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The arduous quest for translating health care productivity gains into cost savings. Lessons from their evolution at economic scoring agencies in the Netherlands and the US

Ab Klink[a,*], H. Christiaan Schakel[b,d], Sander Visser[c], Patrick Jeurissen[b]

[a] Faculty of Social Sciences, VU University Amsterdam, De Boelelaan 1105, 1081 HV, Amsterdam, The Netherlands
[b] Celsus, Academy for Sustainable Healthcare, IQ Healthcare, Radboud University and Medical Center, P.O. Box 9101, 114 6500 HB Nijmegen, The Netherlands
[c] Strategy&, part of the PwC Network, Thomas R. Malthusstraat 5, 1066 JT, Amsterdam, The Netherlands
[d] NYU Wagner School of Public Service, New York University, 295 Lafayette street, 10012 New York, NY, USA

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ABSTRACT

We analyze the assessments of recent health reforms by the Congressional Budget Office (CBO) in the United States and the Bureau for Economic Policy Analysis (CPB) in the Netherlands.

Both reforms aim to capitalize on productivity gains, which is appealing for policymakers because of the potential for cost savings while maintaining – or enhancing – quality and access. These measures however generally translate into more health care, rather than care that is affordable and appropriate. Scoring agencies therefore have rightfully been reluctant to assign significant savings to these measures.

Thus with regard to cost savings, both agencies instead have favored more traditional policy measures in the past. They are however increasingly mapping out loose ends and dilemmas for payers, including information asymmetries, reputation issues and provider business models that contradict the goals of policymakers. This calls for further exploring this avenue and the development of more integrated agendas that might commit actors and the spread of best practices.

1. Introduction

In an attempt to strike a better balance between accessibility, costs and quality, health policy makers increasingly rely on the forces of (quasi) competition to pursue public objectives. Such reforms are studied extensively [1,2]. Before and while being implemented, these reforms are often assessed by (independent) economic scoring agencies. How economic agencies have evaluated these reforms has not been systematically studied.

In this paper we analyze the assessments of the Netherlands Bureau for Economic Policy Analysis (CPB) and the US Congressional Budget Office (CBO) in the period before, during and after the major health care reforms of the last decade. These reforms (the Dutch Health Insurance Act of 2006 and the US Patient Protection and Affordable Care Act of 2010) were aimed at creating broad or universal access, while also boosting productivity. Our explicit focus is on the agencies' assessments of the reforms, rather than on the success of the reforms themselves.

Both bureaus have the task of assisting policymakers and politicians with economic evidence. They directly influence decision-making of the government and politi-

* Corresponding author.
E-mail addresses: klink.ab@gmail.com (A. Klink), christiaan.schakel@radboudumc.nl, h.c.schakel@gmail.com (H.C. Schakel).

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cal parties. A study of their projections is therefore highly relevant. Politicians are often highly aware of the models used and – at least in the Netherlands – might even reshape their proposals in an attempt to circumvent negative assessments (e.g. Smith et al. [3], White [4]). The bureaus constantly reflect on their earlier projections. Those reflections show us the continuous struggle to incorporate the latest scientific insights and offer assessments that do justice to the ambition of policymakers for a health system that is accessible, affordable and of good quality.

We present an analytical review on how the agencies developed their thinking and assessment along the way on the fiscal effects of the health reforms. Section 2 describes how the Dutch CPB has assessed the Dutch health reforms. Section 3 follows the same approach for the CBO and the Patient Protection and Affordable Care Act. Section 4 discusses the open ends and dilemmas the agencies, each in its own way, uncover. Dilemmas that also challenge the classical assumptions of the agencies with regard to cost saving policies in health care. Section 5 concludes.

2. The Netherlands Bureau for Economic Policy Analysis (CPB) and health reform

The CPB provides economic forecasts on which the government bases its fiscal policy at the start of, and throughout a Cabinet period. The bureau also assesses the election programs of political parties. The assessment framework for health is relatively straightforward. It projects a (regular) cost growth trajectory that is largely based on historical data [5]. This is not without importance since it implies that past high cost growth rates breed future projected high growth rates of health expenses. High growth of health expenses in turn reduces the fiscal space of other (discretionary) public services. If the base-line projection of health expenses come close to or are equal to the total amount of fiscal space, political parties might seek for savings to create room for other public services or specific cost increasing priorities in health. The bureau assesses the budgetary impact of proposals of the respective political parties, including budget cuts and budgetary incentives. We look at its successive projections in 2003, 2006, 2010 and 2012.

2.1. 2003: supporting health care reform proposals, but reluctant to quantify potential savings

Around 2000, many political parties agreed that the Dutch health system was in need of repair. Most volume incentives had been eliminated and the strict budgeting policy predictably led to long waiting lists and increased pressure on the system [6]. A number of lawsuits were filed opposing the tardiness of the delivery of health care services. The pressure on the government to change this policy increased [7,8]. To eliminate waiting lists, large sums of money were injected into the system. Due to the high level of spending autonomy of providers, policy makers and politicians had little insight as to where the extra money went [9].

While injecting extra money in the system was not very efficient in the short run, it would surely not be sustainable in the long run. In an effort to develop an alternative approach, center and rightwing parties advocated a transition toward a competition-based delivery system [10,11]. Competition was believed to be the key to restoring labor productivity, which in turn would lower the price of delivery. Sickness funds would be transformed into private health insurers, which were supposed to compete among each other for the best contracts to purchase health care providers; and translate their bargaining powers into competitive premiums and/or good quality of care. Plans would be financed through income- and employer-based contributions, a monthly nominal premium (children would be exempt), and general tax revenues. Tax subsidies would support low-income individuals and families to purchase health insurance.

The CPB has a very respected an influential position on economic issues toward all policy stakeholders. As an extraordinary task it then provided an extensive 'qualitative assessment' of the conditions under which regulated competition could be most successful [12,13]. It gave no budgetary estimate of potential costs or benefits of the proposed transitions, although it legitimized the proposed reform by linking it to potential efficiency gains and to increasing transparency of the health care market.

The CPB explained its reluctance to quantify the economic impact of the reforms. Long-term effects of the transition were unknown. With foresight, the bureau stated that an efficient delivery system could also exert upward pressure to overall expenditures through supplier-induced demand, through an accelerated adoption of cost-increasing technologies, less cost-effective treatments, and through a greater number and diversity of suppliers and associated services. To counterbalance these risks, the bureau pointed to the possibility of higher co-payments, but also suggested better protocols and guidelines and degressive tariffs.

2.2. 2006: more confidence in reforms

The health system reform became law in the election year 2006 (Table 1). The CPB provided budgetary estimates of the policy proposals within the election programs of the different political parties. The bureau granted traditional proposals concerning deductibles, the benefit package, (lower) subsidies for lower income groups and some efficiency measures [14]. However, this time, the CPB also projected cost reductions as a result of the introduction of increased competition. Thus, the bureau became more explicit in its assessment of efficiency gains through market forces than it was in 2003. This also aligns with the assignment of the bureau to explicitly score the fiscal consequences of the political programs. The Christian Democratic party for example pushed for a broad liberalization of prices (up to 80% of hospital care) and larger risk bearing responsibilities for insurers; the CPB estimated that such a price liberalization would allow insurers to recoup € 0,3 billion through productivity increases by 2011, climbing to € 1,0 billion in 2018.