


Recent studies, including those of the Mental Health Economics European Network, have shown that there are two dominant trends in mental health care financing in Europe. The first is a partial shift of funding to the social care and housing sectors. The second is a liberalisation of the health care sector and of health care financing as a whole.1,2,3

Specific to the current changes in Dutch mental health care is that the first trend – the transfer of mental health care funds to non-health care domains – only takes place at a very limited level. To a much greater extent, Dutch mental health has become subject to a broader liberalisation process taking place within the health care sector.

Summary: A process of liberalisation is taking place in health care in the Netherlands. The impact of this process varies over the various health care domains. Mental health care is a domain for which the impact seems to be relatively large. Dutch mental health care is in the process of being transformed from a homogeneous, regionally organised, integrated mental health care system, financed by a single social insurance, to a more heterogeneous working field, financed through several sources and subject to market forces. Stakeholders in Dutch mental health care welcome new possibilities this presents for providers, but concerns are expressed about the consequences of these changes for the quality and comprehensiveness of long term (community) care and for the sustainability of the mental health care system as a whole.

Keywords: Mental Health Care; Financing; Health Insurance System; Deinstitutionalisation Policy; the Netherlands

Frank van Hoof, Ineke Kok and Joost Vijeslaar

Health and social care financing
Since 2007 health and social care in the Netherlands have been funded through three financing systems (Box 1). The first, the Health Insurance Act (ZVW or Zorgverzekeringswet) covers basic, essential health care. The ZVW was introduced in 2006 and replaced several previous health care insurance systems. The ZVW is the main vehicle for the liberalisation of health care in the Netherlands. It places a strong emphasis on market competition between insurers, and between health care providers. Under the new legislation all citizens are obliged to...
purchase health insurance for basic health services. Consumers are free to choose any health insurer. Health insurers in their turn are expected to compete for clients on the basis of their premium rates and the quality of contracted providers. Health care providers are expected to compete for contracts with insurers on the basis of the price and quality of their services.

The second financing system is the Social Support Act (WMO or Wet Maatschappelijke Ondersteuning) covering a broad range of social care domains, such as household support, youth centres, sheltered accommodation and special transportation facilities for people with physical disabilities. The WMO was introduced in 2007, one year after the implementation of the new health insurance legislation. In this new WMO system, several previous social care laws have been brought together. Under the WMO, local governments are the administrators of budgets and have considerable autonomy in deciding how to spend these. Budgets in the WMO are not earmarked and there are no individual entitlements. The responsibilities of the national government are mainly restricted to decisions concerning the total, national budget for the WMO.

The third financing system for health care and social care in the Netherlands is the Special Medical Expenses Act (AWBZ or Algemene Wet Bijzondere Ziektekosten) covering care for older people, people with disabilities and, until recently, most of the care for people with mental health problems. The AWBZ is the oldest of the three financing systems. It was introduced in 1968. The AWBZ is a relatively solid social insurance, which places an emphasis on strong and precise entitlements to care for people with more severe or chronic health problems or disabilities. Regional AWBZ offices are the administrators of the AWBZ. Unlike the WMO, these administrators perform their role within strict, nationally regulated procedures.

### Costs, sustainability and market competition

The recent reforms in health care financing in the Netherlands are motivated by one principal objective: preserving the sustainability of the health care system, or to be more precise the wish to gain control over the rising costs of health care. The ZVW is, in fact, the result of a policy process that started around 1992. As a result of that process subsequent government advisory boards have placed considerable confidence in liberalisation as a means of reaching a more sustainable health care system. In line with these views, the current Dutch government places great confidence in the ZVW to achieve cost reduction and quality gains. The WMO is also viewed as an important means of enhancing the sustainability of the health care system, albeit in a different way to the ZVW. The WMO offers the national government the opportunity to control total budgets (whereas open-end financing would lack that opportunity), leaving it to independent local governments to make ends meet.

In short, at a national government level there is much confidence in the ZVW and the WMO. The concerns of the current government concentrate on the AWBZ. It is argued that the costs of the AWBZ are rising too rapidly. In addition, the AWBZ, with its solid entitlements, open-end financing and lack of market incentives, is seen as one of the principal threats to the sustainability of the health care system.

Some advisory boards have already argued for the abolition of the AWBZ, and the transfer of its most important elements to the ZVW and the WMO respectively. In fact, for some AWBZ-financed health care and social care services, these transfers have already taken place. These include the transfer of the majority of mental health care responsibilities in early 2008.

### The financing of mental health care

Over a period of thirty years, the AWBZ had become the principal source of financing for almost the entire mental health care system in the Netherlands. During its early years, the AWBZ was mainly used to fund long term clinical care and long-stay facilities. In trying to reach a more uniform financing system, and to stimulate cooperation between inpatient and outpatient care, outpatient services were incorporated step by step into the AWBZ-system. Since the mid 1980s, inpatient and outpatient mental health facilities, including short term mental health services, have been fully financed by the AWBZ.

The AWBZ has played an important role in the development of the current mental health care system in the Netherlands. From a rather patchy network of local, regional and nationally financed facilities, each with its own historical background, methods, and client population, Dutch mental health care has grown over the past three decades into a relatively homogeneous, regionally organised, integrated health care system that is clearly delimited from other health care domains.

The fact that all mental health care services were grouped under one financing-system has facilitated this development. So did the fact that mental health care was covered by a separate and specific set of entitlements within the AWBZ. A national policy emphasising regional cooperation and integration of mental health care services, alongside the organisation of the administrative management of the AWBZ through the regional AWBZ offices, further enhanced the regional integration of mental health care. Ultimately, this integration process culminated in mergers between mental health care providers on a regional level. As a result, Dutch mental health care in 2006 was dominated by forty regionally operating mental health care providers, each providing the full scale of mental health interventions (clinical and non-clinical) for their respective regional client populations.
It may thus be concluded that the current constellation of mental health care in the Netherlands has largely been the result of a long lasting and deliberate national policy. The main objective of that policy could be described as the implementation of a solid, comprehensive, recognisable and accessible mental health care system. The AWBZ was used as an important vehicle to reach this objective.

Turning point
It is important to note that the gradual integration of the mental health care system over recent decades has not been without criticism, for example from client organisations and mental health care researchers. Some argued that the development of a homogeneous mental health care sector, clearly delineated from other domains, could hamper cooperation with other health and social sectors and the integration of mental health care services in other domains. It was asserted that mental health care might be at risk of becoming an inwardly oriented sector on its own, insufficiently responsive to developments and demands from the outside. It was also contended that the vested interests in the solidly organised mental health care sector hampered the deinstitutionalisation process and the reintegration of people with long term mental health problems into society.5

Until the beginning of this century, however, the positive elements of the system were considered by the national government to outweigh these concerns. Not only had mental health care grown into a recognisable and accessible health care sector, the integration of mental health care services also enhanced the comprehensiveness, continuity and coherence of mental health care, especially for people with long term mental health problems. While it was also acknowledged that deinstitutionalisation was not a speedy process, it was also argued that some substantial progress was made, be it at a cautious pace, in the development of community based services, housing facilities, and rehabilitation and vocational services for persons with long term mental health problems. All in all, none of the subsequent national governments felt a need for a substantial policy shift.

In 2003, that perspective drastically changed. Specifically, the installation of a new government proved to be a turning point for Dutch mental health care policy. In the process of preparing the ZVW and the WMO laws, new policy papers were published on mental health care. These policy papers emphasised the disadvantages of a homogeneous mental health care sector, clearly delineated from other domains. Concerns were expressed about mental health care being run by providers that operated as regional monopolies, leaving no room for consumer choice. It was also stated, that the relatively risk-free financing position of mental health care providers in the AWBZ offered insufficient incentives for innovation. It was concluded that mental health care would be better off if it could benefit from both the new, competition-oriented ZVW and locally embedded WMO.6

New incentives and disincentives in the provision of mental health care
Preparations for the transfer of mental health financing were not complete until 2007. In early 2007 a relatively small percentage (about 3%) was transferred to the WMO (subsidies on consumer run projects, mental disorder prevention actions and outreach programmes for people with mental health problems, such as the homeless). Subsequently in 2008, a much larger proportion of financing was transferred to the ZVW. As a consequence, the ZVW has become the main financing source for mental health care, covering about two thirds of expected total mental health care expenses. In particular, the ZVW covers all short-term inpatient and outpatient mental health care, and all long-term community mental health care. Ultimately, only long-term inpatient mental health care and institutional housing facilities remain within the AWBZ.

The impacts of these reforms in mental health care financing on the structure of mental health care in the Netherlands are twofold. First there is the transformation from one to (at least) three financing sources. This means that, from the financial perspective, mental health care can no longer be viewed as a single health care sector. As a matter of fact, mental health care as such is no longer a delimited domain for national policy. No single government agency any longer holds responsibility for the whole of mental health care. Responsibilities are spread over several departments, with each defining and implementing policies on the ZVW, the AWBZ and the WMO respectively.

Second, market competition is being rapidly introduced into a field that used to be determined by relatively secure annual incomes and by efforts to enhance cooperation. Specifically, conditions are being created where mental health care providers can no longer depend on their dominance on a regional level, and where opportunities are rapidly growing for competition for market share in other regions.7,8

In short, the incentives contained within the new financing structures seem to be leading Dutch mental health care into a transformation process from a relatively homogeneous, regionally organised, integrated mental health care system (with all its pros and cons) to a more heterogeneous working field, financed through several sources, and subject to market forces.

First signs of a new mental health care system
The changes in mental health care financing are still very fresh and the exact consequences have yet to be fully grasped. Still, the first signs of these consequences can be gleaned from the way mental health care providers have so far anticipated the new financing system and from the growing discussion on the future of mental health care in the Netherlands.

The first signs from the mental health care field itself indicate that providers have already begun competing with each other for market share in the provision of short-term mental health care for people with mild mental health problems.

Some providers have begun developing facilities in the territory of their former colleague providers – now competitors. Marketing is a rapidly emerging activity in mental health care; new ‘brands’ for short-term care are emerging; and some providers are actively beginning to explore new niches in the market. In efforts to further ensure a solid market position, mergers are now taking place on an almost monthly basis.

Meanwhile, the regional organisation of the mental health care system is losing its dominance. Large, nationally operating providers are emerging alongside small, specialised, partially commercial mental health care providers. Initial findings also suggest that local governments are not always aware of their new (WMO) responsibilities for people with mental health problems.9

The new financing system has also generated debate about the future of mental health care in the Netherlands. In these discussions many welcome the new
opportunities in terms of the diversification of care products, the emergence of new providers and the supposedly growing possibilities for consumer choice. But there are also discussions on the risks of the new system, in particular those concerning the quality of care for people with more severe and/or chronic mental health problems. Although there are as yet no solid empirical data to support these views, there are concerns that people with severe mental health problems may become unattractive (costly) clients for insurers. The new financing system might then encourage insurers to disinvest in good long-term community care.

There is also concern about the dispersion of responsibilities. Some fear that the new system carries incentives for local governments and insurers to shift the responsibility between each other for the financing of community support and rehabilitation and vocational services. There is also concern that local governments and insurers will try to shift patients from WMO and ZVW financed services back to long term inpatient facilities, financed by the AWBZ. In particular, many mental health prevention programmes and consumer run projects have been forced to end their activities, as they are not viewed as priorities by local governments.

In short, the first signs of the consequences of the new financing system for mental health care indicate a growing dynamic in the provision of short term mental health care services and in the market positioning of providers. Clearly at the same time, there are increasing concerns about the potential consequences for the sustainability of long-term, community mental health care services.

Conclusion

The changes in mental health care financing in the Netherlands are still very new. The real impact will become clear over the coming years. For the time being it seems safe to conclude that, in the slipstream of a broader liberalisation process of health care in the Netherlands, Dutch mental health care has entered an important transformation process. First impressions indicate that the new system has generated incentives for diversification and growth of short term mental health care, and for strategic manoeuvring of mental health care providers to strengthen their market position. Early indications also raise questions as to how these changes could facilitate the attainment of national and international long term mental health care policy goals that have been set out in recent decades: deinstitutionalisation coupled with the development of community care and the enhancement of social inclusion of people with severe mental health problems. In fact, it is unclear what value is still attached to these goals by the current Dutch government.

These impressions lead back to the main objective of the current health care reforms: the sustainability of the health care system. The supposed cost-reducing mechanisms of the new financing system might require time to show and prove themselves. In addition, it is important to be alert to two possible risks. The first may be accelerating growth of (mental) health care, as a result of incentives within the competitive market system for providers to attract (new) clients. Referring to psychiatric epidemiological data, mental health care providers suggest that there is still a huge reservoir of untreated psychiatric disorders. Some have now started to search more actively for these potential new clients. The second risk might be in a stagnation of the development of rehabilitation and vocational services for people with long term mental health problems, resulting in less participation and greater costs both in terms of social welfare benefits and impacts on other social care domains. If these risks are borne out, what has been intended to be a means to preserve sustainability by reducing costs per product, might then threaten that sustainability by resulting in growing mental health care consumption and in additional costs to other publicly financed domains.

At this moment, however, the speed and the magnitude of change in mental health care financing, and the dispersion of responsibilities, mainly seem to lead to feelings of uncertainty about the future and to a sense of lack of direction for mental health care in the Netherlands. For these and the above reasons it would be desirable for these changes in mental health care financing to be accompanied by a new coordinated national mental health care policy, emphasising social inclusion and the full participation of people with mental health problems.

References
