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Effects of regulated competition on key outcomes of care: Cataract surgeries in the Netherlands

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ABSTRACT

Similar to several other countries, the Netherlands implemented market-oriented health care reforms in recent years. Previous studies raised questions on the effects of these reforms on key outcomes such as quality, costs, and prices. The empirical evidence is up to now mixed. This study looked at the variation in prices, volume, and quality of cataract surgeries since the introduction of price competition in 2006. We found no price convergence over time and constant price differences between hospitals. Quality indicators generally showed positive results in cataract care, though the quality and scope of the indicators was suboptimal at this stage. Furthermore, we found limited between-hospital variation in quality and there was no clear-cut relation between prices and quality. Volume of cataract care strongly increased in the period studied. These findings indicate that health insurers may not have been able to drive prices down, make trade-offs between price and quality, and selectively contract health care without usable quality information. Positive results coming out from the 2006 reform should not be taken for granted. Looking forward, future research on similar topics and with newer data should clarify the extent to which these findings can be generalized.

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1. Introduction

Regulated competition is playing an important role in the current Dutch health care system since the major reform in 2006. Several market-based mechanisms were introduced to attain multiple goals of efficiency, cost containment, quality improvement, and innovation, while guaranteeing access to care through regulation. This shift toward market mechanisms in health care has taken place in several countries since the late 1980's [1,2]. To a large extent, these reforms are based on Enthoven's theoretical model of managed competition [2,3]. This model is grounded in economic theory and aims to "reward with more subscribers and revenue those that do the best job of improving quality, cutting cost and satisfying patients" [3]. Competition is 'managed' or 'regulated' in order to guarantee accessibility and to address market failures. Consumers can choose, and their preferences and interests are bundled within organizations in order to increase purchasing power and reduce information asymmetry. In the original US-based model, these organizations (often employers) negotiate and conclude contracts with health care plans, i.e. organizations where insurers and providers are integrated, to stimulate provider competition. Nevertheless, this theory also relates to systems where purchasers and providers of health care are separated, as in most social health insurance (SHI) countries [2]. Several SHI countries shifted toward regulated competition, by giving

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consumers a yearly free choice of health insurer, which stimulates insurer competition [2]. The main idea is that insurers will respond to consumer preferences and stimulate efficiency in health care provision. Other countries, such as England, have relied on patient-driven provider competition, instead of payer-driven competition [4,5]. Market-based reforms thus come in different forms and diverse institutional contexts.

Van de Ven et al. study the preconditions that need to be fulfilled in order to achieve efficient and affordable competitive health care markets. Based on Enthoven's theoretical model, ten main preconditions are identified: free choice of insurer, risk-bearing buyers and sellers, guaranteed access to basic care, cross-subsidies without opportunities for free riding, effective quality supervision, consumer information and transparency, contestable markets, freedom to contract and integrate, effective competition regulation, and cross-subsidies without incentives for risk-selection (for a comprehensive explanation, see [2]). The fulfillment of these preconditions does not, however, guarantee an efficient and affordable health care system. Neither can it be ascertained that the theoretical model of regulated competition provides the best way to organize the health care system. This discussion, however, is beyond the scope of this paper. For five SHI countries (Belgium, Germany, Israel, the Netherlands and Switzerland), the authors evaluate the extent to which preconditions are fulfilled. By 2012, the first five preconditions have been fulfilled in all five countries. The remaining five preconditions have been met to varying degrees. Most importantly, there has been a perceived lack of transparency and quality information [6,7], both in the Netherlands and the other countries [2]. With respect to the other four preconditions not being sufficiently met (contestable markets, freedom to contract and integrate, effective competition regulation, and cross-subsidies without incentives for risk-selection), the Dutch system seems to perform better than the other countries [2]. Nevertheless, the risk-equalization scheme – though improved over time – is not perfect, and insurer choice seemed somewhat constrained by supplementary insurance [6].

It comes as no surprise that both academics and policymakers seek evidence on the effects of market-based reforms in health care. The Dutch 2006 health reform received widespread international interest [8–12]. The first qualitative evaluations of the reform showed favorable results, such as strong consensus among stakeholders in favor of regulated competition and fierce price negotiations among health insurers in the first years. At the same time several problems were identified, most importantly the lack of transparency. However, quantitative evidence regarding the effect of competition-based reforms on key outcomes such as quality, volume, and prices of care is still scarce. The literature provides evidence mostly from the UK and the US. The English NHS showed that the 1990s internal market, in which the roles of purchaser and provider were separated (and selective contracting was possible), created lower prices, lower clinical quality, and shorter waiting times particularly in more competitive areas [13]. In the 2000s the New Labor Market, comprising patient choice for elective hospital care and selective contracting by purchasers on quality (fixed tariffs), did not reduce quality [13]. Over time, one of the major issues of the English model has been the absence of competition between purchasers [1]. Evidence from the US showed a 'medical arms race' before the 1990s [13,14]. In a system of patient-driven competition and fee-for-service payment, hospitals engaged in massive investments in expensive medical technology and modern buildings to attract more patients. This resulted in escalating health care costs. In the later era of managed competition, substantial price reductions were realized mainly in areas with lower provider concentration [15,16]. However, this effect disappeared in the end of the 1990s, partly because the insured required greater choice of providers [17]. The impact of negotiations on quality has been ambiguous in the US. Results varied between quality measures and conditions [18,19]. In addition much depends on the institutional settings [13,15]. Overseeing the empirical evidence, Bevan and Skellern concluded that the impact of competition, particularly in elective surgery, "remains an open question". Not the least because outcome measures used in previous studies, mostly mortality rates, may not be a valid instrument of health care quality for elective surgery [12].

In this study, we aimed to contribute to the empirical literature. We studied price, volume, and quality of elective hospital care in the Netherlands. We concentrated on elective hospital care, in particular cataract surgeries, because price competition was introduced in 2006 in this segment. Our main goal was to understand changes in price, volume, and quality after the introduction of price competition using data from 2006 to 2009. Did prices reduce or converge? Did the system move toward a better price-quality ratio as expected with regulated competition? In contrast to most previous studies, we used negotiated prices instead of public list prices or other proxies. We examined price variation over time and between hospitals. RIVM [20] reports some descriptive figures for Dutch hospital care on trends in average prices and variation in prices for several conditions, among which cataract care. The statistics cover the period 2006–2008 and show moderate variation in cataract prices. In this study, we go a step further: first, we analyzed the relationship between negotiated price and several quality indicators. Second, we explored the relationship between price and provider concentration. We focused specifically on cataract surgery but also provided information on general trends in elective hospital care. This study is an intermediate evaluation, since market-based reforms are work-in-progress and develop over time. This article is organized as follows. Section 2 describes the funding and organization of Dutch hospital care. In section 3 we present the data and methodology. Sections 4 and 5 summarize and discuss the results. Section 6 describes the implications for policymakers. Section 7 concludes.

2. Funding and organization of hospital care in the Netherlands

Since the early 1990s the Dutch health care system has been in transition from strong supply-side government regulation toward regulated competition [6]. In the 1980s Dutch hospitals received budgets that were based on

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