitals that adopted this payment scheme, it was found that the mean waiting time between diagnosis and clinical intervention across these hospitals increased by about 25 percent [9]. Contrary to the preceding years, in 1995 the growth of hospitals' productivity and total production was very low, which was at least partly attributed to the new payment system for medical specialists [10]. In addition to the introduction of the lump sum, in 1996 the government also decided to freeze the number of officially approved specialist positions in hospitals that were eligible for reimbursement from social health insurance. This budget and capacity constraint further contributed to increasing waiting lists and waiting times for hospital treatment. Although this capacity constraint was subsequently somewhat released by terminating the freeze

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