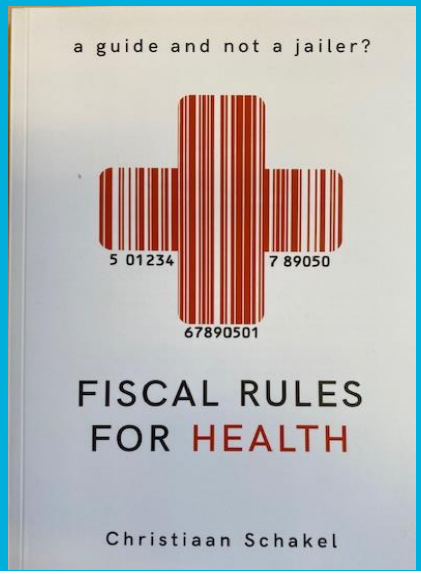
What are ‘right’ fiscal rules for health spending?

Prof. Dr. Patrick Jeurissen



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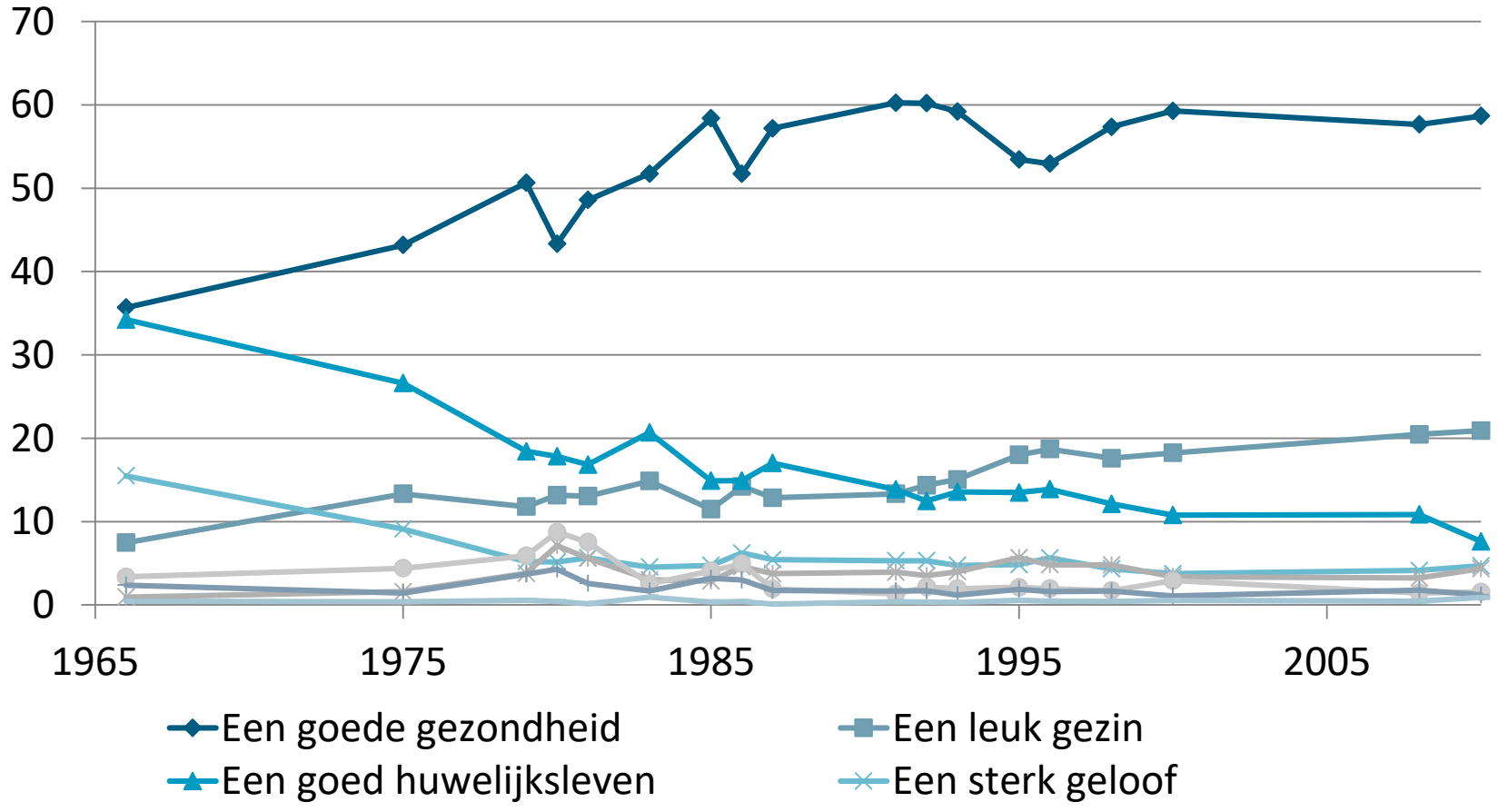
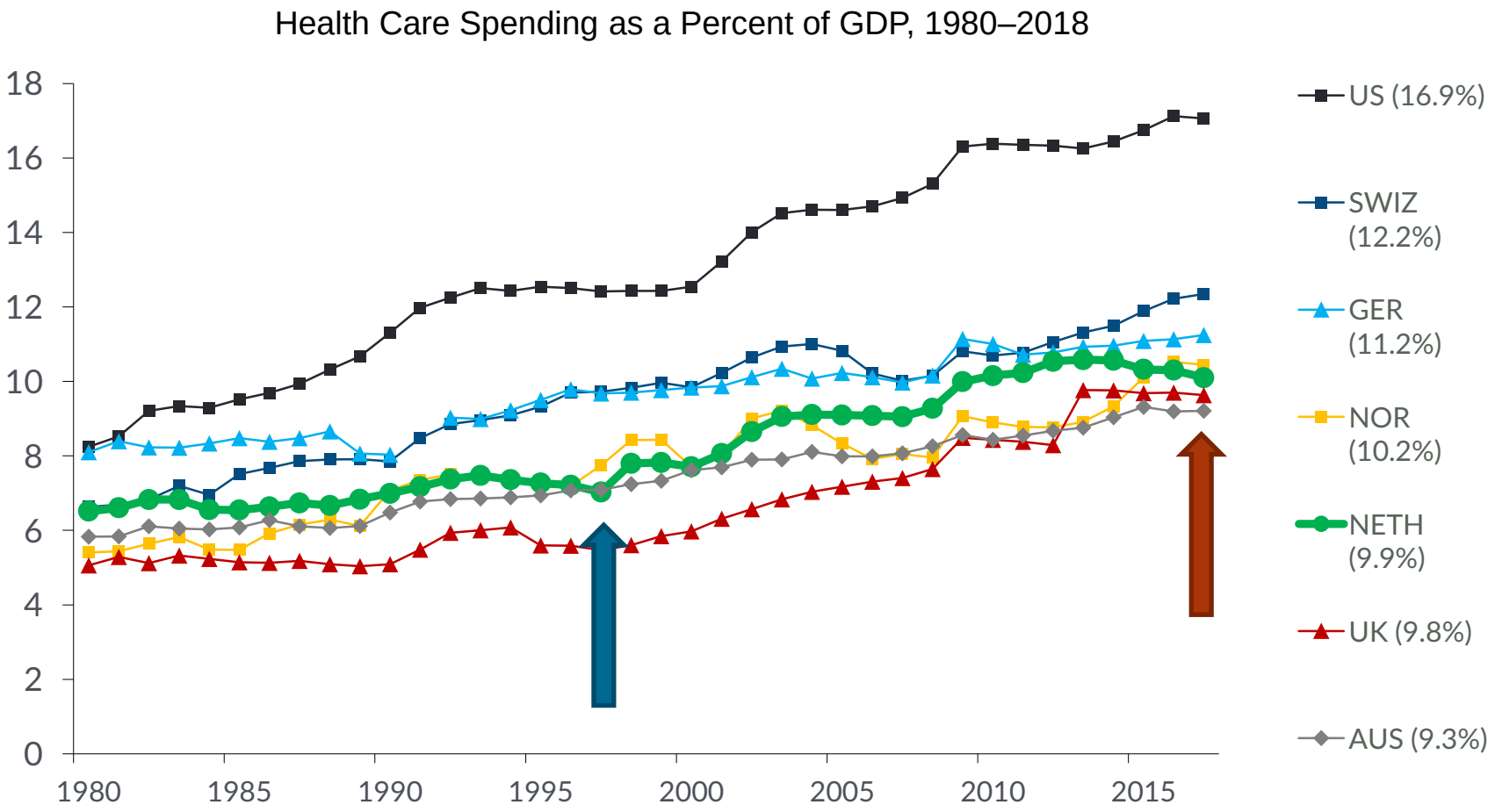
People value health the most in their lives (Dutch figures)



International trends health expenses



Source: OECD Health Data 2019

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Political economy of health spending

- **High benefits** (and willingness to pay), but **largely non monetary**
- **Increasing unit costs** of additional health gains (Cutler, 2006)
- **Increasing solidarity transfers** (benefits very concentrated, costs dispersed)
- Due to 'needed' solidarity for HNHC patients, acts as a **tax on the economy**
- Increases more rapidly than GDP and thus **decreases level of *fiscal space***
- And thus more fierce **competition with other necessary public expenses**
- **Substantial** part of health expenses considered to be **'waste'** or inefficient
- **Substantial barriers for change**: vested interests, voters are also patients and many depend for their income on providing care

Agenda

- Fiscal rules and health spending: they can help
- Setting spending targets for health: be objective
- The problem of optimal allocation of health care spending: multiple payers may sometimes not do better

1. Fiscal rules and health spending

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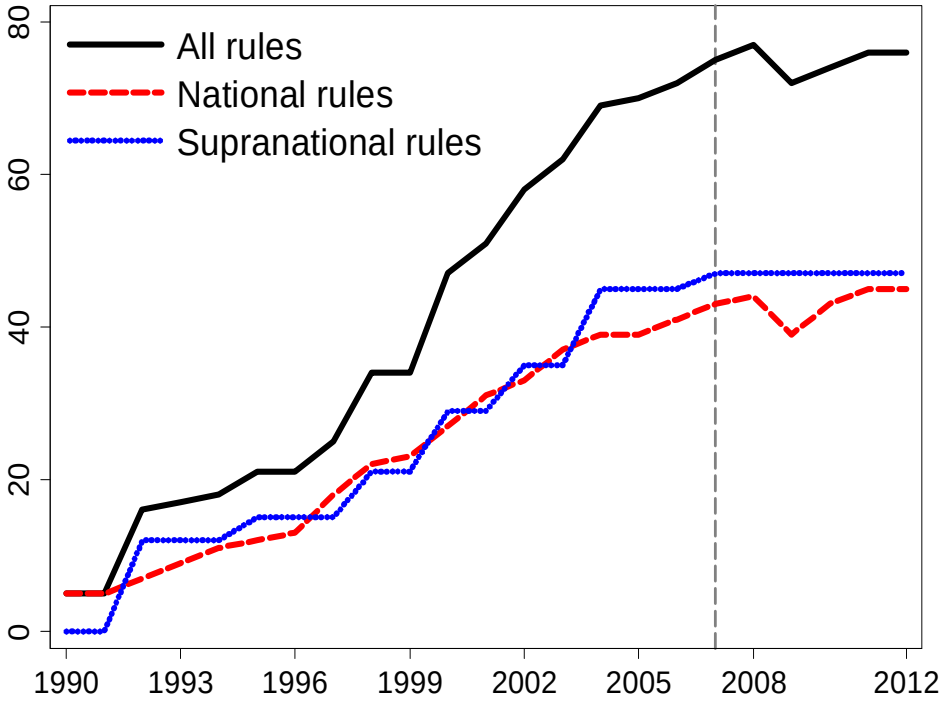
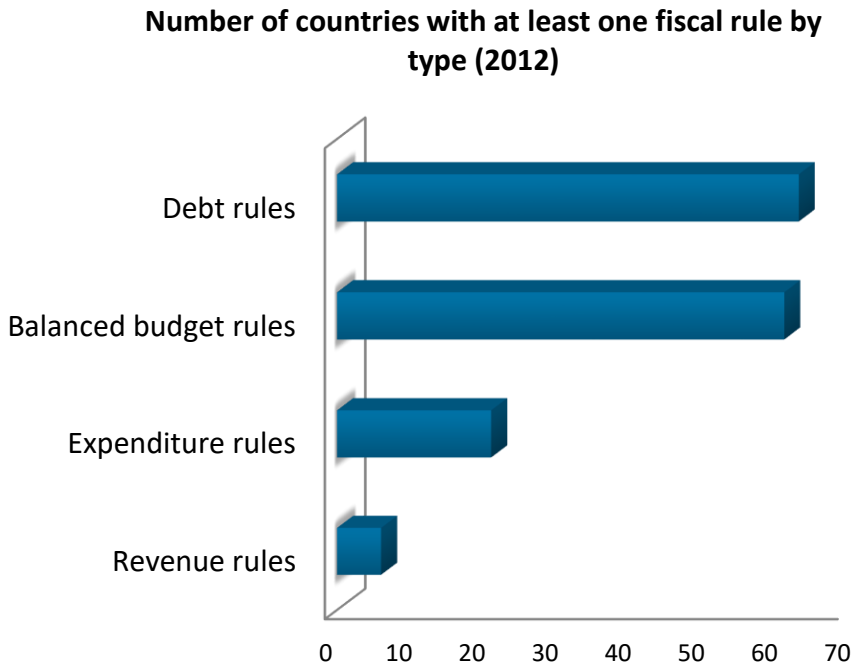
Fiscal rules (OECD member states)



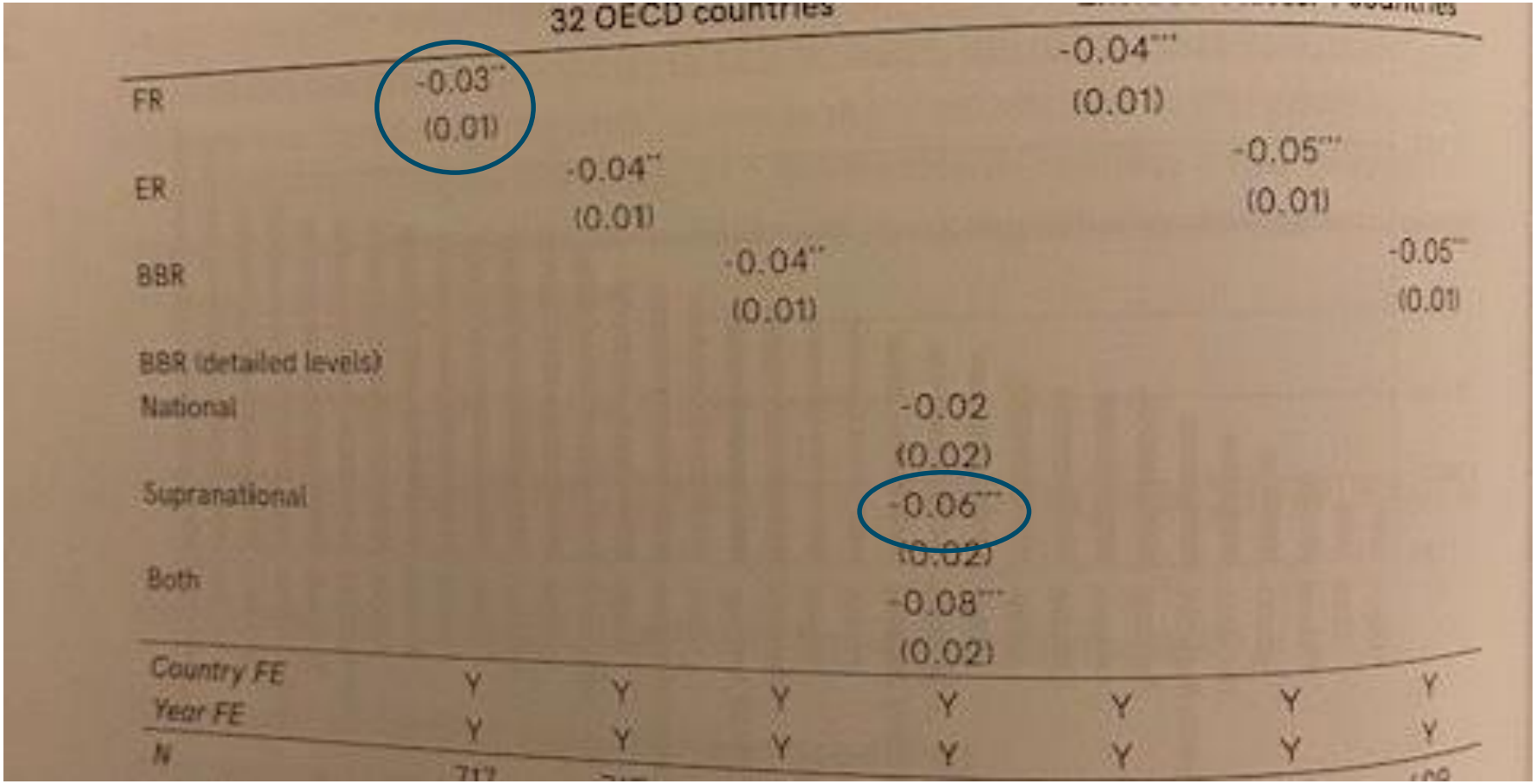


Source: Budina et al. 2012

Fiscal rules and health spending

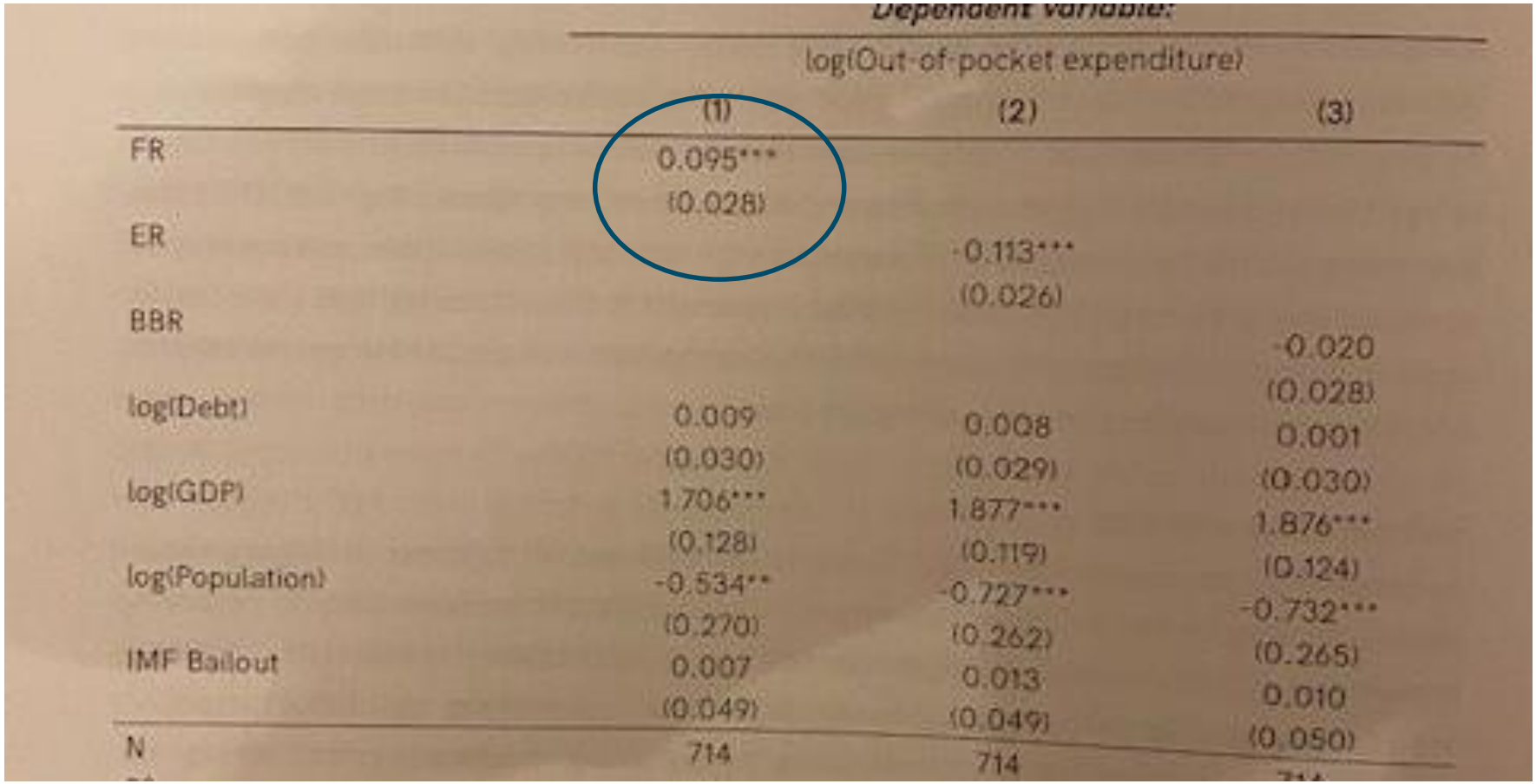
- Compliance towards fiscal rules ultimately depends on **political commitment**, especially in health (Alan Schick)
- Fiscal rules (with time-lag) are associated with **3% lower public health expenses**
- **Fiscal rules 'not' neutral**: seem to lower preventive expenses, while they increase private expenses and shift costs to the private sector
- Scoring agencies (CBO, CPB) **hesitant with accepting that efficiency policies trickle down to actual savings** in health spending
- **Effects** of cost-containment policies **on macro spending is limited** and diverse

Fiscal rules correlate with lower spending



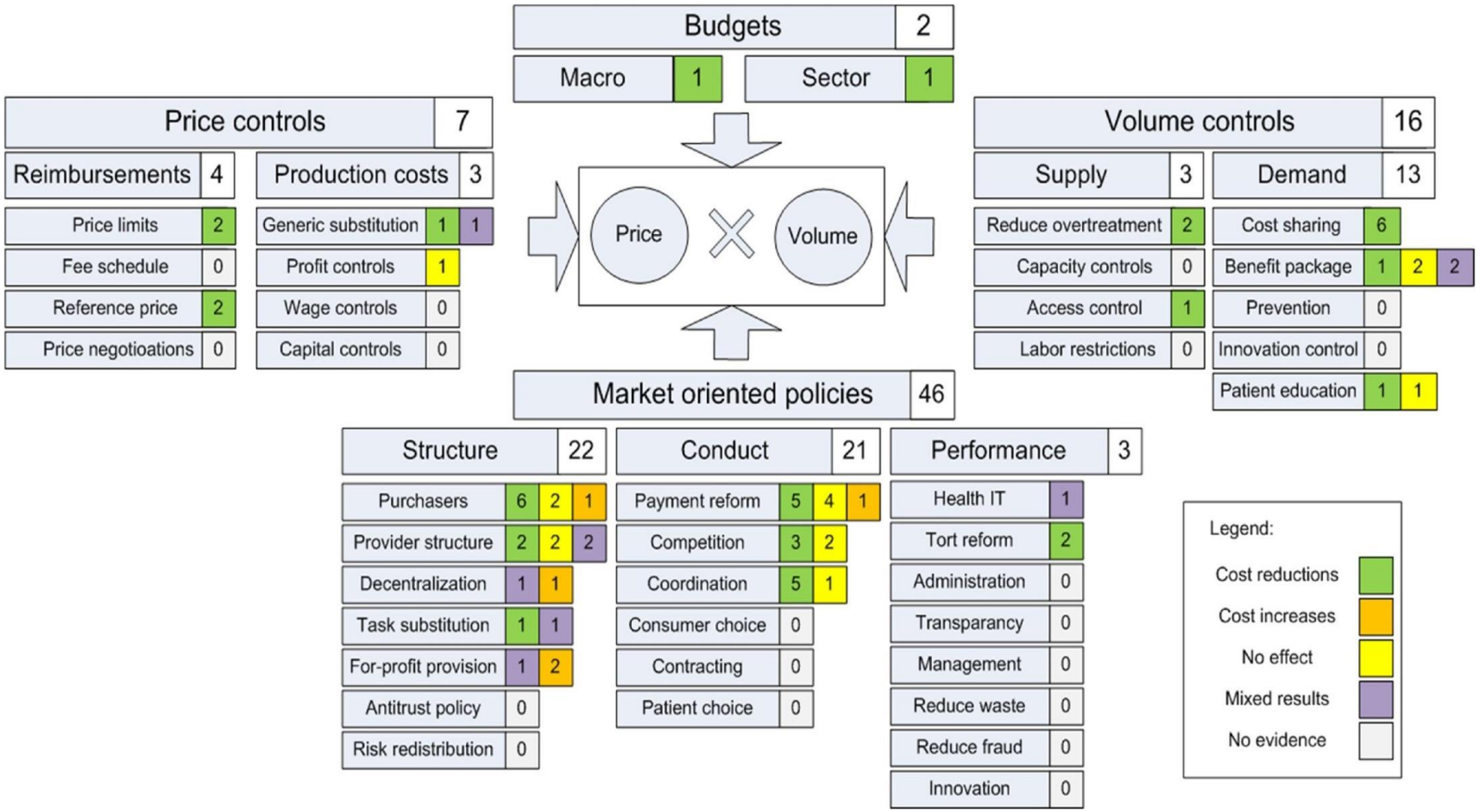
	32 OECD countries						
FR	-0.03** (0.01)				-0.04*** (0.01)		
ER		-0.04** (0.01)				-0.05*** (0.01)	
BBR			-0.04** (0.01)				-0.05*** (0.01)
BBR (detailed levels)							
National				-0.02 (0.02)			
Supranational				-0.06*** (0.02)			
Both				-0.08*** (0.02)			
Country FE	Y	Y	Y	Y	Y	Y	Y
Year FE	Y	Y	Y	Y	Y	Y	Y
N	713						

Fiscal rules correlate with higher OOP spending



	Dependent variable:		
	log(Out-of-pocket expenditure)		
	(1)	(2)	(3)
FR	0.095***		
	(0.028)		
ER		-0.113***	
		(0.026)	
BBR			-0.020
			(0.028)
log(Debt)	0.009	0.008	0.001
	(0.030)	(0.029)	(0.030)
log(GDP)	1.706***	1.877***	1.876***
	(0.128)	(0.119)	(0.124)
log(Population)	-0.534**	-0.727***	-0.732***
	(0.270)	(0.262)	(0.265)
IMF Bailout	0.007	0.013	0.010
	(0.049)	(0.049)	(0.050)
N	714	714	

Effects cost-containment on macro-expenses limited and diverse (1971 …)



Stadhouders and Jeurissen, 2019

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2. Setting spending targets for health

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Setting spending targets

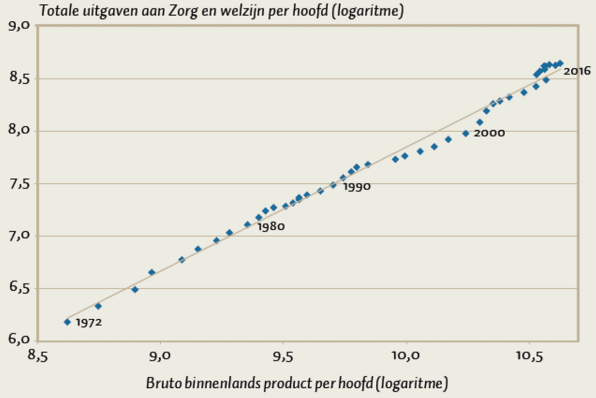
- Share main cost drivers health spending different to calculate
- **Underspending Dutch multiple payer system**, mainly because of (downward) financial risk insurance companies; more risk also strengthened balance-sheets of providers and insurers
- Who prepares spending targets: **independent agencies**, MoF, MoH
- How do we forecast: 1) **historic patterns**, 2) political targets, 3) (objective) health needs
- Politicians that seek for certain fiscal goals are independently challenged on the robustness of their calculations

Explanation of rising health care expenses not so clear

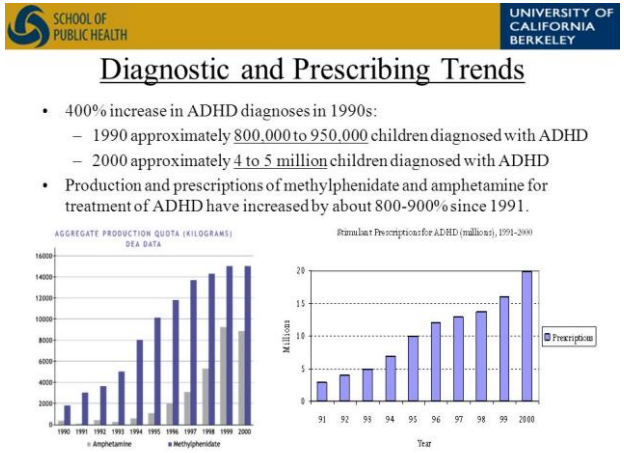
- Rising wealth and GDP (income elasticity)
- New (expensive) technologies
- Baumols' disease
- Aging
- Lifestyle
- Epidemiology
- Medicalization
- **Policy!**

We cannot make exact calculations of all the different components of rising health costs … **difficult to set objective fiscal rules**

Inkomen en zorguitgaven, per hoofd in Nederland

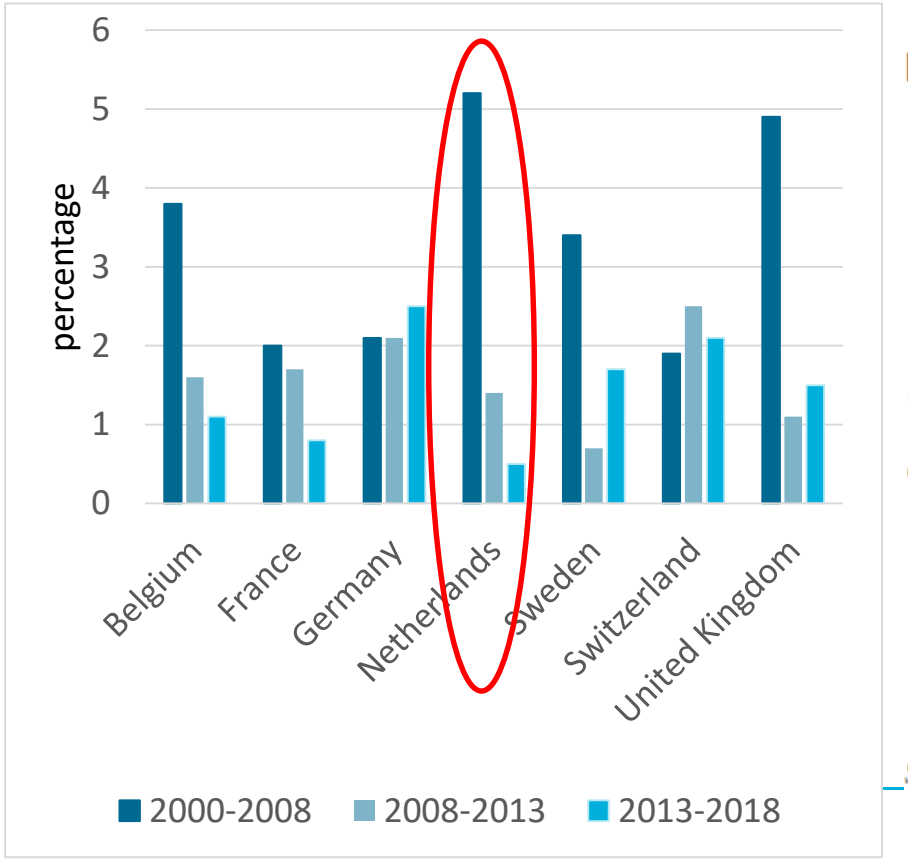


Bron: CBS, bewerkt door CPB | ESB

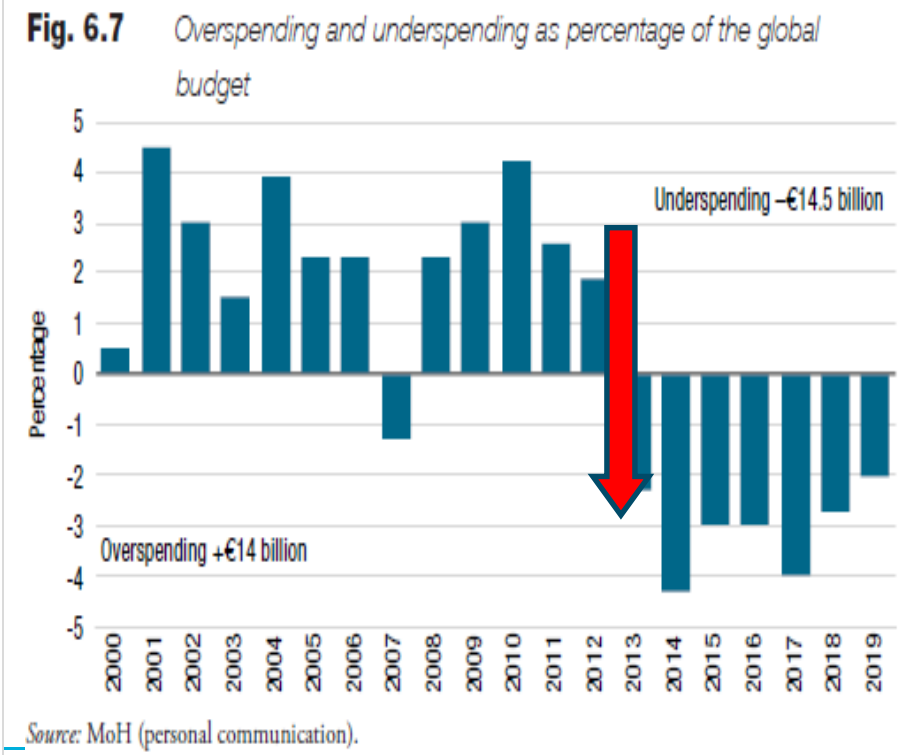


Miracle? Very slow growth expenses (since 2012), major underspending

Very low per capita growth in health expenses versus surrounding countries



Substantial underspending (since) 2012



Source: MoH (personal communication).

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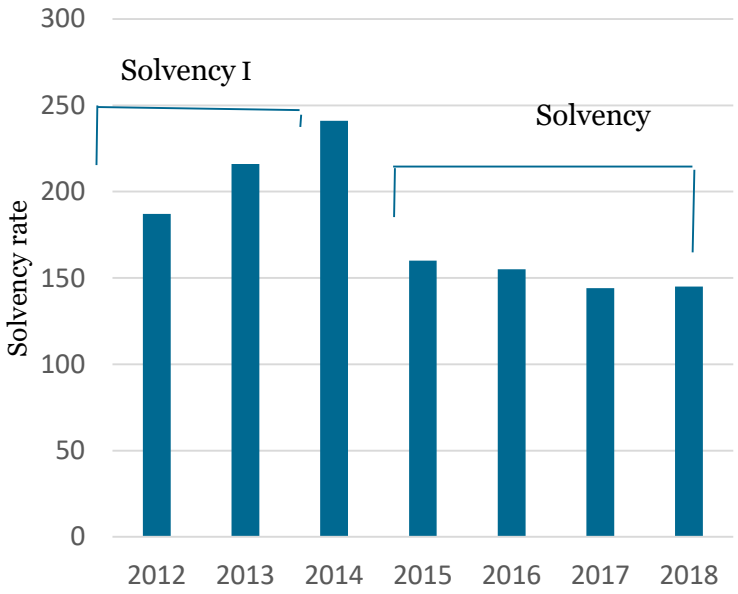
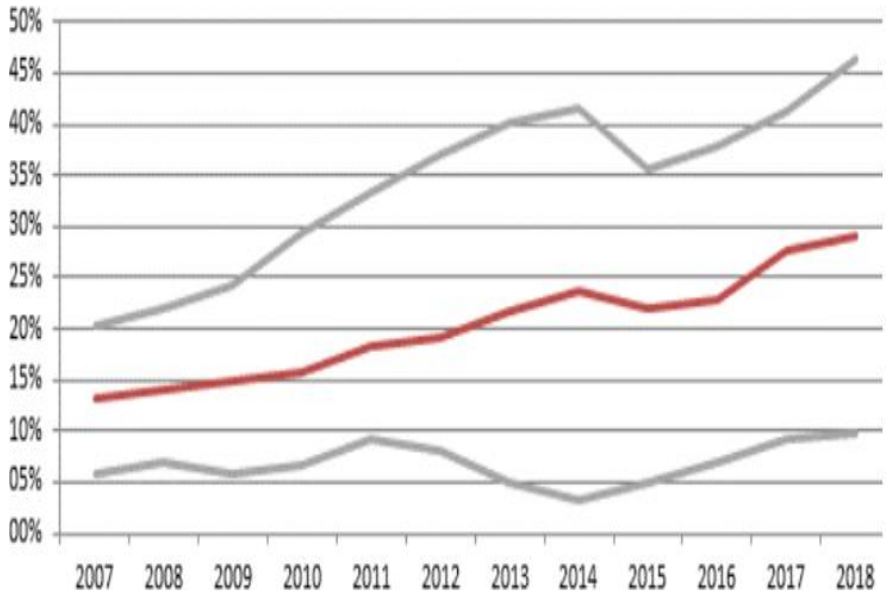
Additional gains: (much) stronger solvency

Healthcare insurers



Hospitals (solvency)



2006: 8% minimum solvency; 2023: around 30% solvency

Possible explanations underspending

- Regression to the mean, followed a period of high spending growth
- **Few associations between any increases in spending targets and over/underspending**: lowering of targets does decrease underspending and vice versa
- 2012: covenants create anchors in purchasing practices (ceiling), but does not explain underspending; claw-back procedure overspending
- **2012: substantially more (underwriting) risk for insurers (purchasers)**
- 2012: substantial increases in deductibles and co-payments (less demand)
- 2012: lowering budgets (LTC) may bend the curve, but typically does not lead to underspending

Fiscal anchor: forecast CPB, 2017 and 2021 (4-years)

2017	Demografie	Inkomen	Reële lonen en prijzen	Overige groei	Beleid	Reëel	Nominaal
Zvw	1,1	0,7	0,6	1,1	0,0	3,5	5,0
Wlz	1,7	0,7	0,7	0,5	-0,5	3,1	4,7
Wmo/jeugdzorg (BKZ)	0,7	0,7	0,8	0,8	0,3	3,3	4,9
Totaal (Zvw, Wlz, Wmo, jeugdzorg)	1,2	0,7	0,7	0,9	-0,1	3,4	4,9

2020	Demo	Inkomen	Reële lonen en prijzen	Overige groei	Beleid	Reeel	Nominaal
Zvw	1,1	0,7	0.5	0.1	-0.1	2.3	3.8
Wlz	1,7	0,6	0.5	0.6	0.2	3.6	5.1
Wmo/jeugd	0,8	0,7	0.6	0.4	0.0	2.5	4.1
Totaal	1,2	0,7	0.5	0.3	0.0	2.7	4.2

Fiscal health policies new government

	2022	2023	2024	2025	2026	Struct.
Health (in mln.)	88.398	90.763	92.282	93.152	94.549	
Coalition agreement	785	1.496	1.226	43	-782	-4.519
Appropriate care	40	50	60	60	30	-1.140
Purchasing pharmaceutivals		-15	-35	-50	-60	-130
Standaardisatie gegevensuitwisseling		200	400	200	200	-340
Standaardisatie verantwoording Zvw			-30	-30	-30	-30
Substitution		380	380	280	180	-300
Rate setting			-120	-140	-147	-147
Covenant	80	-295	-572	-886	-1.281	-1.489
Cure in LTC to curative care				-170	-170	-170
Freeze deductible		223	449	477	479	479

3. The problem of optimal allocation of health spending

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Optimal allocation of health spending

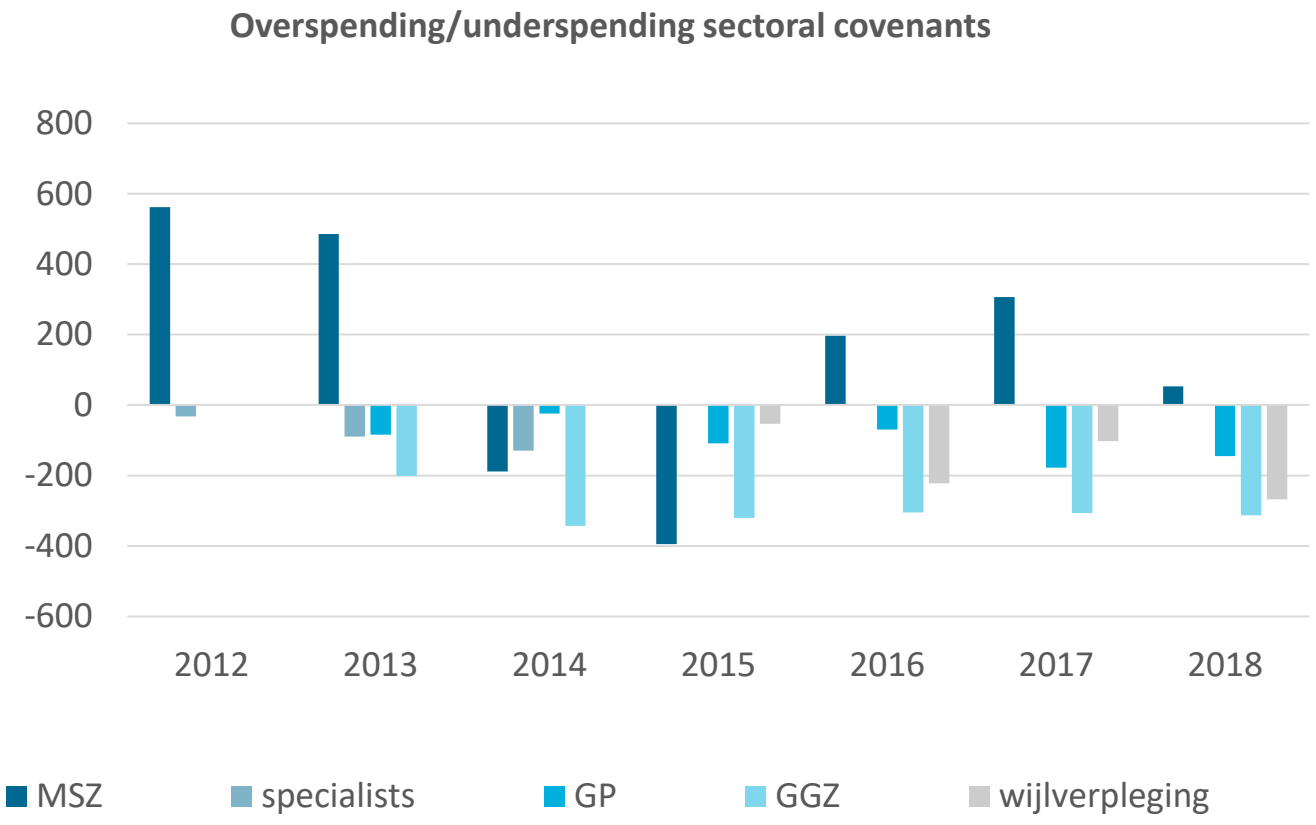
- **Despite prioritization on a sectoral level** health expenses tend to be **very sti**cky, also in a multiple payer system. This is a main challenge to long-term fiscal sustainability

- Despite active purchasing, the **financial volatility** on most provider markets **is low**

- Efficient fiscal allocation may often imply **substantial transfers** between providers, which **come with (fierce) resistance**

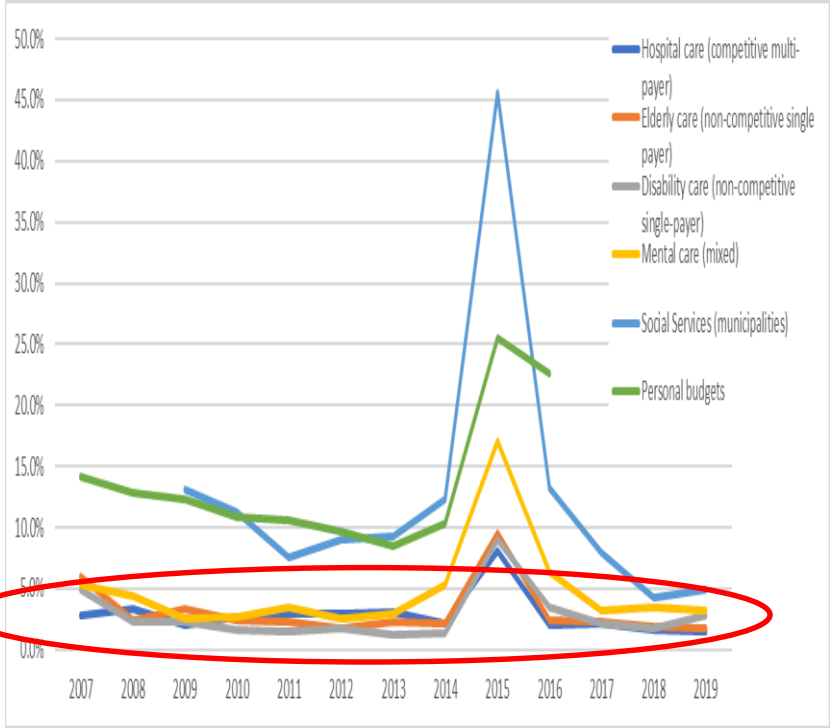
- Complex steering mechanisms, detailed reimbursement mechanisms, many cross-subsidies and high fixed costs create **huge principal agent problems that hamper optimal allocation**

Underspending community care (and generics)

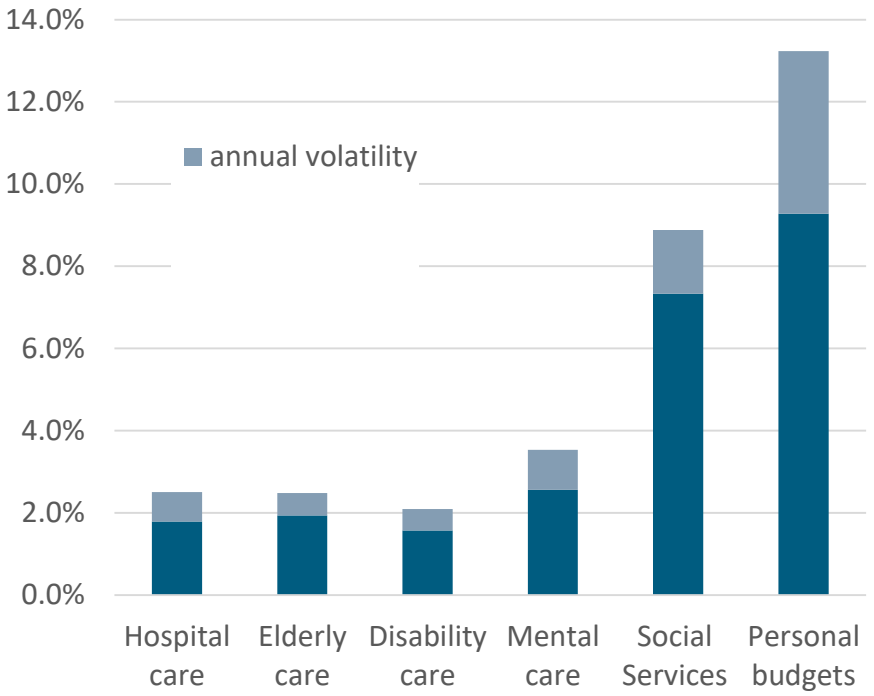


Purchasing holds limited influence on hospital MAI

Limited changes in market activity index (MAI)



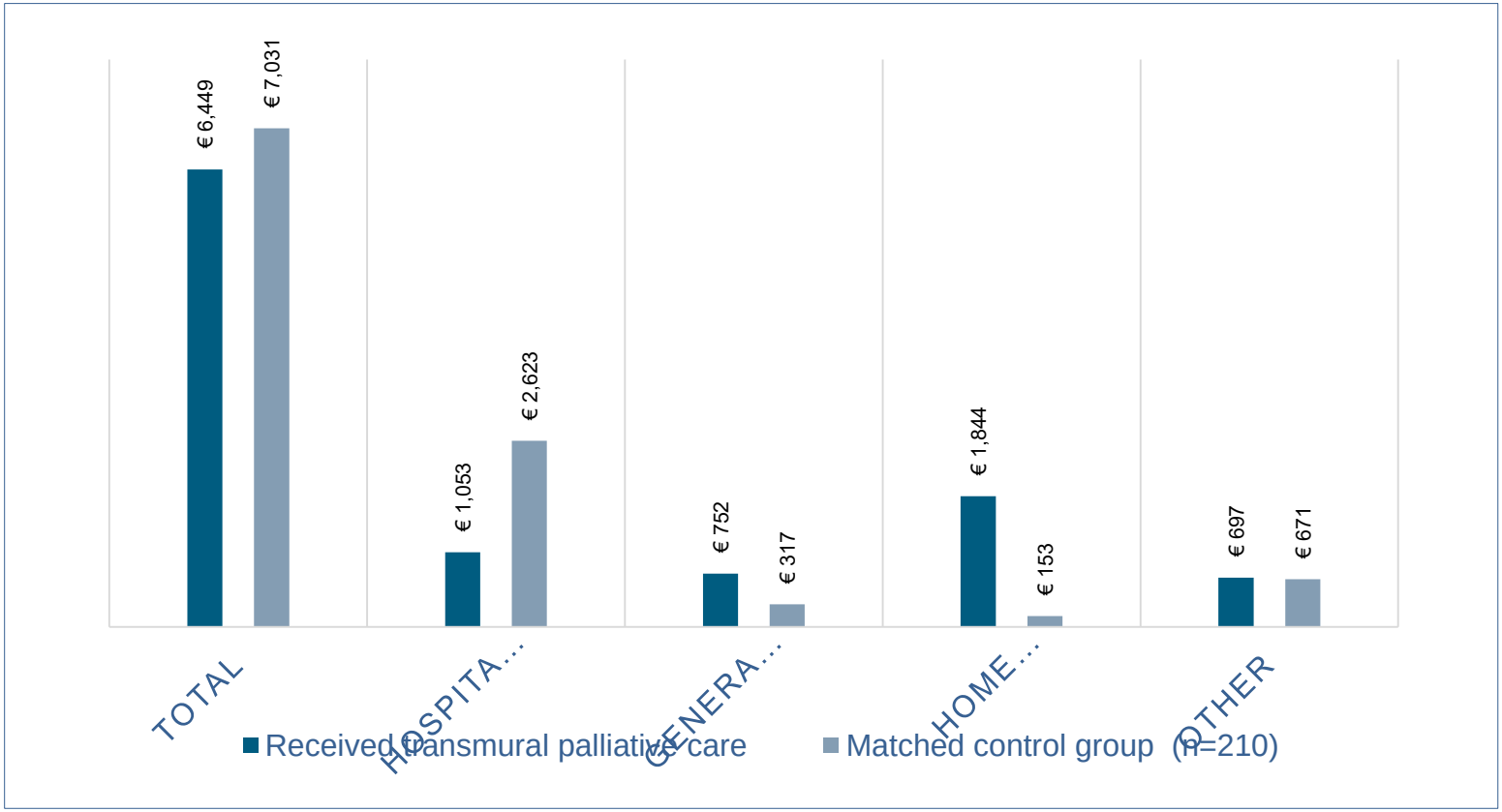
… but largely structural MAI changes



Stadhouders, Jeurissen et al (2022, under review)

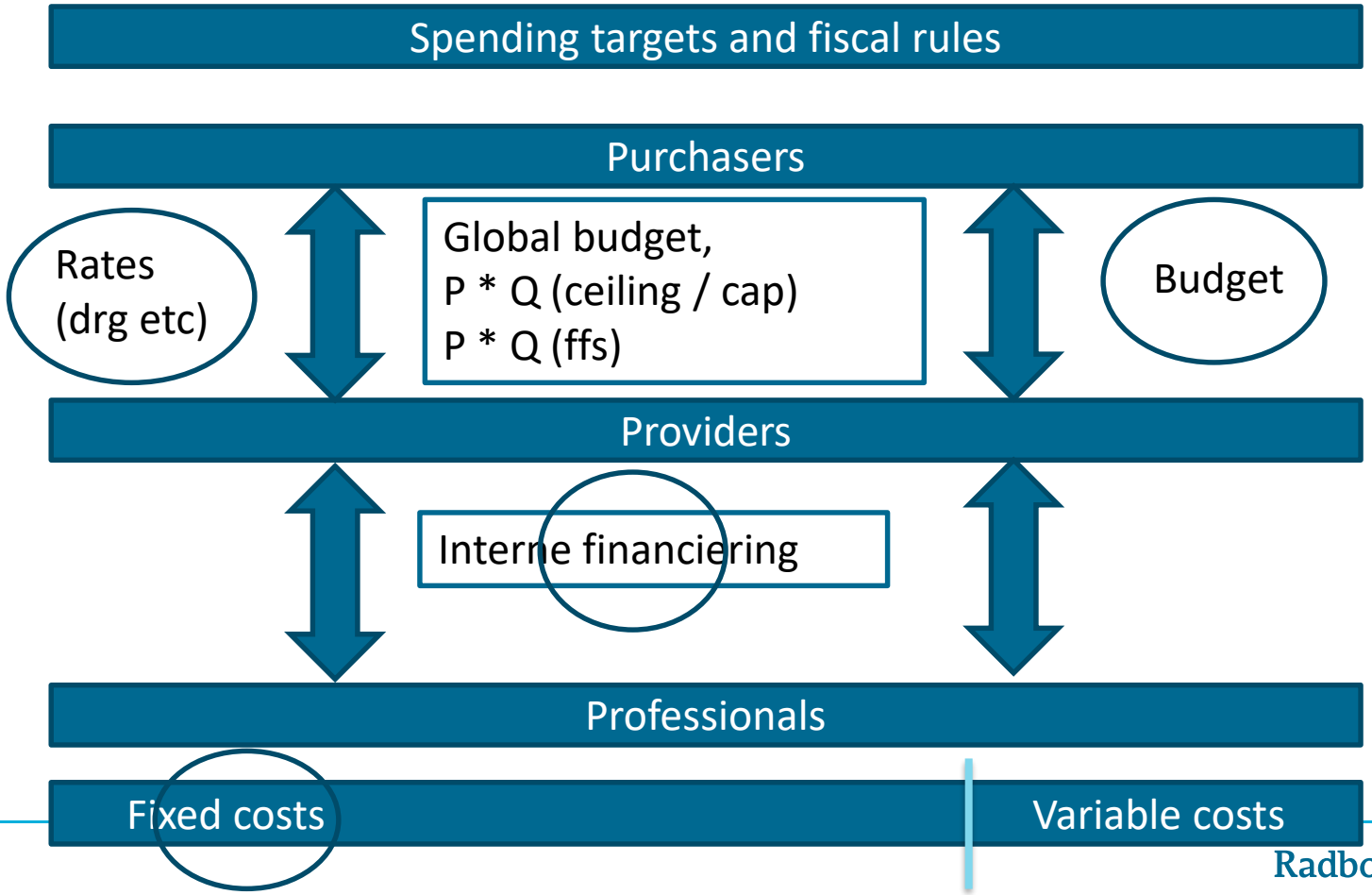
1. Level contracting, 2. quality of care or 3. provider scale all non-significant on MAI

Optimal allocation implies substantial shifts in provider budgets



Median healthcare costs last 30 days deceased adults receiving transmural palliative care (n=210) compared to a matched control group

Complex steering, lack of cost insight and many cross-subsidies



Lessons and conclusions

- **Fiscal rules** are somewhat effective to **contain healthcare costs**. We should develop specific fiscal rules that take the peculiarities of the health sector better into account.

- Underspending does not so much depend on the actual fiscal target, but on **downward financial risk for the different agents**; it prevents complicated political discussions on how to compensate for overspending.

- For the longer term **fiscal rul**es need to **contribute to the underlying systemic aspects that stimulate efficiency and resilience**. The Dutch case is sobering on aspects that may increase sustainability (substitution of care, rewarding more efficient providers, lower volumes instead of prices etc.)

- More **richer and independent forecasts** (based on needs and cost-drivers) **are non-regret**

Thank you for your attention.

Questions, remarks: patrick.jeurissen@radboudumc.nl

Theory managed competition

Stewardship
MOH: system
MOF: global budget

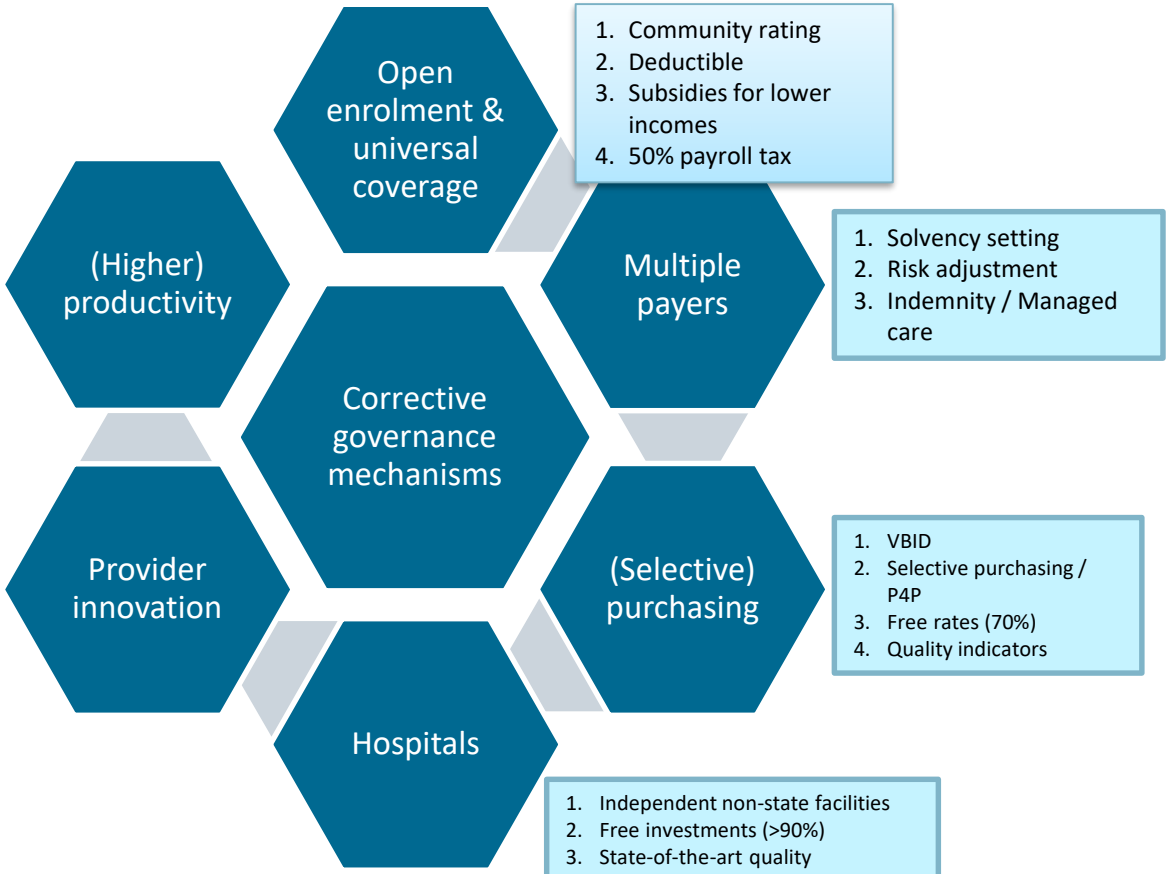
Agencies

Independent
Central bank
Competition authority
Central economic bureau

Arms-length
Health market authority
Healthcare Institute

Inspectorates
Patient safety
Fraud and abuse

Semi-private governance
Social-economic council
Covenants: building coalitions
Credit enhancement
Professional standards
Interest groups



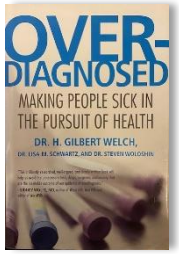
Agenda's voor maken keuzes

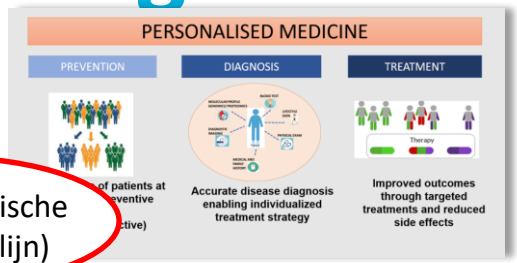
- WRR (2021) : financiele, personele & maatschappelijke houdbaarheid onder druk
- Niet oplosbaar met doelmatigheid: kiezen
- Versterk instituties om te kiezen: OPA, begroting etc.
- Meer geld: jeugd, GGZ en delen ouderenzorg

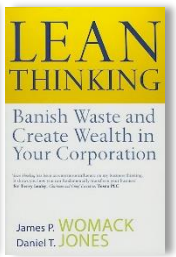
- Betaalbare zorg (2018)
- Transformatie zorg vraagt op straffe van hoge transactiekosten om meer expliciete keuzes. Impliciete keuzen werken goed in situatie van stabiliteit en die is er steeds minder.

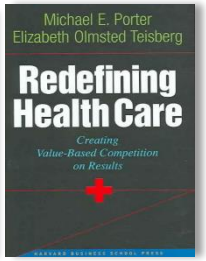
- https://www.youtube.com/channel/UCumLNMmaIDJJw2LKE2rBMkQ/videos?view=0&sort=da

‘Bermuda’ driehoek zorg









Top specialistische zorg (derde lijn)

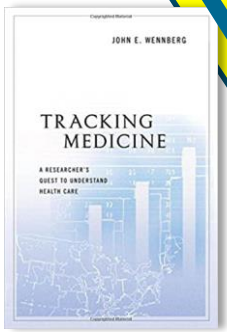
Population health

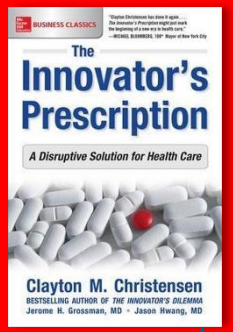
Betere kwaliteit

Solution shops

Value-adding processes

Triple aim





Per capita kosten

Facilitated network

Niet patiënt / cliënt gebonden uitgaven

Multi-morbiditeit / multi-problematiek

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