



Rijksinstituut voor Volksgezondheid
en Milieu
*Ministerie van Volksgezondheid,
Welzijn en Sport*

Kostenontwikkeling GGZ

Kosten van ziekten notities 2012-1

AM Bijenhof
MA Folkertsma
GJ Kommer
LCJ Slobbe
JJ Polder

A. van Leeuwenhoeklaan 9
3721 MA Bilthoven
Postbus 1
3720 BA Bilthoven
www.rivm.nl
KvK Utrecht 30276683
T 030 274 91 11
F 030 274 29 71
info@rivm.nl

Contact:
Centrum voor Volksgezondheid Toekomstverkenningen
kostenvanziekten@rivm.nl

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Samenvatting

Het afgelopen decennia zijn de uitgaven van verschillende sectoren van de Nederlandse gezondheidszorg fors gestegen. De kosten van de Geestelijke Gezondheidszorg (GGZ) zijn relatief het meest toegenomen. Een stijgende vraag om professionele hulp voor psychische gezondheidsproblemen ligt ten grondslag aan de groei van de GGZ. Ook is de zorg voor psychische gezondheidsproblemen toegankelijker geworden, waardoor het aantal patiënten en behandelingen is toegenomen. Daarnaast heeft de liberalisering van de zorgmarkt het mogelijk gemaakt voor nieuwe aanbieders om zich te vestigen en werd bestaand aanbod uitgebreid. Beleidsmaatregelen gericht op een beteugeling van de kostenstijging hebben bovendien nauwelijks effect gehad. Hoewel prijsdalingen bereikt zijn in de GGZ hebben maatregelen, waarbij budgetmaxima werden opgeheven en nieuwe financieringssystemen geïntroduceerd, voornamelijk geleid tot een toename van de zorgproductie.

Stimulering van het gebruik van de goedkopere eerstelijns wordt gezien als een mogelijkheid om de GGZ uitgaven te remmen. Om dit te bereiken zijn er verschillende maatregelen genomen om de eerstelijnszorg te versterken. Zo zijn er samenwerkingsverbanden tussen huisartsen en andere aanbieders van eerstelijns GGZ gevormd. Tevens is vergoeding van eerstelijns GGZ in 2008 geïntroduceerd. Hoewel het gebruik van eerstelijnszorg met deze maatregelen werd gestimuleerd, heeft dit niet geleid tot een reductie van het gebruik van gespecialiseerde zorg. Substitutie van zorg tussen de lijnen lijkt daarom nog niet plaats te vinden. Verdere bevordering van het behandelen van patiënten in de eerstelijns lijkt echter wel noodzakelijk om de groeiende vraag op te kunnen vangen en de tweedelijns daarbij zoveel mogelijk te ontwijken.

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1 Inleiding

Vanaf 2012 worden jaarlijks vier korte verdiepende notities rond 'Kosten van Ziekten' opgesteld. Deze eerste notitie gaat over de GGZ. Uitgaven aan de GGZ zijn een actueel thema in de zorg. Sinds 2000 zijn deze uitgaven fors gestegen, ondanks vele beleidsmaatregelen om deze groei te beteugelen. De afdeling Macro-economische Verkenningen en Arbeidsmarkt vraagstukken (MEVA) van het ministerie van Volksgezondheid, Welzijn en Sport (VWS) heeft daarom aan het RIVM gevraagd een verdiepende analyse te maken van het beleid in het afgelopen decennium dat ingezet is om deze uitgaven te beteugelen. Daarnaast wil MEVA meer inzicht in de onderliggende determinanten van de uitgavengroei binnen de GGZ.

Bij het opstellen van de notitie is gebruik gemaakt van twee deelonderzoeken die zijn uitgevoerd in het kader van de Master Policy and Organisation of Health Care van de Vrije Universiteit in Amsterdam.

Een onderzoek heeft zich gericht op het inventariseren van GGZ-uitgaven, beleidsmaatregelen van de overheid met gevolgen voor de GGZ en hun effecten op de bekostiging binnen het terrein van de GGZ.

Het andere onderzoek heeft met behulp van zorgregistraties de effecten van enkele beleidsmaatregelen op de verwijzing door de huisarts van patiënten naar eerste- en tweedelijns GGZ onderzocht. Dit laatste onderzoek was mogelijk dankzij de beschikbaarstelling van gegevens uit huisartsenregistratie LINH door het Nederlands Instituut voor Onderzoek van de Gezondheidszorg (NIVEL). In het bijzonder willen wij prof. dr. P.F.M. Verhaak bedanken voor de geboden ondersteuning. Bij de uitvoering van de statistische analyses heeft dr. A. Wong van het RIVM belangrijke statistische ondersteuning geboden, waarvoor dank.

De (engelstalige) masterscripties zijn als bijlagen bij deze notitie opgenomen. In deze scripties is ook een uitgebreide literatuurverantwoording te vinden.

2 De GGZ Sector

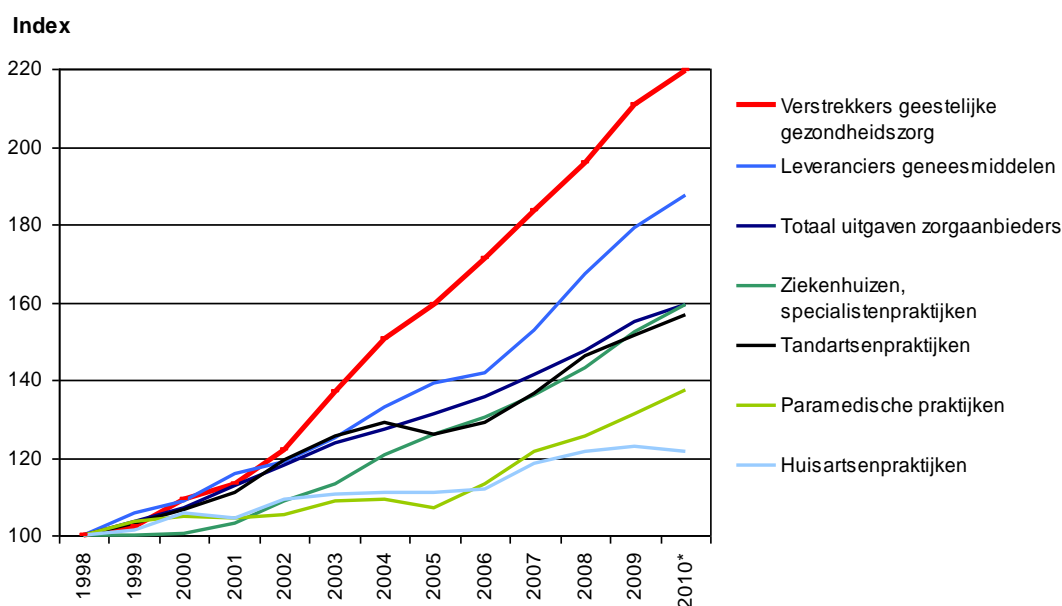
De GGZ biedt zorg aan mensen met psychische problemen. Deze psychische problemen variëren van milde klachten tot ernstige psychische stoornissen. Voor lichte problematiek wordt eerstelijns geestelijke gezondheidszorg geboden door de eerstelijnspsycholoog, het algemeen maatschappelijk werk, maar ook binnen de huisartsenpraktijk. In steeds meer huisartsenpraktijken zijn verpleegkundigen gespecialiseerd in geestelijke gezondheidszorg werkzaam. Daarnaast wordt gespecialiseerde zorg voor psychische problemen geboden door de tweedelijns GGZ, bestaande uit verslavingsklinieken, psychiatrische ziekenhuizen, psychiatrische afdelingen van algemene ziekenhuizen, RIAGG's en vrijgevestigde psychotherapeuten en psychiaters. Deze zorg is bedoeld voor patiënten met ernstige vormen van psychische stoornissen. In de tweedelijns wordt de zorg in verschillende vormen geboden, namelijk ambulante, in deeltijd, gemengd residentieel of residentieel. Het overgrote deel van de patiënten, 90%, wordt ambulante behandeld. Dit houdt in dat de patiënt voor behandeling naar de zorginstelling toekomt maar hier niet verblijft. Bij deeltijdzorg gaat de patiënt een aantal dagdelen per week naar de zorginstelling. Gemengd residentieel is een combinatie van ambulante en klinische zorg. Bij residentiële zorg wordt er intramurale klinische zorg geboden of woont de patiënt in een beschermde woonomgeving. Ten slotte zijn instellingen die topklinische zorg bieden voor bepaalde aandoeningen, zoals depressie of eetstoornissen, sterk in ontwikkeling.

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3 Kostenontwikkeling

Uitgaven GGZ stijgen sneller dan elke andere zorgsector

De afgelopen jaren hebben de zorguitgaven in Nederland een stijgende trend laten zien (figuur 1). Verwacht wordt dat deze uitgaven de komende jaren blijven toenemen. De totale zorguitgaven zijn in deze periode sneller gestegen dan het nationaal inkomen, zodat de zorgquote toenam tot circa 13% van het bruto binnenlands product (BBP) in 2010, en andere collectieve uitgaven onder druk zijn komen te staan. Door de huidige economische recessie vormen de groeiende zorgkosten een dilemma. Binnen de zorg heeft de GGZ sector de grootste uitgavengroei doorgemaakt.



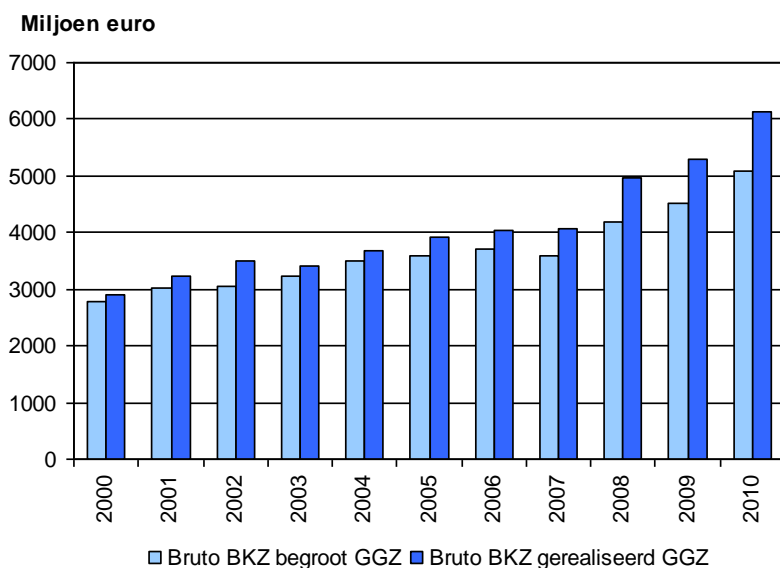
Figuur 1: Geïndexeerde (1998 = 100) ontwikkeling van de gezondheidszorguitgaven in de periode 1998 - 2010 in constante prijzen per zorgsector. *Voorlopige cijfers. Bron: zorgrekeningen CBS.

Tot aan 2002 stegen de kosten van de GGZ met een zelfde trend als het totaal van zorguitgaven. Na dit jaar is er een relatief sterkere toename waarneembaar ten opzichte van andere zorgsectoren. Vanaf 2006 nemen de uitgaven voor alle zorgsectoren harder toe dan tijdens voorgaande jaren. Ook in deze periode blijft de GGZ een van de snelste groeiers.

Budgettair Kader Zorg elk jaar weer overschreden

In het Budgettair Kader Zorg werd tussen 2000 en 2010 een stijging van de GGZ uitgaven voorzien. Desondanks bleek deze budgettaire verruiming niet toereikend te zijn om de werkelijke stijging van de uitgaven op te vangen (figuur 2). Het BKZ wordt begrensd door de collectieve uitgaven van de zorg. Het begrote BKZ voor de GGZ steeg van € 2,78 miljard in 2000 naar € 5,09 miljard in 2010. De gerealiseerde uitgaven zijn zelfs meer dan verdubbeld tijdens deze periode, van € 2,91 miljard naar €6,14 miljard.

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Figuur 2: Uitgaven aan de GGZ in begroot en gerealiseerd bruto BKZ 2000-2010.

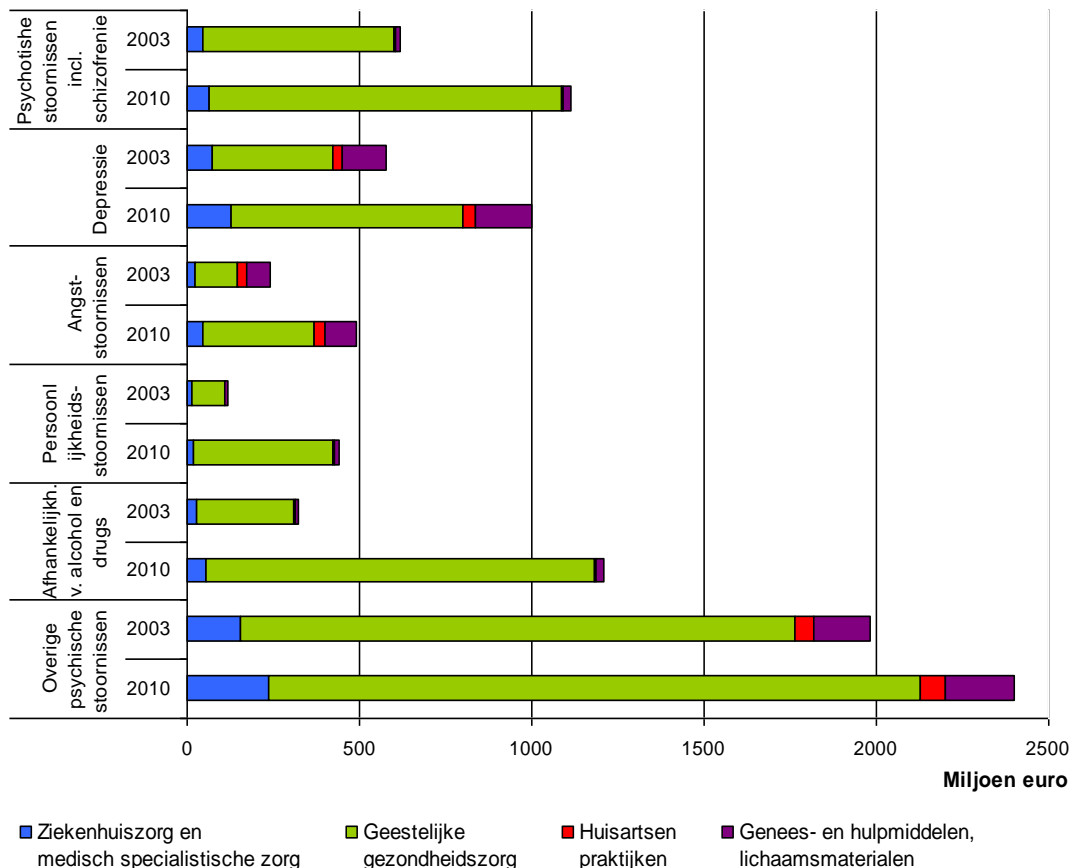
Ondanks een jaarlijkse verruiming van het budget, het groeipercentage lag in de periode 2000 tot 2010 gemiddeld op 6,4%, wordt het bruto BKZ elk jaar weer overschreden. In 2000 liggen de begrote en gerealiseerde uitgaven nog relatief dicht bij elkaar. Vanaf 2008 zijn de grootste overschrijdingen waarneembaar. In 2010 is het verschil tussen het begrote en gerealiseerde budget toegenomen tot meer dan een miljard, ondanks een verhoging van het GGZ budget met 12,9% in dit jaar.

Uitgaven aan psychische stoornissen in andere zorgsectoren ook gestegen

Gezondheidszorg voor psychische stoornissen en klachten wordt in verschillende zorgsectoren aangeboden. De GGZ sector neemt 80% van de uitgaven voor zijn rekening (figuur 3). De resterende uitgaven gaan naar de ziekenhuis- en medisch-specialistische zorg, de huisartsenzorg en de verstrekking van genees- en hulpmiddelen. Naast de GGZ, zijn de uitgaven van deze sectoren aan psychische gezondheidsproblemen ook fors gestegen. Figuur 3 laat zien dat de uitgaven aan zorg voor psychische stoornissen binnen de huisartsenpraktijk relatief laag waren, hoewel de huisarts de voornaamste zorgverlener is voor deze groep patiënten.¹ Een relatief klein gedeelte wordt doorverwezen naar andere aanbieders van eerstelijns GGZ of gespecialiseerde zorg. Hieruit blijkt dat het overgrote deel van de zorguitgaven wordt gegenereerd voor een klein gedeelte van de patiëntenpopulatie.

¹ Verhaak et al. (2012). Mental health care as delivered by Dutch general practitioners between 2004 and 2008. *Scandinavian Journal of Primary Health Care* 2012, Early Online: 1-7.

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Figuur 3: GGZ uitgaven in 2003 en 2010 in miljoen euro (lopende prijzen), naar diagnose en zorgsector. Bron: Kosten van Ziektenstudie, RIVM.

Uitgavenstijgingen GGZ naar psychische stoornis, leeftijd en geslacht

In tabel 1 worden de uitgavenstijgingen van de GGZ onderverdeeld naar psychische stoornis, leeftijd en geslacht weergegeven. De kosten van alle psychische stoornissen zijn toegenomen sinds 1999. De groep van overige psychische stoornissen is kleiner geworden tussen 2005 en 2010, wat de daling in kosten verklaard in deze periode. Uitgaven aan afhankelijkheid van alcohol en drugs en daarna psychotische stoornissen, zijn relatief het meest gestegen tussen 1999 en 2010. Beide stoornissen worden voornamelijk in de gespecialiseerde GGZ behandeld. De sector verslavingszorg heeft zich sterk ontwikkeld en uitgebreid tijdens de afgelopen decennia. Daarnaast kan een deel van de uitgavenstijging aan o.a. afhankelijkheid van alcohol en drugs worden verklaard uit de overgang naar de DBC-registratie in 2007. Sinds deze wijziging in het financieringssysteem werd het voor behandelaars belangrijker een specifieke diagnose te registreren. Bij het vergelijken van mannen en vrouwen valt op dat de absolute uitgaven aan angststoornissen en depressie sneller gestegen zijn bij vrouwen dan bij mannen. Daarentegen zijn de uitgaven aan psychotische stoornissen en afhankelijkheid van alcohol en drugs sneller gestegen bij het mannelijke geslacht. Deze verschillen zijn te verklaren uit de verschillen in prevalenties van deze stoornissen onder mannen en vrouwen. Angststoornissen en depressies komen vaker voor bij

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vrouwen en afhankelijkheid van alcohol en drugs heeft een veel hogere prevalentie onder mannen. Procentueel gezien zijn de uitgavenstijgingen bij mannen en vrouwen daarom vergelijkbaar. Wel zijn de kosten van persoonlijkheidsstoornissen en afhankelijkheid van alcohol en drugs relatief sneller toegenomen onder vrouwen.

Patiënten jonger dan 20 jaar zorgen voor de laagste uitgaven van de vier leeftijdscategorieën. Wel groeiden de kosten van psychische stoornissen onder deze leeftijdsgroep het snelst. In beide periodes, 1999-2005 en 2005-2010, zijn de uitgaven aan jeugd-GGZ ongeveer verdubbeld.

Tabel 1: Uitgavenstijgingen van de GGZ sector in miljoenen euro's, in percentages tussen haakjes, onderverdeeld naar leeftijdscategorieën, geslacht en psychische diagnoses over de periodes 1999-2005 en 2005-2010. Gegevens van de uitgaven aan persoonlijkheidsstoornissen over 1999 zijn niet beschikbaar. Bron: www.kostenvanziekten.nl.

Diagnose	Leeftijd	Man		Vrouw	
		1999-2005	2005-2010	1999-2005	2005-2010
Psychotische stoornissen inclusief schizofrenie	0-19	4,0 (254)	9,8 (175)	2,2 (532)	6,0 (523)
	20-44	119,3 (107)	170,3 (74)	40,8 (111)	66,9 (137)
	45-64	59,2 (103)	49,5 (42)	46,0 (108)	70,8 (110)
	65+	3,6 (14)	10,5 (35)	15,3 (38)	26,1 (69)
	Totaal	186,1 (94)	240,1 (63)	104,3 (87)	169,8 (76)
Depressie	0-19	2,2 (49)	8,1 (180)	9,9 (76)	18,5 (143)
	20-44	27,9 (49)	6,3 (11)	56,4 (53)	17,4 (16)
	45-64	27,6 (50)	18,9 (35)	42,8 (49)	43,1 (50)
	65+	10,6 (37)	24,0 (83)	24,0 (29)	74,9 (90)
	Totaal	68,3 (89)	57,3 (40)	133,1 (85)	154,0 (53)
Angststoornissen	0-19	2,1 (44)	15,6 (323)	4,6 (60)	26,0 (337)
	20-44	10,7 (46)	24,3 (103)	20,9 (47)	48,9 (111)
	45-64	5,2 (53)	21,1 (215)	10,2 (54)	24,9 (133)
	65+	0,17 (7)	9,0 (346)	5,0 (47)	18,4 (170)
	Totaal	18,2 (81)	69,9 (172)	40,8 (100)	118,2 (145)
Persoonlijkheidsstoornissen	0-19	-	3,8 (273)	-	9,8 (305)
	20-44	-	44,5 (154)	-	118,4 (246)
	45-64	-	13,1 (78)	-	53,1 (218)
	65+	-	8,5 (205)	-	5,8 (62)
	Totaal	-	69,9 (137)	-	187,1 (220)
Afhankelijkheid van alcohol en drugs	0-19	2,4 (78)	9,6 (319)	0,9 (71)	2,8 (235)
	20-44	61,3 (50)	198,5 (162)	34,3 (75)	75,0 (165)
	45-64	48,1 (60)	225,0 (280)	24,4 (67)	88,9 (246)
	65+	3,1 (27)	107,2 (941)	0,6 (9)	109,4 (1670)
	Totaal	114,8 (112)	540,4 (249)	60,0 (204)	276,1 (309)
Overige psychische stoornissen	0-19	100,3 (48)	211,9 (101)	67,6 (51)	73,4 (56)
	20-44	169,3 (36)	-178,9 (-38)	134,2 (32)	-114,8 (-27)
	45-64	103,6 (39)	-82,4 (-31)	86,8 (34)	-27,0 (-11)
	65+	10,4 (11)	-15,5 (-16)	23,3 (14)	-41,9 (-25)
	Totaal	10,4 (58)	-64,8 (-6)	311,9 (47)	-110,3 (-11)

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Totaal psychische stoornissen	0-19	112,4 (96)	88,4 (124)	258,8 (113)	136,6 (86)
	20-44	417,4 (81)	334,7 (82)	264,9 (28)	212,4 (29)
	45-64	260,4 (92)	234,5 (86)	245,3 (45)	254,0 (50)
	65+	32,0 (23)	77,6 (30)	143,6 (83)	193,0 (58)
	Totaal	822,2 (78)	735,1 (73)	912,7 (49)	796,0 (46)

4 Determinanten

De uitgavenstijgingen kunnen worden verklaard aan de hand van determinanten die we hier onderverdelen in de volgende categorieën: vraag, aanbod en beleid.

4.1 Vraag

Psychische problemen komen niet vaker voor maar de GGZ vraag stijgt

Psychische stoornissen komen frequent voor onder de Nederlandse bevolking; 42,7% van de Nederlanders ervaart eens in zijn of haar leven een psychische stoornis. Een groot en representatief bevolkingsonderzoek naar het psychisch welzijn in Nederland (Nemesis), toont aan dat op jaarbasis circa 18% van de mensen een psychische stoornis ervaart. Deze prevalentie is de afgelopen 25 jaar constant gebleven. Niet alle personen met een psychische stoornis die in dit onderzoek geïdentificeerd zijn waren zich bewust van hun gezondheidsprobleem. Daarnaast zoeken niet alle personen met een psychisch probleem professionele hulp. De vraag naar zorg voor psychische stoornissen is de afgelopen decennia echter sterk toegenomen. Steeds meer mensen met een psychisch probleem maken gebruik van de GGZ, waardoor de onvervulde zorgbehoefte is afgenomen. De latente vraag wordt dus steeds vaker omgezet in een stap richting de GGZ.

Een belangrijke oorzaak voor de toegenomen vraag naar GGZ zorg onder de Nederlandse bevolking is de verhoogde toegankelijkheid van de sector. Het ministerie van VWS en brancheverenigingen voeren al jaren actief beleid om de GGZ toegankelijker te maken. Door een betere organisatie van de GGZ en een verkleining van het taboe op GGZ zorg groeit het aantal patiënten dat behandeld wordt in deze zorgsector. Daarnaast zorgen een vergrijzende bevolking en een groeiende vraag naar professionele hulp bij gezondheidsproblemen voor een grotere behoefte en vraag naar zorg. Volgens geraadpleegde experts (zie bijlage 1) spelen veranderingen in de samenleving een belangrijke rol in de groeiende behoefte aan hulp voor psychische problemen. Onze samenleving wordt steeds complexer en er wordt steeds meer geestelijke arbeid verricht, waardoor mensen eerder belemmeringen ondervinden van psychische problemen.

Meer psychische diagnoses gesteld binnen de huisartsenpraktijk

De huisarts is voor het merendeel van de personen met psychische gezondheidsproblemen de eerste zorgaanbieder die men bezoekt. Percentages van patiënten gediagnosticeerd met psychische problemen in huisartsenpraktijken in de periode 2005 tot 2010 zijn weergegeven in tabel 2. Het aantal patiënten gediagnosticeerd met een psychische stoornis in de huisartspraktijk is in deze periode substantieel toegenomen. Dit onderbouwt de stijging in zorgvraag voor psychische problemen. Voor verschillende psychische problemen blijkt de vraag naar zorg te zijn toegenomen over de jaren.

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Tabel 2: Absolute aantallen van patiënten met psychische stoornissen in huisartsenpraktijken. Gespecificeerd naar verschillende psychische gezondheidsproblemen. (Percentage van geregistreerde patiënten tussen haakjes). Bron: LINH, Nivel.

	2005	2006	2007	2008	2009	2010
N geregistreerde patiënten	163.465	187.260	188.711	194.707	210.156	226.231
<i>Diagnoses</i>						
Alle p-diagnoses (P01-P99)	13.180 (8,1)	15.469 (8,3)	19.692 (10,4)	22.222 (11,4)	24.159 (11,5)	26.620 (11,8)
Angst (P01, P74)	2.950 (1,8)	3.621 (1,9)	4.460 (2,4)	4.920 (2,5)	5.215 (2,5)	5.543 (2,5)
Depressie (P03, P76)	3.621 (2,2)	4.116 (2,2)	5.248 (2,8)	5.537 (2,8)	5.971 (2,8)	6.367 (2,8)
Slaapstoornissen (P06)	2.394 (1,5)	2.976 (1,6)	3.949 (2,1)	4.364 (2,2)	4.243 (2,0)	4.785 (2,1)
Psychotische stoornissen (P71, P72)	198 (0,1)	239 (0,1)	305 (0,2)	329 (0,2)	384 (0,2)	404 (0,2)
Persoonlijkheidsstoornissen (P80)	203 (0,1)	258 (0,1)	393 (0,2)	460 (0,2)	427 (0,2)	539 (0,2)
Emotionele stress (P02, P78)	2.324 (1,4)	2.499 (1,3)	2.641 (1,4)	2.948 (1,5)	3.250 (1,5)	3.686 (1,6)
Alcohol/drugs (P15, P16, P18, P19)	582 (0,4)	703 (0,4)	961 (0,5)	1.259 (0,6)	1.335 (0,6)	1.444 (0,6)

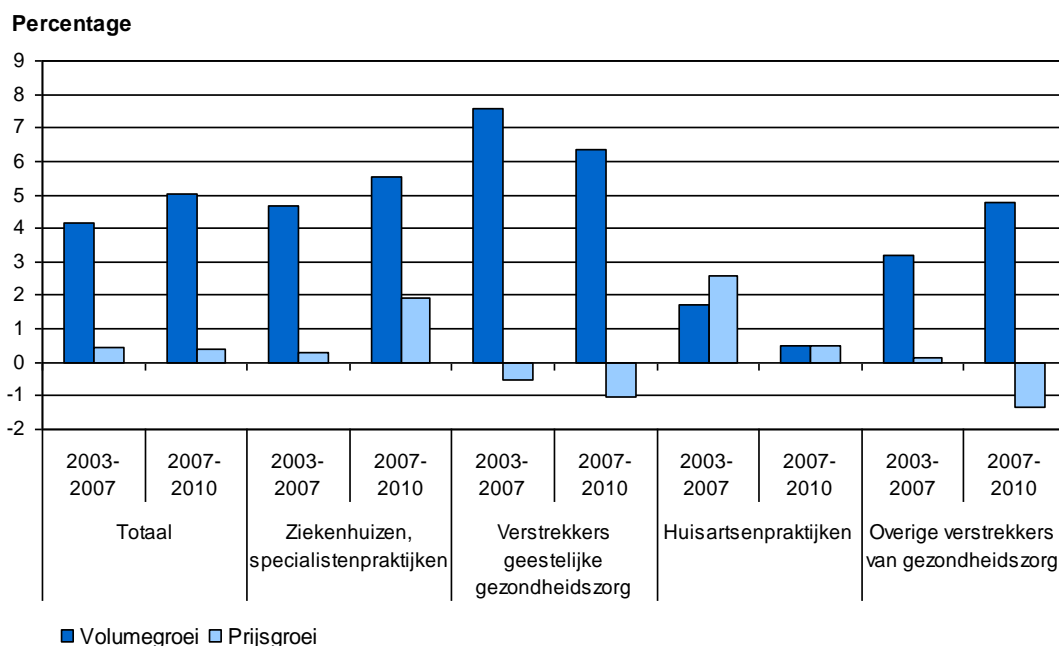
4.2 Aanbod

Toename GGZ aanbieders gestimuleerd door invoering van marktwerking

Het aanbod van GGZ zorg is volop in ontwikkeling sinds de invoering van (gereguleerde) marktwerking. De liberalisering maakte het mogelijk voor nieuwe niet-gebudgetteerde aanbieders om zich te vestigen in de markt. Dit heeft echter niet geleid tot een afname in de uitgaven van gebudgetteerde instellingen, waaruit blijkt dat substitutie van zorg niet plaatsvond. Het aantal gebudgetteerde GGZ aanbieders is constant gebleven over de jaren en uitbreidingen in aanbod vonden ook hier plaats. Gebudgetteerde instellingen hebben zich ontwikkeld tot dynamische aanbieders van zorg, inspeland op maatschappelijke behoeften. Instellingen die voorheen alleen tweedelijnszorg aanboden, kregen door de ingevoerde marktwerking de mogelijkheid om tevens eerstelijns behandelingen te verstrekken. Ook de eerstelijnszorgaanbieders proberen zich te onderscheiden en ontwikkelen nieuwe behandelingen. De ontwikkeling van nieuwe behandelingen gaat vaak samen met een hogere kostenstijging dan gemiddeld.

Door de gereguleerde marktwerking zijn de prijzen van de GGZ gedaald, (figuur 4). Deze reductie is echter meer dan gecompenseerd door een toename van het volume, wat mede is veroorzaakt door het groeiende aanbod van GGZ zorg. Kortom, hoewel de prijs per verleende behandeling in de GGZ is gedaald, zijn de totale uitgaven door het toegenomen volume toch gestegen.

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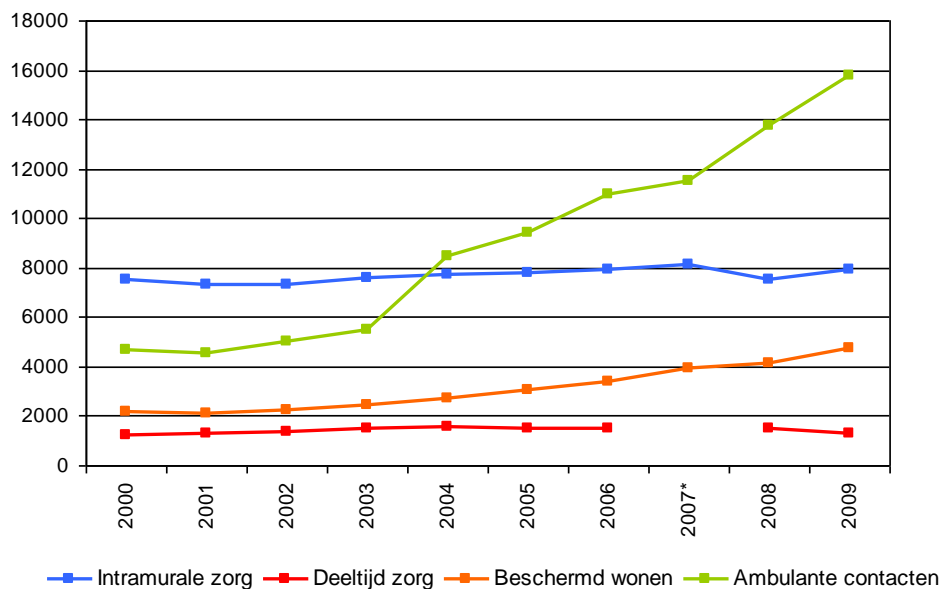
Figuur 4: Zorguitgaven per zorgsector in volumegroei en prijsgroei per jaar voor de periodes 2003-2007 en 2007-2010. Bron: CBS Statline.

Afname aanbod intramurale zorg is niet bereikt in de GGZ

Het aantal ambulante behandelingen in de GGZ is fors gestegen sinds 2000 (figuur 5). Het overheidsbeleid tot vermaatschappelijking van de GGZ heeft hier sterk op aangestuurd. Een verwachte daling van de intramurale zorg is echter uitgebleven. Het aantal klinische opnamedagen is ongeveer constant gebleven over de jaren. Men spreekt daarom ook wel van een relatieve ambulantisering die heeft plaatsgevonden. Een belangrijke oorzaak hiervan is het financieringssysteem. GGZ instellingen ontvangen financiering per bed, wat een beddenreductie niet stimuleert. Daarnaast valt klinische zorg onder de Algemene Wet Bijzondere Ziektekosten (AWBZ) en ambulante zorg onder de Zorgverzekeringswet (ZVW). Zorgverzekeraars zijn dus niet risicodragend voor de intramurale GGZ en daardoor niet geprikkeld de doelmatigheid van GGZ instellingen te bevorderen. Als gevolg hiervan is de intramurale GGZ capaciteit zelfs toegenomen tijdens het afgelopen decennia. Nederland is hierin uitzonderlijk. Landen om ons heen zijn er wel in geslaagd het aanbod van intramurale GGZ terug te brengen. Internationaal gezien heeft Nederland dan ook een groot aantal klinische GGZ-bedden.

KvZ-Notitie2012-1: Kostenontwikkeling GGZ

Absolute productie (x duizend)

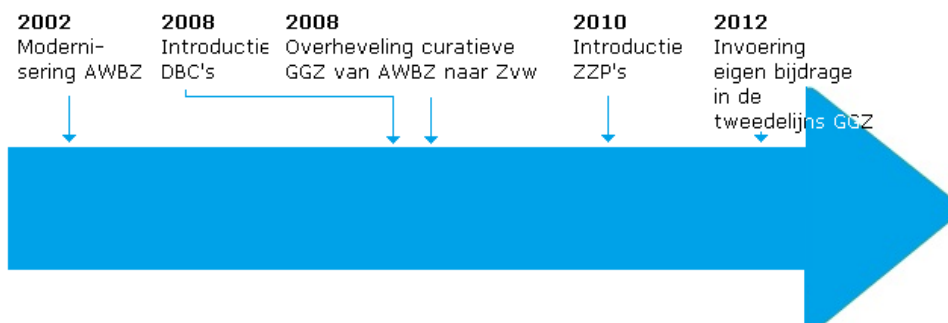


Figuur 5: Productie van GGZ instellingen, uitgedrukt in ambulante contacten, opnamedagen van intramurale zorg, deeltijdbehandelingen en dagen beschermd wonen. Bron: Trimbos instituut. *geen gegevens beschikbaar van deeltijdzorg in 2007.

4.3 Beleid

Het ministerie van VWS heeft vanaf 2000 de toegankelijkheid van de GGZ gestimuleerd en wachtlijsten proberen weg te werken. Vanaf 2008 is het beleid gericht op het toekomstperspectief dat ontwikkeld is voor de gehele geneeskundige gezondheidszorg. Dit perspectief streeft een meer centrale rol voor de patiënt na, meer transparantie in de zorgvraag, het invoeren van prestatiebekostiging en een betere aansluiting tussen de geneeskundige somatische en geestelijke gezondheidszorg en tussen de eerste- en tweedelijnszorg. Met het bereiken van deze doelen wordt naast een hogere kwaliteit met name een beheersing van de zorgkosten beoogd. Er zijn de afgelopen jaren vele beleidsmaatregelen genomen rondom de financiering van de GGZ om een remming van de uitgaven te bereiken. De invoering van de meeste van deze maatregelen gingen echter gepaard met een kostenstijging. De beleidsmaatregelen waarvan men denkt dat deze de grootste invloed hebben gehad, of gaan hebben, op de kostenontwikkeling van de GGZ worden weergegeven in figuur 6.

KvZ-Notitie2012-1: Kostenontwikkeling GGZ



Figuur 6: Tijdlijn van belangrijkste beleidsmaatregelen op het terrein van de GGZ in de periode 2002 tot 2012.

Modernisering van de AWBZ

Met de modernisering van de AWBZ werd getracht de wachtlijsten in de GGZ weg te werken. De budgettering van zorginstellingen werd hierbij losgelaten. Er werd extra budget beschikbaar gesteld aan zorgverzekeraars, zodat meer zorg kon worden gecontracteerd. Het realiseren van extra zorg was hierbij een voorwaarde, en deze maatregel werd daarom ook wel het 'boter bij de vis'-beleid genoemd. Het vergroten van de productie werd als noodzakelijk geacht om een inhaalslag te maken en de groeiende vraag naar zorg op te vangen. Het beleid leidde tot een stijging van de GGZ uitgaven met €240 miljoen, wat de uitschieter van gerealiseerde zorguitgaven in 2002 (figuur 2) verklaart. Het aantal patiënten op wachtlijsten daalde weliswaar met 7%, maar de gemiddelde wachttijd steeg desondanks met 22%. Uiteindelijk werd in 2003 opnieuw een vorm van budgetmaximering ingevoerd.

Overheveling curatieve zorg van AWBZ naar Zvw

Sinds 2008 zijn de overschrijdingen van het bruto BKZ fors gestegen. Dit hangt samen met een grote verandering in de financiering van de GGZ in dit jaar: de overheveling van de geneeskundige GGZ van de AWBZ naar de Zvw. De geneeskundige GGZ omvat alle extramurale geneeskundige zorg en intramurale zorg in het eerste jaar, gericht op behandeling. Sinds 2008 is de Zvw verantwoordelijk voor de bekostiging van de geneeskundige GGZ. Alle niet-geneeskundige GGZ (zowel intra- als extramuraal), alsmede alle zorg vanaf het tweede behandeljaar wordt gefinancierd vanuit de AWBZ. De AWBZ-gefinancierde zorg bestrijkt 30% van de totale GGZ uitgaven en bedient ongeveer 4-6% van alle GGZ cliënten (voornamelijk chronisch zieken en kostbare zorg).

De overheveling had als doel de AWBZ weer terug te brengen naar een verzekeringswet die primair gericht is op langdurige zorg met bijzondere ziektekosten. Daarnaast was verwacht dat het verdwijnen van het financiële schot tussen de onderdelen van de curatieve zorg, zorginhoudelijke samenhang zou bevorderen.

Het grootste nadeel van de overheveling bleek echter het nieuw gevormde schot binnen de financiering van de GGZ. Dit is in het bijzonder problematisch voor deze sector omdat de GGZ een gemiddeld langere behandelingsduur heeft dan de somatische zorg. Door de nieuwe structuur zal het nadelig zijn voor zorgverzekeraars als behandelingen worden verkort naar minder dan een jaar, omdat de besparingen dan in de AWBZ vallen in plaats van in de Zvw. Daarnaast is het door het nieuwe inflexibele bekostigingssysteem niet meer mogelijk om geld over te hevelen van de AWBZ naar de Zvw. De ontwikkeling van een meer

KvZ-Notitie2012-1: Kostenontwikkeling GGZ

intensiever en sneller aanbod van extramurale zorg om een afname in AWBZ zorg te bereiken wordt daardoor niet bevorderd.

Omgekeerd is ook de doorstroom van patiënten uit de geneeskundige naar de niet-geneeskundige en langdurige GGZ belemmerd door het financieringschot. Zorgaanbieders hebben nu te maken met patiënten die overgeheveld dienen te worden naar de AWBZ zorg, wat niet altijd mogelijk is door het bestaan van wachtlijsten. Het financieringsschot verstoort daarom de continuïteit van zorg voor psychische gezondheidsproblemen.

De totale kosten van de overheveling worden door het CVZ geschat op €1,1 miljard euro. Hiervan bestaat €500 miljoen uit eenmalige administratieve kosten.

Introductie DBC's

Met de introductie van de DBC-systematiek voor de curatieve GGZ werd een tweede grote verandering in de financiering van de GGZ doorgevoerd in 2008. Door de kosten van behandelingen te berekenen via een Diagnose Behandel Combinatie (DBC) werd een relatie gelegd tussen de diagnose van de patiënt en de daarbij horende kosten van de behandeling. De budgetsystematiek werd opgeheven en vrijgevestigde en nieuwe zorgaanbieders kregen de mogelijkheid om zich te vestigen op de markt. Op dit moment bevinden gebudgetteerde GGZ-instellingen zich in een transitiefase waarbij financiering plaatsvindt via DBC's, maar de uiteindelijke bekostiging nog gebaseerd is op de budgetsystematiek. Per 1 januari 2013 gaan de instellingen over naar volledige prestatiebekostiging via DBC's.

De invoering van de nieuwe financieringssysteem zorgde voor een toestroom van eerstelijnszorgaanbieders op de markt. De opvolgende forse groei van nieuwe en niet-gebudgeteerde instellingen, en in mindere mate de opkomst van vrijgevestigde zorgaanbieders, gingen samen met een toename van de uitgaven. Daarnaast kennen DBC's geen budgetplafonds en brengen deze volumeprikkels met zich mee omdat meer productie leidt tot meer inkomsten voor zorgaanbieders. Dit stimuleerde calculerend gedrag bij alle betrokken partijen. Zo wordt er door zorgaanbieders vaak gekozen voor de DBC met het hoogst mogelijke tarief d.m.v. up- en sidecoding. Los hiervan hebben investeringen in ICT en de grote administratieve lastendruk waarmee DBC's gepaard gaan, ook geleid tot forse uitgavenstijgingen.

Introductie ZZP's

Vanaf 2010 wordt de AWBZ-gefinancierde verblijfszorg bekostigd via Zorgzwaarte Pakketten (ZZP's). Bekostiging op basis van budgetparameters is hiermee komen te vervallen. Een uitzondering hierop vormen de zorg voor kinderen en klinisch intensieve behandelingen. Een ZZP is een beschrijving van de zorgzwaarte, en is gebaseerd op de behoeften van de patiënt, welke in dit bekostigingssysteem centraal worden gesteld. Daarnaast geeft dit systeem meer inzicht in de zorgzwaarte van de patiënt.

Door middel van ZZP's is het gehele budget gekoppeld aan de werkelijk gerealiseerde productie en instellingen lopen daardoor volledig bezettingsrisico. Het budget voor de ZZP's wordt bepaald door (productie) afspraken die zorgaanbieders met verzekeraars maken. Het ZZP-tarief, waarover onderhandeld wordt tussen het zorgkantoor en de zorgaanbieder, moet binnen de door de NZa vastgestelde bandbreedte vallen. De kosten per ZZP bleken fors hoger uit te vallen dan de kosten ten tijde van de budgetparameters. Om toch budgetneutraal uit te komen is er een korting toegepast. Dit heeft tot gevolg dat een instelling geld tekort kan komen (tot circa 24%) als deze de in de ZZP geregelde zorg daadwerkelijk levert.

Invoering eigen bijdrage in de tweedelijns GGZ

Om de sterke uitgavenstijging van de tweedelijns GGZ te beteugelen is in 2012 een eigen bijdrage geïntroduceerd. Het aantal cliënten in de tweedelijns GGZ

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groeit jaarlijks met circa 10%. Tot 2008 werd alleen tweedelijns GGZ vergoed vanuit de AWBZ wat een barrière vormde voor het gebruik van de eerstelijns. Vanaf 2008 wordt de eerstelijns GGZ gedeeltelijk vergoed vanuit de Zvw terwijl de tweedelijnszorg nog steeds volledig gedekt werd. Door de kosten van tweedelijnszorg ook niet meer volledig te vergoeden wordt verplaatsing van de hulpvraag naar de goedkopere eerstelijns beoogd. Of de maatregel zal leiden tot een meer bewust gebruik van zorg zal pas over enige tijd duidelijk worden.

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5 Verwijsbeleid GGZ nader geanalyseerd

Beleidsmakers hebben ook geprobeerd de kostengroei te beteugelen door het bijsturen van zorginhoudelijke processen. Zo is er vanaf het jaar 2000 beleid gevoerd ter versterking van de eerstelijns GGZ, als barrière voor de duurdere tweedelijns. In deze paragraaf zoomen we daar op in, en onderzoeken we met behulp van statistische methoden de effecten van een aantal van de genomen maatregelen op het verwijsgedrag van huisartsen.

5.1 Inleiding

Huisartsen spelen een belangrijke rol in de zorg voor mensen met psychische gezondheidsproblemen. De meeste patiënten met psychische klachten worden behandeld in de eerstelijnszorg, inclusief een groot deel van de patiënten met ernstige psychische stoornissen. Hoewel niet alle personen met psychische gezondheidsproblemen zorg ontvangen zijn er ook vermoedens van overbehandeling. Patiënten met lichte psychische problematiek worden behandeld in de duurdere, specialistische tweedelijns en medicijnen worden voorgeschreven voor milde problemen of zelfs bij het ontbreken van een diagnose.

De huisarts heeft een belangrijke rol in het herkennen en behandelen van psychische stoornissen. Daarnaast fungeert de huisarts als poortwachter naar de specialistische tweedelijns aanbieders van GGZ. Door de al hoge werkdruk en groeiende vraag naar hulp aan de huisarts bij psychische problemen, ontstaat er bij deze aanbieder vaak een gebrek aan tijd en kennis voor behandeling van deze patiënten. Studies in Nederland hebben aangetoond dat een toenemende werkdruk zelfs om kan slaan naar een verhoging van het aantal verwijzingen naar andere aanbieders. Doorverwijzen naar de specialistische tweedelijnszorg is echter duur en de behandelingsplaatsen zijn beperkt. Het ministerie van VWS heeft daarom beleidsmaatregelen ontworpen om de eerstelijns GGZ en de poortwachterfunctie van de huisarts te versterken. Dit beleid is onder andere gericht op het versterken van samenwerking binnen de eerstelijns en tussen eerste- en tweedelijnsaanbieders van GGZ. Daarnaast is de financiële drempel van de eerstelijnspsycholoog verlaagd door de introductie van deze zorg in het basispakket in 2008.

5.2 Onderzoeksmethoden

Voor de uitgevoerde analyses is gebruik gemaakt van het Landelijk Informatie Netwerk Huisartsenzorg (LINH) van het Nederlands Instituut voor Onderzoek van de Gezondheidszorg (NIVEL). De LINH database bevat gegevens uit elektronische patiëntendossiers van een groot aantal huisartsenpraktijken in Nederland. Gegevens over gestelde diagnoses en verwijzingen van patiënten zijn hieraan ontleend. Informatie over samenwerkingsverbanden van huisartsen komen uit de landelijke huisartsenregistratie van het NIVEL.

Regressie analyses (multivariaat multilevel) zijn uitgevoerd om de effecten van samenwerkingsverbanden en de introductie van de eerstelijnspsychologische zorg op het diagnosticeren en verwijzen van psychische stoornissen te kunnen bepalen. Een uitgebreide verantwoording van deze analyses is te vinden in bijlage 2. In deze notitie beperken we ons tot de belangrijkste bevindingen en conclusies.

KvZ-Notitie2012-1: Kostenontwikkeling GGZ

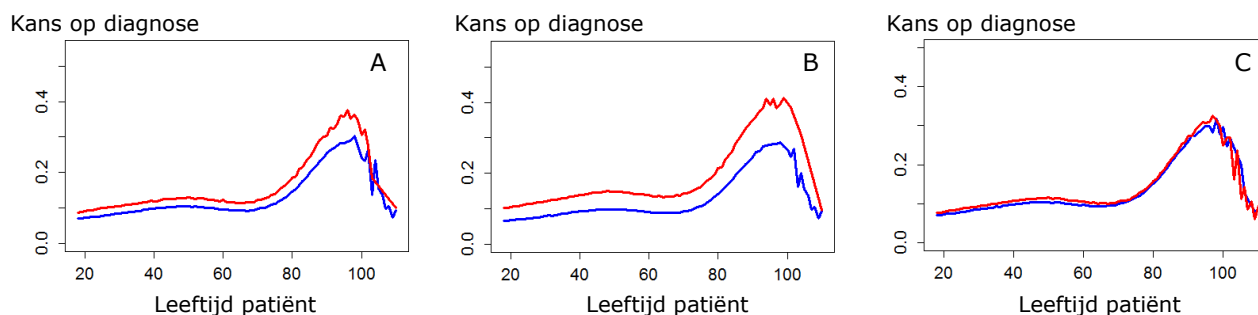
5.3 Resultaten

Identificatie psychische stoornissen verbeterd door samenwerking met AMW

Samenwerkingsverbanden tussen de huisarts en het algemeen maatschappelijk werk (AMW) blijken de identificatie van milde psychische problemen te bevorderen. Huisartsen in deze samenwerkingsverbanden constateren significant vaker dergelijke klachten (figuur 7). Dit effect zou kunnen worden toegeschreven aan een grotere betrokkenheid van deze huisartsen bij patiënten met psychosociale problemen. Daarbij is het AMW de enige zorgaanbieder naast de huisarts die vaak door patiënten op eigen initiatief wordt bezocht. AMW'ers die samenwerken met huisartsen zouden patiënten daarom vaker terug kunnen verwijzen naar de huisarts, wat de toename in diagnoses verklaart.

Huisartsen die samenwerkingsverbanden hebben gevormd met sociaal psychiatrisch verpleegkundigen (spv'ers) of eerstelijnspsychologen laten geen significante veranderingen zien in het aantal patiënten dat gediagnosticeerd wordt. Samenwerking met deze aanbieders leidt dus niet tot een verhoging van het aantal gestelde diagnoses. De herkenning van psychische gezondheidsproblemen door de huisarts lijkt niet te zijn verbeterd.

Belangrijk is om op te merken dat niet alle psychische problemen behandeling behoeven. Voor bijvoorbeeld depressie bestaat er een redelijke kans op herstel zonder behandeling in drie maanden en is een afwachtende benadering daarom een aanbeveling in behandelrichtlijnen van de huisarts. Het is daarom essentieel dat huisartsen problemen van patiënten herkennen die zonder behandeling niet zullen herstellen of zullen verslechteren.



Figuur 7: Regressie analyses van de effecten van samenwerkingsverbanden van huisartsen met eerstelijnspsychologen (A), AMW'ers (B) en spv'ers (C) op het stellen van psychologische diagnoses over 2010. De kans op het stellen van een psychologische diagnose is uitgezet per leeftijdsjaar van de patiënt. Verschillen tussen samenwerkende huisartspraktijken (rood) en praktijken zonder samenwerkingsverband (blauw) zijn weergegeven. Alleen huisartsen samenwerkend met AMW'ers diagnosticeren significant meer patiënten.

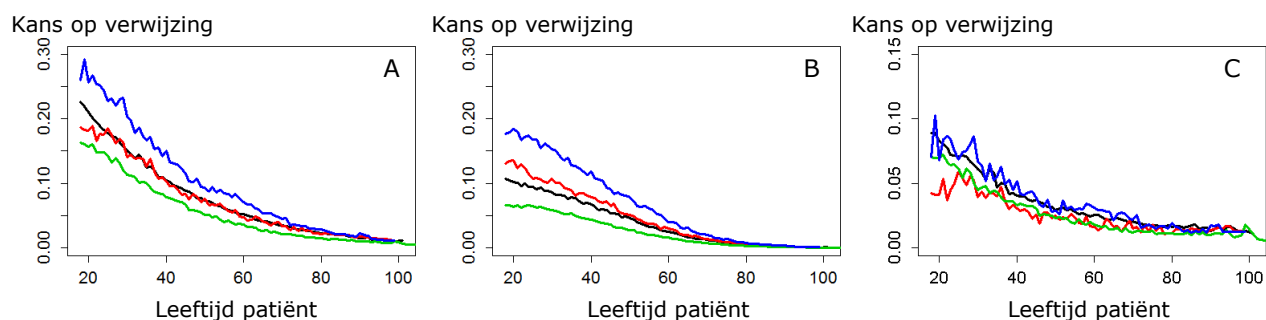
Verwijzing psychische stoornissen naar eerstelijns bevorderd

Samenwerkingsverbanden tussen huisartsen en spv'ers lijken er toe te leiden dat minder patiënten verwezen worden naar andere aanbieders en dus vaker behandeld worden binnen de praktijk (figuur 8). Dit sluit aan bij de functie van spv'ers, het ondersteunen van huisartsen in de zorg voor patiënten met psychische gezondheidsproblemen. Er vinden vooral minder verwijzingen plaats naar andere eerstelijnsaanbieders. Het aantal verwijzingen naar de tweedelijns GGZ wordt niet beïnvloed. De spv'er lijkt daarom kennis en tijd naar de huisarts te brengen waardoor deze in staat is meer patiënten met voornamelijk lichte psychische problemen binnen de praktijk te behandelen.

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Samenwerking met de eerstelijnspsycholoog leidt juist tot significant meer verwijzingen naar de eerstelijns GGZ. Deze stijging wordt voornamelijk veroorzaakt door een groei in het aantal verwijzingen naar de eerstelijnspsycholoog zelf. Hetzelfde verband is waarneembaar bij samenwerking met het AMW; praktijken die samenwerken met deze aanbieder verwijzen ook meer patiënten naar het AMW. Deze effecten zijn te verklaren uit bevindingen van eerdere studies die aantonen dat samenwerking leidt tot betere communicatie en een grotere kennis van elkaars bekwaamheden, waardoor verwijzing sneller plaatsvindt. Tegelijkertijd blijken deze twee samenwerkingsverbanden geen effect te hebben op het aantal verwijzingen naar de tweedelijns.

Samenwerkingsverbanden tussen de huisarts en andere eerstelijnsaanbieders leiden dus in veel gevallen tot een groei van het gebruik van eerstelijnszorg. Desondanks blijft het aantal verwijzingen naar de specialistische zorg onveranderd. De beoogde substitutie van zorg vindt dus niet plaats.



Figuur 8: Regressie analyses van de invloed van samenwerkingsverbanden met de eerstelijnspsycholoog (rood), de spv'er (groen) en een combinatie van deze aanbieders (blauw) op verwijzingen naar de totale (A), eerstelijns (B) en tweedelijns GGZ (C). Toelichting in de tekst.

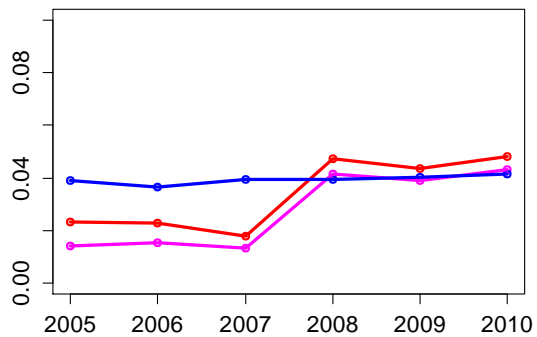
Vergoeding eerstelijnspsycholoog stimuleert registratie verwijzingen

In 2008 is de eerstelijnspsychologische zorg geïntroduceerd in het basispakket, wat betekende dat de eerste acht behandelingen vergoed werden. Daarvoor werd alleen de tweedelijns GGZ vergoed, vanuit de AWBZ.

In het jaar van de introductie vond er een significante stijging plaats van het aantal patiënten dat verwezen werd naar de eerstelijns, veroorzaakt door een toename in het aantal verwijzingen naar de eerstelijnspsycholoog. Uit cijfers van de Landelijke Vereniging van Eerstelijnspsychologen (LVE) blijkt echter dat het aantal patiënten in behandeling bij eerstelijnspsychologen in 2008 nauwelijks harder is gestegen dan in voorgaande jaren. Dit duidt erop dat voornamelijk de registratie van verwijzingen door huisartsen is verbeterd. Voor de introductie was een officiële verwijzing niet nodig, aangezien alle eerstelijns zorgverleners direct toegankelijk zijn in Nederland. Veel patiënten kwamen daardoor bij de eerstelijns psycholoog terecht op aanraden van de huisarts maar zonder expliciete verwijzing. Vanaf 2008 zaten er echter financiële gevolgen aan voor de patiënt; alleen bij verwijzing vanuit de huisarts wordt eerstelijnspsychologische zorg vergoed. Huisartsen zullen daarom waarschijnlijk vaker zorgen voor een officiële verwijzing.

KvZ-Notitie2012-1: Kostenontwikkeling GGZ

Kans op verwijzing



Figuur 9: Trends van de kans op verwijzing naar aanbieders van tweedelijns GGZ (blauw), eerstelijns GGZ (rood) en de eerstelijnspsycholoog (roze) vanuit de huisartsenpraktijk. In 2008 worden er significant meer patiënten verwezen door de huisarts naar de eerstelijns en de eerstelijnspsycholoog t.o.v. 2007.

KvZ-Notitie2012-1: Kostenontwikkeling GGZ

6 Conclusies

Poortwachter niet voldoende versterkt voor substitutie van tweedelijns

De huidige samenwerkingsverbanden tussen huisartsen en andere eerstelijnsaanbieders versterken de eerstelijns GGZ slechts in beperkte mate. Het herkennen van milde psychische problemen lijkt te zijn verbeterd door samenwerking met het AMW. Daarnaast kan samenwerking met de spv'er behandeling binnen de praktijk stimuleren en daardoor het gebruik van GGZ verminderen. Stimulering van het gebruik van eerstelijnszorg lijkt echter niet bij te dragen aan de beoogde reductie van gespecialiseerde GGZ. Substitutie van dure tweedelijnszorg vindt niet plaats en de uitgavenontwikkeling wordt niet afgeremd. Daarnaast heeft de introductie van vergoeding van eerstelijnspsychologische zorg een klein effect gehad op het gebruik van dit type zorg en vooral de registratie van verwijzingen door huisartsen verbeterd. Ook lijkt deze vorm van zorg de dure tweedelijns psychologische zorg niet te vervangen. De versterkte en groeiende eerstelijns GGZ spreekt daarom waarschijnlijk voornamelijk de latente vraag naar zorg voor psychische problemen aan.

Stijgende GGZ uitgaven hangen nauw samen met een groeiende zorgvraag

Door een veranderende samenleving is de behoefte van zorg voor psychische problemen de laatste decennia toegenomen. Niet alleen is het stigma rondom psychische stoornissen en het ontvangen van hulp voor deze gezondheidsproblemen verminderd, ook de toegankelijkheid van de GGZ is verhoogd. Daarnaast is de samenleving aan het verouderen en bestaat er een groeiende vraag naar professionele hulp voor gezondheidsproblemen. Ook worden er eerder belemmeringen ondervonden van psychische problemen door een verschuiving van lichamelijke arbeid naar een kenniseconomie die een sterker appel doet op cognitieve en psychische vermogens. Daarnaast wordt de vraag naar GGZ gestuurd door het toenemende aanbod. De introductie van marktwerking heeft er voor gezorgd dat het aantal aanbieders van GGZ sterk is uitgebreid en het aanbod van instellingen is verbreed.

Als gevolg hiervan worden er in de huisartsenpraktijk elk jaar meer patiënten gediagnosticeerd met een psychische stoornis. Daarnaast worden er meer patiënten doorverwezen vanuit de huisarts naar eerste- of tweedelijns GGZ, wat resulteert in een hoger zorggebruik en stijgende kosten. Niet alleen worden er meer patiënten behandeld in de GGZ, ook vinden er meer behandelingen per patiënt plaats.

GGZ beleid heeft herhaaldelijk geleid tot incentives voor productie

Het afgelopen decennia zijn er een aantal grote veranderingen ingevoerd rondom de financiering van de GGZ. De effecten van het overheidsbeleid gericht op de zorguitgaven blijken vooraf moeilijk in te schatten. De maatregelen hebben niet geleid tot een beteugeling van de kostenstijging; ze lijken productie van zorg telkens weer te stimuleren. Soms bedoeld, andere keren als bijeffect. In 2002 werd budgetmaximering van zorginstellingen opgeheven met als doel de wachtlijsten te verkorten. Productie van zorg werd hierdoor sterk gestimuleerd bij instellingen, met een forse uitgavenstijging tot gevolg. Wachttijden werden echter niet effectief teruggebracht en namen zelfs toe. In het opvolgende jaar werd budgetmaximering daarom weer ingevoerd. Met de invoering van DBC-systematiek in 2008 is de budgettering voor de curatieve GGZ opnieuw losgelaten. Als gevolg hiervan betraden nieuwe aanbieders de GGZ markt en werd er meer zorg geproduceerd. Het nieuwe bekostigingssysteem dat transparantie hoorde te verhogen bleek ook volumeprikkels bij bestaande aanbieders met zich mee te brengen. Ten slotte heeft de introductie van ZZP's een hogere bezetting

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van bedden in de langdurige GGZ gestimuleerd, omdat hiermee het AWBZ budget van instellingen werd verbonden aan de eigenlijke productie van zorg.

Deze conclusies onderstrepen het grote belang van samenhangend beleid, waarbij maatregelen gericht op specifieke onderdelen van de zorg in lijn zijn met het algemene volksgezondheids- en zorgbeleid en adequaat rekening houden met de grote maatschappelijke en zorginhoudelijke trends.

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Bijlage 1: scriptie Marijke Folkertsma

EFFECTS OF POLICY MEASURES ON MENTAL HEALTH CARE EXPENDITURES IN THE NETHERLANDS

Marijke A. Folkertsma^{1,2}, Johan J. Polder², Geert Jan Kommer², Lany Slobbe²,
Maurits van Tulder¹

1. VU University Amsterdam

2. National Institute for Public Health and the Environment, Bilthoven

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ABSTRACT

BACKGROUND

The expenditure on health care is increasing every year and is expected to continue to rise rapidly over the forthcoming years. The sector Mental Health Care (MHC) is responsible for the fastest growing health care expenditure. Since 2002, the Dutch government has taken incessant policy measures to diminish the MHC expenditure, but the effect of these policy measures remains unknown. The central research question of this study is *'How did the Mental Health Care (MHC) expenditures develop in the Netherlands in the past decennium and what were the effects of policy measures during 2002- 2012 on MHC expenditures?'*

METHODS

To gain insight into the effects, first an inventory of the most important national MHC policy measures implemented during 2002-2012 was made. For this purpose, a literature study was performed and MHC policy experts were interviewed. Next, effects of these policy measures were studied in a literature research. For a good understanding of the effects of policy measures, seven interviews with in total eleven experts in the field of Mental Health Care and policy were held. The policy measures and the interviews were analysed using the policy effect chain.

To gain insight in the development of the MHC expenditure, data from the government and Dutch research institutes were used.

RESULTS

In the past decennium, the MHC expenditure more than doubled. In 2002, policy on eliminating waiting lists was implemented; this led to an expenditure increase of €240 million. Due to the implementation of regulated competition in the MHC, which is expressed in the policy measures 'implementation of the DBC's in the curative MHC', and the 'transfer of the curative MHC from the Exceptional Medical Expenses Act (AWBZ) to the Health Insurers Act (Zvw)' in 2008, the MHC expenditure increased more rapidly than ever before. To stimulate more intentional use of care and to keep costs in control, co-payment in the secondary MHC was introduced in 2012.

CONCLUSIONS

The effects of policy on the MHC expenditure are not explicit, however, implemented policy measures during period 2002-2012 were accompanied by increased costs.

Keywords: Mental Health Care (MHC) expenditure, policy measures, evaluation, the Netherlands

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INTRODUCTION

Over the last 40 years health care expenditure in the Netherlands increased every year and is expected to continue to rise rapidly over the forthcoming years (Besseling and Shestalova 2011). Based on information from the Dutch Health and Social Care accounts ("Zorgrekeningen"), health care expenditure in the beginning of 1970 counted for circa 8% of the gross domestic product (GDP), which equals about €6 billion. In 2010 the expenditure rose to €87.1 billion, which accounts for approximately 13% of the GDP, and is still growing (CBS Statline 2010). Health care spending is rising faster now than the economy as a whole and faster than workers' earnings (Slobbe, Smit et al. 2011). The current economic deterioration makes health care expenditure even more a point of concern. Health care supplants many other public finances already and this effect will increase because of a growth rate of the health care budget of 4.3% per year (Jeurissen, Gill - van Kampen et al. 2012). Calculations of Statistics Netherlands show that in 2010 the sector 'hospitals and specialist practices' counted for 25.6% of the total spending on health care and was accountable for the majority of health care costs. However, spending on Mental Health Care (MHC) increased faster than all other health care sectors; the expenditure on MHC in 2010 was €5.5 billion, which is 6.5% of the total spending on health care (Zorgbalans 2011). The rising health care expenditure was not detrimental; the benefits of the health care system in the recent years are eminent. People live longer and in better health, the employment is larger and health care contributes to happiness and welfare. Research Institutes in the Netherlands, such as Nivel and Trimbos, claim that every invested euro on primary MHC yields €2.59 (Lokkerbol, Verhaak et al. 2011). However, more additional expenditure on health care does not necessarily lead to proportional higher benefits (Van der Horst, F. van Erp et al. 2011).

To manage the rising costs in the MHC in the past decennium, the government took incessant policy measures. However, MHC expenditures are expected to continue to rise. At this time, it has not been studied what the effects of policy measures during 2002-2012 are on the MHC expenditure. Aims of this study are to provide an overview of the most important policy measures focused on the MHC expenditure during 2002-2012 and to gain insight in the intended and actual effects of these policy measures.

The central research question is *How did the Mental Health Care (MHC) expenditures develop in the Netherlands in the past decennium and what were the effects of policy measures during 2002- 2012 on MHC expenditures?* In addition, the research focussed on explanations for cost developments during 2002-2012. Also, goals and instruments of policy measures were analysed, as well as effects on process, goal achievement, quality, and accessibility of MHC. Finally, necessary conditions for effective implementation were investigated.

DATA AND METHODS

Design and procedure

The research can be described as explorative, since the first aim of the research was to gain insight in all relevant information about policy measures in the Mental Health Care. Subsequently a selection of important information was made and a central question was formulated (Van der Zee 2004). Two research strategies were used to answer the central question. First, a literature study was carried out. Second, interviews with experts were held. *Table 1* displays the research questions. It divides the second part of the central research question into two questions. The methods of the research will be explained in the next section.

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Table 1. Explanation of methods

Research Question	Methods
1. <i>How did the Mental Health Care (MHC) expenditures develop the past decennium?</i>	Analysis MHC expenditure Interviews Literature Study
2A. <i>What policy measures had most influence on the MHC cost development during 2002-2012?</i>	Literature Study Interviews Analysis MHC expenditure
2B. <i>What are the effects of these policy measures on the MHC expenditure?</i>	Literature Study Interviews Analysis MHC expenditure

1. How did the Mental Health Care (MHC) expenditures develop the past decennium?

To gain insight in the MHC expenditure, data from the Statistics Netherlands, Budget Memoranda (Rijksbegroting) 2000-2011, National Financial Annual Reports (Financieel Jaarverslagen) 2001 and 2011, Care Reports (Zorgnota) 2000-2003, Departmental Budget 2011 and the Final Budget Act (Slotwet) 2005-2009 were used to develop *figure 1, 2 and 3*.

Literature derived from the literature study was consulted to validate the statistics. In the digital literature database Pubmed search terms 'Mental health care costs' AND 'The Netherlands', 'Mental health care' AND 'The Netherlands' AND 'cost development' were used. These search terms did not produce relevant articles. Since the subject of this article concerns policy in the Netherlands, international literature databases did not provide relevant articles. Therefore, websites and reports from the government were consulted and search machine Google was used to find reports from Dutch Research Institutes and consultancy offices. Search terms were (in Dutch): 'GGZ EN Kostenontwikkeling', 'GGZ EN Kosten', 'GGZ EN Stijgende uitgaven'. By using the snowball method, through consulting the relevant cited publications, new papers and reports were found.

In addition, the figures concerning the development of the MHC expenditures were discussed with the experts during the interviews to gain more background information about the MHC expenditure development. Also explanations for the increased MHC expenditures were discussed. These explanations are underpinned with information obtained from the literature study and described in the first paragraph of the result section.

2. What policy measures had most influence on the MHC cost development during 2002-2012 and what are the effects of policy measures during 2002-2012 on MHC expenditure?

Literature study

An extensive literature research was undertaken to answer research questions 2A en 2B. Again digital literature database PubMed was consulted. The following search terms were used: 'mental health care' AND 'Netherlands', 'mental health care' AND 'Netherlands' AND 'policy measures'. These search terms were also used for the digital database Medline and the digital database Google Scholar. This did not produce relevant articles or reports. With search machine Google the following search terms were used (in Dutch): 'GGZ', 'GGZ EN Beleid' en 'GGZ EN Overheid'. Also with this literature study, the snowball method was used. For the purpose of this study, papers and reports from as recent as possible resources were used. *Figure 4, 5 and 6* were made to underpin the information from the literature search. Therefore, statistics from the Cost of Illness Study (Kosten van Ziekten, 2011), data from the Dutch Health Authority (NZa) (report 'GGZ in tabellen 2010' Research Institute Trimbos) and Statistics Netherlands, were used. National publications, reports from interest organisations and associations, Dutch research institutes, the Dutch Health Authority, and official policy papers from the

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government were also studied. During this research, the interviews, and the analysis of the health care expenditure, derivative research questions arose. Therefore, besides costs, goals and instruments of policy measures were analysed as well as effects on process, goal achievement, quality, and accessibility of MHC. Finally, the necessary conditions for effective implementation were investigated.

Interviews

Table 2. Characteristics study population interviews

Organization	Function of interviewed persons	Number of interviewed persons
Ministry of Health, Welfare and Sport (MEVA)	Chief Strategy and Knowledge Management Group. Ministry of Health, Welfare & Sports	1
Dutch Association of Mental Health and Addiction Care (GGZ NL)	(Senior) Policy Advisors	3
Dutch Health Authority (NZa)	Senior Policy Advisor, Policy Advisor unit MHC	2
Research institute Tranzo / MHC provider Altrecht	Affiliate Professor Economics and Organisation of Health Care, Member Board of Directors Altrecht	1
Dutch Association of Health Insurers (ZN)	Policy Advisor Curative MHC	1
Health Care Insurance Board (CVZ)	Advisors Care Advice	2
Trimbos-institute VU University	Senior Research Fellow in the field of Psychiatric & Addiction, Epidemiology and Health Economics, Trimbos-institute and Professor of Evidence-Based Public Mental Health at the department of Epidemiology and Biostatistics, VU University	1

In addition to the literature study and the analysis of the MHC expenditure, seven face-to-face interviews with in total eleven experts in the field of Mental Health Care and policy were held to gain a good understanding of the development of the MHC expenditures and the effects of policy measures in the past decennium. *Table 2* displays the organizations the expert represents and the position of each expert. The experts were approached by e-mail or phone. The interviews took place in March and April 2012. On the arranged date, the interviews were conducted at the office of the experts. They lasted approximately one hour. Prior to each interview, every participant received a brief memo in which the topic of the interview and important policy measures, emerged from the literature search, was explained. During the interviews, the policy measures that affected the MHC expenditures most were identified, by discussing the effect of these policy measures on the MHC expenditures. *Table 3* shows the policy measures which arose from the interviews and the literature study.

Data Collection

The face-to-face depth interviews were scheduled at a time of the participant's choice and a semi-structured interview format was used. Each interview opened with a short explanation of the aim of the research. It was semi-structured, because only four questions were asked, which gave the experts the opportunity to talk freely about the topic in their own words (Plochg, Juttman et al. 2007). All the interviews were audio-taped and notes were made. Afterwards the interviews were summarized per theme. In each subsequent interview, the understanding of the themes arising through the interviews was shared with the participants, to gain more information. Four of the seven interviews were held by one interviewer and at the other three interviews a colleague was accompanying. She also made notes and checked the summaries of the interviews.

Analysis

At first, the summary of each interview was read carefully to identify themes relevant for the research. Second, parts of the text about the same theme were

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clustered together and were given definitions. The interviews were analysed using the policy effect chain (*figure 1*). The results of the literature study were also structured according to this (adjusted to this study) theoretical model. With the policy effect chain, it is possible to analyse the effectiveness of policy by arranging the information systematically (De Bekker 2011). The policy effect chain is based on the input-output evaluation systematic, as can be seen in *figure 1*.

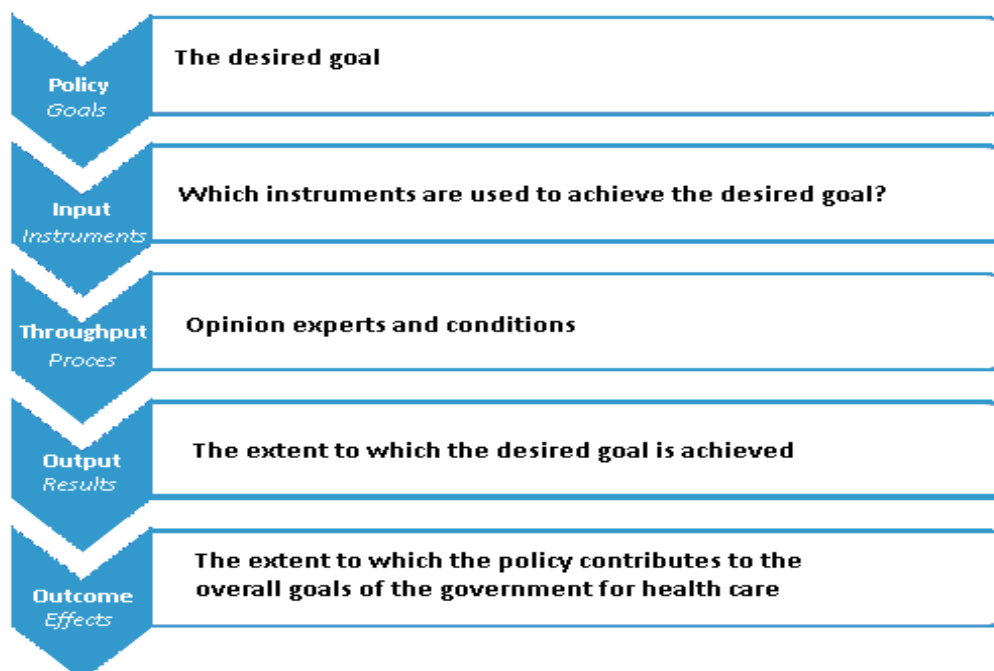


Figure 1: The policy effect chain.

The policy effect chain consists of five links. In the first link, *Policy*, the result or the desired goal derived from official policy papers, was described. The second link, *Input*, describes the instruments to achieve the goal. Information was gained from official policy papers from the government, implementing reports from research institute Trimbos, the Dutch Health Authority (NZa) and reports from consultancy offices. The opinion of the experts about the policy measure and the conditions that the policy measure must comply, are shown in the third link; *Throughput*, underpinned with information from reports and papers from institutes and organisations named at the second link. The fourth link, *Output*, indicates the extent to which the desired goal as described in link 1 is achieved. Finally link five, *Outcome*, describes to which extent the policy measures contribute to the overall goals of the government for health care: quality, accessibility and affordability (Murray and Evans 2003). 'Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (IOM 2001). 'Accessibility of care is the degree to which individuals are facilitated in their ability to gain entry to, and to receive care and services from the health care system' (Smits, Droomers et al. 2002). And finally, 'Affordability of health care is the ratio between costs and resources' (Zorgbalans 2012). In total, five most important policy measures were analysed by the policy effect chain, displayed in a matrix, as can be seen in the chapter 'results', *figure 4,5 and 6*.

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RESULTS

How did the Mental Health Care (MHC) expenditures develop the past decennium?

Statistics Netherlands divided the providers of health care into 11 different sectors for the purpose of health care expenditure statistics. Six of these sectors (and the increase of the total expenditure of care providers) are displayed in *figure 2*, in indexed numbers. The spending of Mental Health Care (MHC) increased much faster than all other sectors. A large rise of expenditure in almost every sector, from circa 2002, can also be seen.

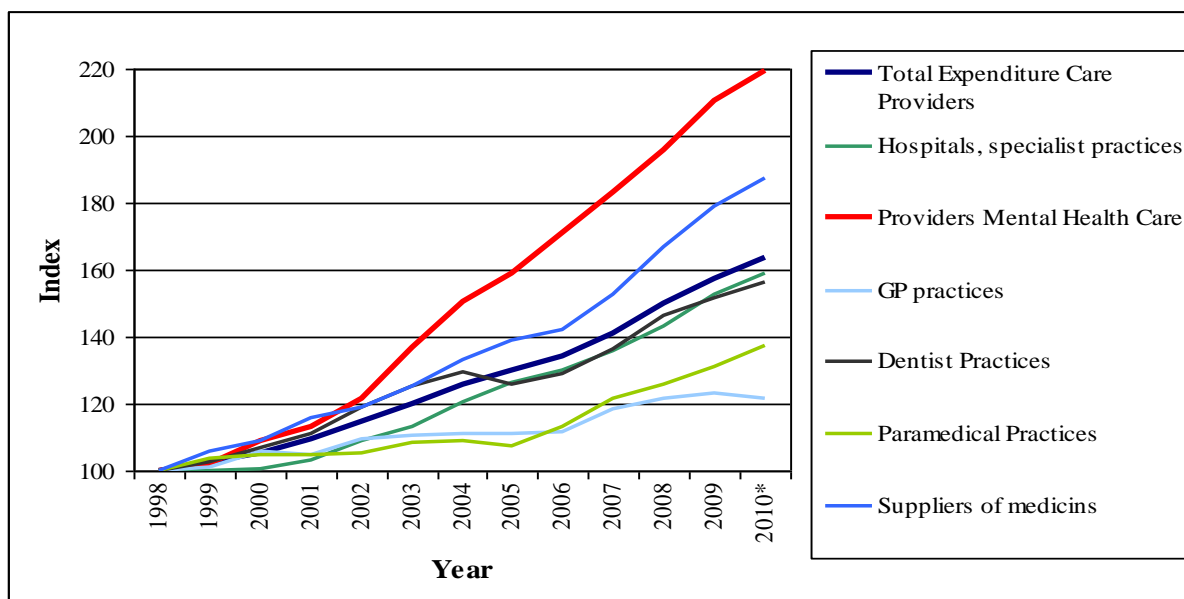


Figure 2: Development of Health Care Expenditure 1998-2010. Constant Prices (index 1998 = 100). * Provisional. Data derived from Statistics Netherlands 2012.

The increase of MHC expenditures is outlined in *figure 3*. It displays the budgeted and the actual expenditures on MHC during 2000 – 2010 in Gross BKZ. For the Central Governmental Budget, the Gross Healthcare Budget Framework (Budgettair Kader Zorg, BKZ) is used. The Gross BKZ expenditures are the total of expenditures that are financed by revenues from premium taxes: the Exceptional Medical Expenses Act (AWBZ), the Health Insurance Act (Zorgverzekeringswet, Zvw), private insurances, governmental contributions and user fees from patients. The Gross BKZ is limited to governmental responsibility and excludes welfare (Rijksbegroting 2005).

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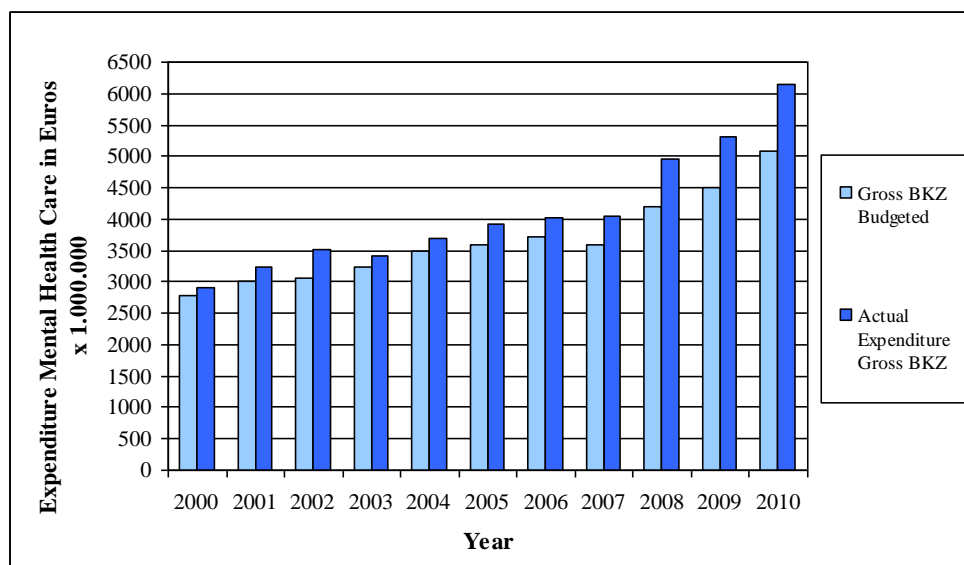


Figure 3: Expenditure on Mental Health Care, in Budgeted and Actual Gross Health Care Budget Framework. Statistics derived from the Budget Memoranda 2000-2011, the National Financial Annual Reports 2001 and 2011, Care Reports 2000 – 2003, Departmental Budget 2011 and the Final Budget Act 2005-2009.

In 2000, the budgeted Gross BKZ was € 2.78 billion; in 2010, the budgeted Gross BKZ rose to € 5.09 billion. The actual Gross BKZ in 2010 rose even to €6.14 billion, which means that the MHC expenditures more than doubled during 2000-2010. Data from 2011 and obviously from 2012 are not available yet.

Figure 3 reveals that the budget plan for MHC has been exceeded every year, and that the exceeding has been increasing every year since 2007. Since 2008, the MHC expenditure is rising more rapidly than ever before.

Every year the ministries of the Netherlands present their final budgets to the Ministry of Finance, which form together the central governmental budget. After Budget Day, where the budget plans are presented, the central governmental budget is debated in the Parliament. Budget plans can be changed then; this is one explanation for the differences between the budgeted plans and the actual expenditures (Rijksoverheid 2012). In *Figure 3*, a large exceeding and rise of cost is visible from 2006 onwards, and one outlier in 2002 in the period 2000-2006. This outlier can be explained by the policy on eliminating waiting lists, ('boter bij de vis'-beleid).

Many explanations for the rise of MHC expenditure are given in both literature and in the interviews held with the experts. The explanations can be clustered into three themes: demand, supply and policy.

Remarkable is that all players in the MHC field gave different explanations for the MHC expenditure growth; explanations that fit the organization and/or the institution, which the expert and/or the report represents. The organizations omit, whether intentionally or accidentally, to improve the function of the health care system together (Van den Berg, Van Dam et al. 2012). Own interest seems more important than the common interest.

Demand

The demand for MHC is undiminished rising from the nineties, although the mental health of the Dutch population did not change much over the past decennium. The NEMESIS-2 study showed that mental disorders appear frequently among the Dutch population, 42.7% experienced a mental disorder

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once in lifetime, and 18.0% in the past 12 months (De Graaf, Ten Have et al. 2010). The demand for MHC increased partly due to social changes. The government played an active role in the improvement of the accessibility of the MHC by reducing the stigma on MHC. This policy led to a better organised MHC, faster identification of mental problems in the primary care, and more attention for prevention (NZa 2011), (Nuijen 2010). Similarly, this resulted in a sharp decline in unmet health care needs, even for people with a mental disorder, as a consequence this led to a higher demand of MHC (De Graaf, Ten Have et al. 2010). More supply of care led automatically to more demand of care, as the accessibility improved. More supply led to higher expenditure (Houkes-Hommes 2010).

Supply

Since the implementation of more competition in the health care sector, starting in 2008, new (primary) health care providers established themselves in the market and responded to social needs of the population; by providing modern and dynamic MHC (BS Health Consultancy 2008). This resulted in a growing supply of MHC, as the new suppliers exist next to the established MHC institutions. The managed competition in the MHC has led to a decrease in price, but also led to an increase in demand, since MHC is faster and more easily to attain. Partly due to the competition, more and new treatments were and still are developed. The implementation and accommodation of these new treatments are more expensive than the established treatments (Van Diggelen, Kroes et al. 2012). Another important reason for the rising MHC expenditure is the high referral rate from general practitioners (GP's) from the primary to the (more costly) secondary MHC (NZa 2011). Despite of the 'stepped care' principle, a decrease of referrals cannot be seen. Various factors affected the GP's referral; better knowledge of mental disorders, more collaboration with specialised MHC and new ideas about the effectiveness of MHC (Nuijen 2010). Furthermore, an increasing recognition for the combination of psychical and mental illnesses can be seen, the so-called multi morbidity. This also led to higher costs in the MHC, without a decrease in costs in the somatic sector (Jeurissen, Gill - van Kampen et al. 2012).

Policy

The ministry of VWS developed a future perspective for the MHC. Goals of this perspective are; a more central role for the patient, more transparency in health care demand, introduction of funding based on performance, a better connection between the somatic care and the MHC, a better connection between the primary and secondary care and at last, an affordable MHC, now and on the long term (De Vos, Kornalijnslijper et al. 2009). Due to this perspective, the MHC sector has been subject of numerous, complex and costly changes in policy the past ten years. In the next section, the most important policy measures will be discussed and displayed in three matrixes (*table 3, 4 and 5*).

What policy measures had most influence on the MHC cost development during 2002-2012?

In *table 3*, the five most important policy measures, emerged from the interviews, and the used instruments to achieve the goals are displayed in the policy effect chain. In appendix 1, a more comprehensive policy chain is shown. The displayed policy measures had most influence on the MHC expenditure, compared to all other policy measures the government took during 2002-2012.

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Table 3: First two links of the Policy effect chain of policy measures in the Mental Health Care between 2002-2012.

	2002	2008	2008	2010	2012
Policy	Modernization of the Exceptional Medical Expenses Act (AWBZ) 'Boter bij de vis'-policy	Introduction and implementation of the Diagnosis Treatment Combination (DBC) in the MHC	Transfer of the curative MHC from the AWBZ to the Health Insurance Act (Zvw)	Introduction Care Intensity Package (ZZP'S) in the secondary MHC	Introduction of co-payment in the secondary MHC
Analysis					
Goals	Elimination of waiting lists	Cost control through more efficiency, transparency, quality and better responsiveness	Efficiency profit, more consistency in care, cost control	Focus on the patient, better distribution of costs and more insight in care intensity	Fostering primary MHC referral, cost control in secondary MHC.
Input Instruments	Releasing budget maximization	Abolition of the budget systematic, introduction of a new finance system	Transfer of all the curative MHC from the AWBZ to the Zvw. Release of extra budget for the Zvw.	Budget is related to the actual production of care institutions	Co-payments in the secondary MHC (except for youth, forced care and crisis care)

Notable in *table 3* is that in the period between 2003 and 2008 no new policy measures were implemented. The period can be described as relatively calm, although in 2006 a fundamental reform of the Dutch health care system took place. A compulsory health insurance system and managed competition for providers and insurers was introduced (CBS 2006). However, the effect of the managed competition in the MHC emerged in 2008, with the introduction of DBC's and the transfer of the curative MHC from the AWBZ to the Zvw, and therefore not mentioned as individual policy measure (CVZ 2008), (NZa 2010). *Table 3* also shows that the policy measures are all focused on cost control, except for the modernization of the AWBZ. Instruments to achieve the goals, were all different. Remarkable is the contradictory policy in 2008; of both policy measures, main goals were the achievement of cost control. However, instruments were the release of the budget systematic and the release of extra budget for the Zvw.

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What are the effects of these policy measures on the MHC expenditure?

Table 4: Second three links of the Policy effect chain of policy measures in the Mental Health Care between 2002-2012.

	2002	2008	2008	2010	2012
Policy	Modernization of the Exceptional Medical Expenses Act (AWBZ) 'Boter bij de vis'-policy	Introduction and implementation of the Diagnosis Treatment Combination (DBC) in the MHC	Transfer of the curative MHC from the AWBZ to the Health Insurance Act (Zvw)	Introduction Care Intensity Packages (ZZP'S) in the secondary MHC	Introduction of co-payment in the secondary MHC
Analysis					
Through-put Process	Due to an inadequate waiting list registration, there was insufficient information about the waiting lists. However, an increase of 6% new patients, next to 7% increase of production can be seen.	The introduction took place at the same time as the transfer of the curative MHC. This had financial impact on the care suppliers due to the late start up of DBC declaration for the non-budgeted MHC suppliers and the disbursement for the secondary MHC.	Similar with the introduction of the DBC's, the transfer took place. Both policy measures have major impact on the MHC. Secondary MHC has waiting lists, a small part of primary MHC also. Due to the waiting lists, transfer from primary to secondary care is impeded.	The transition to care based on personal needs of the patients caused much effort of provider and patient. Care agencies, and in the future, health insurers, have an important role to support the care suppliers to provide higher quality of care.	To ensure access of MHC, the co-payment is before introduction decreased from €275 to €100 per DBC. For 2013, alternative measures will be studied.
Output The extent to which the goals are achieved	The number of waiting patients decreased with 7%, the mean waiting time increased with 22%.	One-off cost rise of €1.4 billion. DBC's led to perverse incentives in MHC care and demand. For care suppliers the DBC's led to more transparency, for health insurers the DBC's are insufficient transparent.	There is no flexibility in the two financing systems, which leads to waiting lists for the secondary and primary MHC. The transfer led to a large growth in MHC expenditure, and because of longer treatment duration, the consistency in care is disadvantageous for the MHC.	More insight in care intensity, focusing on the patient. However, financing per patient appears to be too expensive, a discount is applied to hatch budget neutral.	The final effects of the co-payment are unknown by now. Expected is that, in the short term, the policy measure is highly effective to reduce the demand of MHC.
Outcome Overall goals of health care	Quality + It is expected that through expanded treatments, more	Quality More insight in costs and use of care for care suppliers,	Quality - No flexibility between the two finance systems, this seems	Quality + More insight in care, but the effect of ZZP's on the quality	Quality There is a risk that financial, instead of medical

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	<p>supply and shorter waiting lists, the quality of care will be increased.</p> <p>Accessibility - Increase of the waiting time with 22%, but decrease of the waiting lists with 7%, due to more care supply.</p> <p>Affordability -- MHC expenditure rose with €240 million. More supply leads to more demand.</p>	<p>although the effect of DBC's on quality of care is unknown.</p> <p>Accessibility + Establishment of many new care suppliers what leads to better accessibility of care.</p> <p>Affordability -- No budget maximization, the turnover could be much higher than budgeted, which led to a large increase in expenditure.</p>	<p>to have a negative effect on the quality of care.</p> <p>Accessibility - The referral is more difficult and therefore waiting lists arise.</p> <p>Affordability -- Because there is no transfer possible between the two systems, an increase of MHC expenditure can be seen.</p>	<p>of care is unknown.</p> <p>Accessibility ZZP indication is complex, but with a right indication, the ZZP's had no negative or positive effect on the accessibility.</p> <p>Affordability The actual costs of the ZZP's are higher than the current budget, the government adjusted for this. For the care supplier this is detrimental when in ZZP's arranged care is supplied.</p>	<p>considerations, determine the care supply and care demand.</p> <p>Accessibility - The health differences between poor and rich people can grow. In other countries with co-payment systematic, this phenomenon is hardly observed.</p> <p>Affordability + Co-payment leads to more awareness in use of care. However, substitution to other sectors should be avoided.</p>
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The effects of the policy measures on MHC expenditures are shown in *table 4*. It displays three links of the policy effect chain.

Modernization of the Exceptional Medical Expenses Act (AWBZ)

In 2002, the policy on eliminating waiting lists was introduced. Care insurers were able to put more care under contract, therefore care suppliers could produce more care (VWS 2003). Eliminating waiting lists was part of the modernization of the AWBZ. Extra production of care was needed to comply with the growing MHC demand and to eliminate the continuously growing waiting lists. The government released the budget maximization in 2002 and the MHC expenditures rose with €240 million (7.5%). Because of this growth of MHC expenditures, and the marginal decrease of waiting lists, the budget maximization was reintroduced in 2003 (VWS 2004). The modernization of the AWBZ has probably led to a better quality of care, because the duration of the treatment expanded and more care was supplied. This led on the one side to a better accessibility of MHC, but the average waiting time increased up to 22%. Finally, this policy measure did not lead to an affordable MHC, since the expenditures grew with €240 million.

Introduction and implementation of the Diagnosis Treatment Combination (DBC) in the MHC

In 2008, the Diagnosis Treatment Combinations (DBC's) were introduced and implemented in the MHC. The health system reform in 2006, and, in particular, the introduction of DBC's made it possible for non-budgeted care providers to establish themselves in the (primary) care market which resulted in a large growth of new and non-budgeted care providers in 2008 – 2009; the number of non-budgeted institutions increased with 262% in 2009 compared to 2008. The number of budgeted care providers has been stable the recent years, and is still responsible for more than 90% of the care providing in the MHC. The cost of non-budgeted institutions rose from € 10.5 million in 2008 to € 51.7 million in 2009. For new care providers, the costs per DBC in 2009 increased with 56% compared to 2008 (Van Diggelen, Kroes et al. 2012), (Jeurissen, Gill - van Kampen et al. 2012). The rise of expenditures in the new and non-budgeted care providers did not lead to a decrease of expenditures growth in the budgeted institutions, which means there is no substitution of care (Jeurissen, Gill - van Kampen et al. 2012). One goal of the DBC's (see *table 3*) is more transparency of the MHC. The transparency for health insurers is insufficient as the DBC-systematic contains several perverse incentives. One of the perverse incentives is up-coding, which leads to calculated behaviour among MHC suppliers. It is assumed that the DBC's provided more insight in the costs and use of MHC, and thus led to more transparency for the MHC suppliers. A sharp increase of the administrative burden is a consequence of more transparency (Van Hoof F., Knispel A. et al. 2009). The effect of DBC's on quality remains unknown, though the attention for quality measuring in the MHC has risen considerably. Because of the establishment of many new care providers in the primary MHC, the primary MHC is better attainable and accessible. The secondary MHC is much more costly and therefore less attractive for new MHC suppliers and health insurers (Van Hoof F., Knispel A. et al. 2009). The introduction of the DBC's resulted in a one-off cost rise of 1.4 billion, due to administrative burden and ICT investments (Van Diggelen, Kroes et al. 2012). The affordability of MHC is obviously reduced.

Transfer of the curative MHC from the AWBZ to the Health Insurance Act (Zvw)

Also in 2008, the transfer of the curative MHC from the AWBZ to the Zvw took place. The curative MHC contains all outpatient curative care and the first year of inpatient curative care, even lengthy residence. Since 2008, the Zvw is financial responsible for the curative MHC. The AWBZ care presumptions are all non-

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curative MHC (in- and outpatient), as well as the second year of treatment and further inpatient care (CVZ 2008). The AWBZ is responsible for 30% of total MHC expenditures, while 4-6% of all MHC patients receive AWBZ financed care. With the transfer, harmonisation between the AWBZ and the Zvw in the total health care sector has been achieved. Main drawback for the MHC is the longer average treatment duration, compared to the somatic health care sector. A decrease of AWBZ care is mostly caused by more intensive and faster supply of outpatient care. Health insurers experience disadvantages when treatment duration shortens to less than one year, as the savings are for the AWBZ, and possible extra costs for the health insurers (Rijksoverheid 2010). Cost control is one of the goals of the transfer (see *table 3*). By stimulating outpatient care, the AWBZ expenditures will decrease, and the less costly Zvw will increase. Before 2008, outpatient care was funded with transferred money from the AWBZ, by reduction of the number of inpatient's places. As a result of this transfer, the flexibility between the two finance systems no longer exists and the budget cannot be transferred from the AWBZ to the Zvw (NZa 2011). Further, health insurers and suppliers are confronted with the waiting lists in the AWBZ. The shift of patients from primary to secondary MHC is therefore impeded and leads to higher costs and a lower quality of care (De Vos, Kornalijnslijper et al. 2009). The Dutch Health Care Insurance Board (College voor Zorgverzekeringen, CVZ) calculated the costs of the transfer for the Zvw up to 1.1 billion Euros. In 2008, more MHC is provided, which led to an increase of more than €500 million; the other €500 million is a one-off administrative expenditure. In the Zvw, the care is charged in the year the diagnosis is set. Care provided in 2009, was charged for 2008. Due to the transfer, the insurance fund was charged for care provided in 2008, whereof the diagnosis was set in 2007. This led to an administrative doubling and led to an extra expenditure of €500 million for the health care insurance fund (Van den Elsen 2010). In addition, the transferred part of the AWBZ to the Zvw is larger than it was for the AWBZ and resulted in increasing MHC expenditures (NZa 2011). The transfer seems to have a negative effect on the quality of MHC since there is no flexibility between the two financing systems. The accessibility became more difficult as waiting lists arose due to this inflexibility and the affordability of the MHC clearly decreased.

Introduction Care Intensity Packages (ZZP'S) in the secondary MHC

In 2010, Care Intensity Packages (Zorg Zwaarte Pakketten, ZZP's) in the secondary MHC were introduced. A ZZP is a description of care intensity and is based on patient's personal needs. The budget of health suppliers depends on the care intensity of patients. ZZP's are part of the AWBZ care (Rijksoverheid 2012). The MHC institutions are now responsible for the occupation of the beds since the budgets are related to the actual production of care (NZa 2012). The actual costs of the ZZP's are higher than the costs were during the budget parameters. Therefore, the government adjusted for the actual costs of the ZZP's (NZa 2012). MHC suppliers will experience disadvantage when in ZZP's arranged care is supplied (Kits and Vos de Weal 2011). However, the budget of MHC suppliers, based on the ZZP's, is now determined by health care agencies in agreement with the MHC suppliers and health insurers, within a certain range (NZa 2012).

The ZZP's gain more insight in patient's care intensity and lead to a central role for the patient in the MHC institutions. In addition, the costs are better distributed since the budget is based on patient's needs. Goals of this policy measure (see *table 3*) are largely achieved (VWS 2012). Main drawbacks from the ZZP's for the MHC institutions are the required complex ZZP indication of patients, this leads in particular to a higher administrative burden, and the strict health care agencies' budget ranges (VWS 2011).

The quality of the secondary MHC has probably been improved, since patient's personal needs play a more central role in the MHC, and MHC institutions obtained more insight in supplied care. The indication of the ZZP is complex for

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MHC suppliers, and ZZP's leads to a high administrative burden. However, ZZP's appear not to have positive or negative effect on the accessibility of the MHC. Although ZZP's are more expensive than MCH was under budget parameters, the effect of ZZP's on the affordability of MHC is unknown.

Introduction of co-payment in the secondary MHC

The introduction of co-payments in the secondary MHC took place in 2012 and arose from the large increase of spending on the MHC sector over recent years. Tempering the MHC cost development was essential for the government. Co-payment was already introduced in the primary MHC in 2009, which has led to substitution of primary MHC by the more expensive secondary MHC (VWS 2012). The co-payment was introduced to stimulate more conscious use of care and better cost control (Lokkerbol and Smit 2011). MHC demand appeared to be relatively elastic, the price elasticity of ambulatory MHC is -0,8%, as the changes in price have a large effect on the quantity of the MHC demand (Jeurissen, Gill - van Kampen et al. 2012). Research institute Nivel conducted an inquiry among 5000 secondary MHC patients in November - December 2011, to gain insight in the effects of the co-payment. This inquiry took place before the co-payments were introduced. The authors concluded that patient's income will determine the demand of MHC, which means that in particular patients with a low educational level and a low income will stop or reduce their MHC use (Koopmans and Verhaak 2012). In the first three months of 2012 a decrease in MHC is notable, further development of secondary MHC demand is unknown (LPGGZ 2012). Substitution to other (health care) sectors is expected.

The policy effect chain, (*table 3 and 4*) makes clear that most policy measures have multiple and unspecific goals. In this complicated goal setting, all players in the MHC field try to maximize or optimize one's own interests and preferences, where the overall goals of health care are sometimes lost out of sight. It is assumed that the overall quality of MHC improved in the past decennium, despite the fact that the measurement of quality is highly debated (Van den Berg, Van Dam et al. 2012). The accessibility of the MHC is high, although this slightly decreased. The waiting times in the MHC are for 25 - 33% of the patients longer than the agreed period for waiting lists (Polder and Van der Lucht 2011). Also the introduction of co-payments might decrease the accessibility of MHC, as financial instead of medical considerations determine the care supply and demand (Lokkerbol and Smit 2011). The affordability of the MHC sharply declined in the past ten years (Van den Berg, Van Dam et al. 2012).

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Conditions for a successful implementation

Table 5: Conditions for a successful implementation of policy measures. Policy effect chain of policy measures in the Mental Health Care between 2002-2012.

	2002	2008	2008	2010	2012
Policy	Modernization of the Exceptional Medical Expenses Act (AWBZ) ; 'Boter bij de vis'-policy	Introduction and implementation of the Diagnosis Treatment Combination (DBC) in the MHC	Transfer of the curative MHC from the AWBZ to the Health Insurance Act (Zvw)	Introduction Care Intensity Package (ZZP'S) in the secondary MHC	Introduction of co-payment in the secondary MHC
Analysis					
Conditions Based on literature and expert views.	<ul style="list-style-type: none"> ▪ Structural and uniform waiting lists registration is needed for a complete and clear registration of the problem. ▪ More transparency and insight in costs of (supplied) care is needed for more insight in costs prices. 	<ul style="list-style-type: none"> ▪ DBC's contain no efficiency incentives, but producing incentives. A transaction systematic would fit better. ▪ More transparency for health insurers is needed. ▪ A correct registration of the DBC by health suppliers ▪ Shorter transition phase of DBC implementation. The budgeted institutions producing according the production agreements. Non-budgeted and new health care suppliers work with DBC's. This leads to skewed ratios between the care suppliers and impedes market competition. 	<ul style="list-style-type: none"> ▪ For more efficiency, a less rigid transfer is needed. ▪ Fostering of better referral from and to primary and secondary MHC is a condition for a connection between curative and long term care. The waiting lists impede the referral. 	<ul style="list-style-type: none"> ▪ Contract areas have to be discussed with the Ministry of VWS and the care agencies. ▪ Less rigid region budgets of care agencies. ▪ More easy and less time-consuming complex indications. 	<ul style="list-style-type: none"> ▪ Substitution to other health care sectors should be avoided. ▪ Patients need to have insights in their health status to make well thought-out decisions based on price and health

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Table 5 shows the conditions the policy measures certainly have to comply with to be successful. Obvious conditions 'enough financial resources' and 'cooperation between all relevant stakeholders' are applicable to all policy measures. At this moment, the conditions named in *table 5*, are not met due to complex and multiple goal setting of the policy measures, unexpected developments in the MHC and a lack of financial resources and cooperation.

Due to insufficient waiting list registration in the MHC before 2003, the size of the waiting list issue was not clear. Effect measures were therefore inconvenient (VWS 2004). In 2008, the introduction and implementation of the DBC's encountered problems. DBC's contain no efficiency incentives, but producing incentives, which leads to calculating behaviour of MHC suppliers. Because DBC's lack transparency, health insurers can not adjust for these 'perverse' incentives. This leads to higher expenditures. In addition, health suppliers have to register the DBC's correct to receive money from the health insurer. Correct registration takes time and is disadvantageous for the patient. At least, the transition phase of the DBC's takes too long (Van Hoof F., Knispel A. et al. 2009; NZa 2010; NZa 2011).

Main problem of the transfer of the curative MHC from the AWBZ to the Zvw is caused by the inflexible finance systems. More flexibility will lead to more efficiency and cost control. (NZa 2011).

Even though the introduction of the ZZP in general was accompanied with little problems, for a successful accomplishment, conditions named in *table 5* have to be met (NZa i.o. (CTZ) 2006; VWS 2011).

Co-payments in the secondary MHC were introduced with much public debate. MHC suppliers and MHC associations expected substitution of care to other health care sectors and suggested the risk that financial, instead of medical considerations would determine the MHC demand. Inequality between poor and rich people could increase further (Lokkerbol and Smit 2011). Because of these arguments and the many complaints from the society, in 2013 alternative policy measures will be investigated (VWS 2012). The conditions named in *table 5* came clearly through after the implementation of the policy measures.

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Increasing volume dominates increasing prices

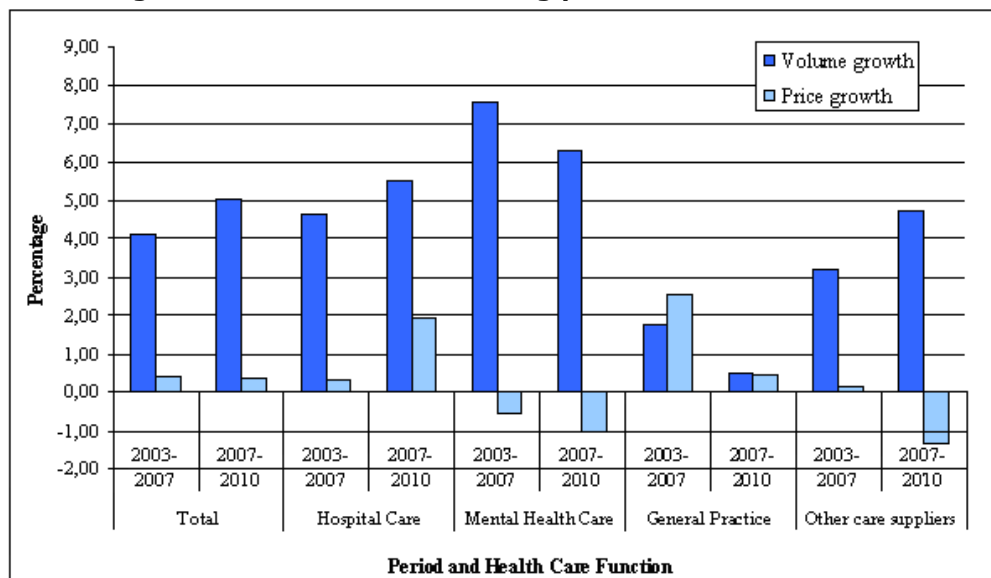


Figure 4: The health care expenditure per health care function in volume growth and price growth per year, in period 2003-2007 and period 2007-2010. Based on statistics from Statistics Netherlands, and statistics from the Cost of Illness Study.

Figure 4 divides the growth of the health care expenditure per health care function in volume and prices, during 2003 - 2007 and 2007-2010. It makes clear that the volume of MHC increased much faster than the prices in the MHC, in 2003-2007 the volume grew with 7,5% per year, the prices decreased with 0,5%. Further shows figure 4 that the MHC sector has the highest percentage of increasing volume, compared to the other three sectors; hospital care, general practices and other care suppliers.

Although the prices decreased, the volume increased also, with rising MHC expenditure as a result. The managed competition made the MHC market better accessible for the health care suppliers, which led to more supply and automatically to more demand. Remarkable is the less rapid increase of volume in 2007-2010, compared to 2003-2007. However, the percentage of MHC's prices decreased during 2007-2010 much faster compared to 2003-2007. For the complete health care sector, an increase in volume, and a minor decrease in prices can be seen, in comparison with the MHC sector.

The MHC growth can also be divided in diagnosis and health care function. A comparison of the MHC expenditure in 2003, after the implementation and reintroduced budget maximization in respectively 2002 and 2003, and the MHC expenditure in 2010, is made in figure 5.

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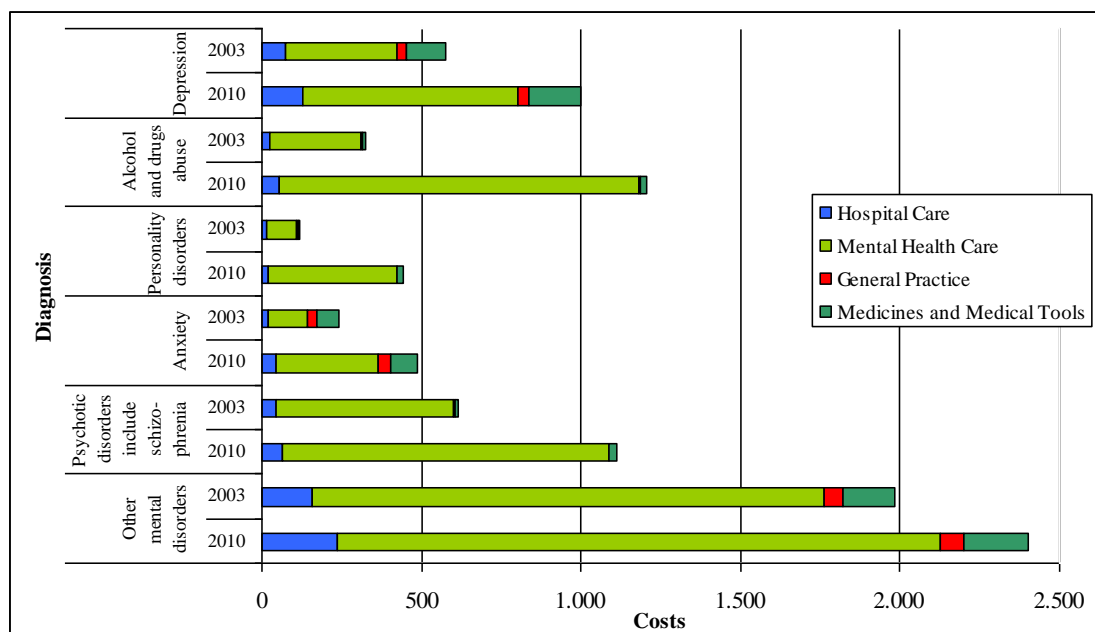


Figure 5: Mental Health Care Expenditure in 2003 and 2010 in million Euros (current prices), in diagnosis and health care function. Data from the Cost of Illness Study.

Figure 5 shows the increased expenditures on mental disorders in 2003 and 2010. The total expenditures almost doubled during 2003 and 2010.

The sector 'Mental Health Care' was, with 80% of the total costs, responsible for the highest expenditure on MHC. The sectors 'Medicines and Medical Tools' and 'Hospital Care' were respectively second and third in highest costs. The sector 'General Practice' was much smaller, only 3% of the total expenditure was covered in this sector.

Diagnosis 'Other mental disorders' have led to highest costs, followed by 'alcohol and drugs abuse' (in 2010). The latter showed a remarkable growth in costs, which can partly be explained by a change in registration of costs during the introduction of the health reform in 2006. However, a large growth in patients with alcohol and drugs problems can also be seen (Slobbe, Smit et al. 2011). The diagnosis 'Personality disorders' was the fastest growing diagnosis, immediately followed by 'Dependence on alcohol and drugs'. The expenditure per diagnosis is skewed. According to data from the NEMESIS-2 study, in 2007, 87.500 people in the Netherlands were diagnosed with schizophrenia, and were responsible for the third highest MHC costs. In 2007, 643.000 people were diagnosed with depression, which were responsible for the fourth highest costs (Nationaal Kompas Volksgezondheid 2012), (Nationaal Kompas Volksgezondheid 2012). In summary, a small group of patients with serious mental disorders, were responsible for major part of the MHC expenditure (Jeurissen, Gill - van Kampen et al. 2012).

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As can be seen in *figure 6*, the number of people using MHC, was rising rapidly with approximately 10% per year, while the total number of people with a mental disorder was not increasing (VWS 2012). This corresponds with the earlier mentioned growing MHC demand.

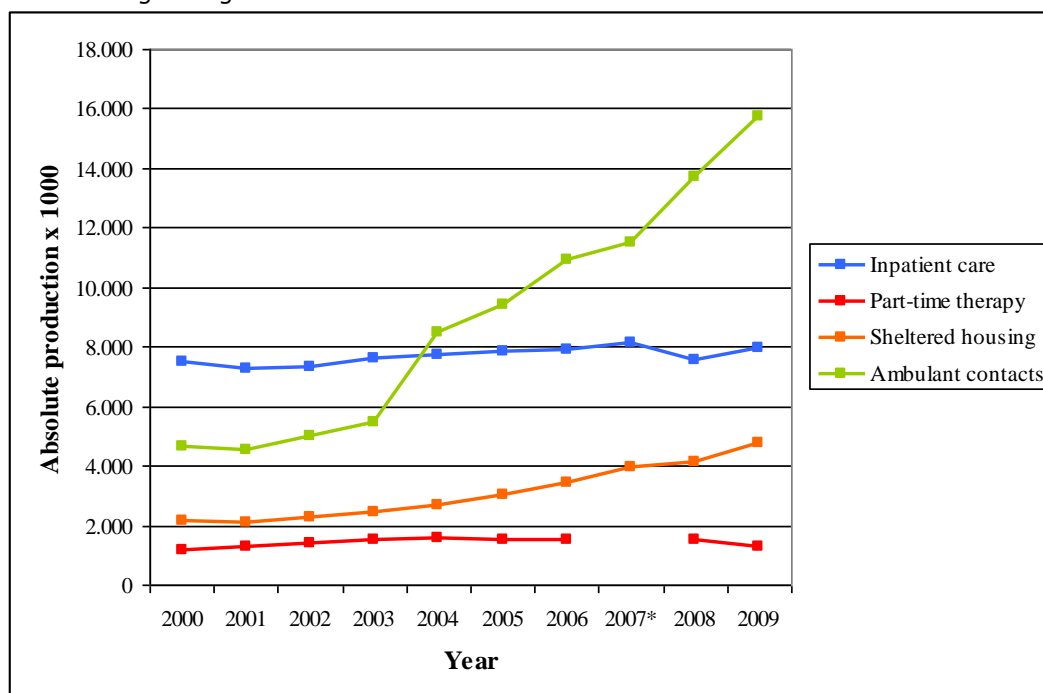


Figure 6: Absolute production of Mental Health Care Institutions (expressed in inpatient days, part-time therapy, days of sheltered housing and ambulant contacts) (Source: Van Dijk, Knispel et al. 2011, Trimbos Institute). *No figures available of part-time therapy in 2007.

Figure 6 also shows that the production of MHC almost doubled in ten years. Research Institute Nivel investigated that in 2002, per 1000 registered patients from GP's, 12 were referred to secondary MHC; psychiatry, ambulatory care and social work. In 2010, this rose up to 27 patients per 1000 registered patients, a growth of 300% (Nivel 2010). The number of ambulant contacts has been increasing since 2004, and almost tripled during 2000 – 2009 (*figure 6*). The increase in ambulant contacts was partly a result of administrative changes, because since 2004 telephone consultation has been counted as well. At the same time, the government introduced policy to reinforce the primary MHC and the ambulatory care (Van Diggelen, Kroes et al. 2012). The inpatient care decreased since 2007, but increased slightly in 2009. Decreased inpatient care due to policy to reinforce the ambulatory care, as named above, remained. This is the result of the financing system; MHC providers receive money per bed and the insurers have limited incentives to increase the efficiency of MHC providers because they are not bearing the financial risk (Plexus and BKB mei 2010). The days of sheltered living increased. Explanation for this phenomenon is the introduction of co-payment in the primary MHC, which makes the transfer to independent living complicated. The policy on eliminating waiting lists and a growing demand of care by new targets is another explanation. Days of sheltered living increased every year, but a small downturn was observable; a growing rate of 15% in 2007, to a growing rate of 3,7% in 2011, due to a production maximum the ministry of Health, Welfare and Sports introduced (RIBW Alliantie 2011). The number of part time therapy stayed stable over time.

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The total expenditure on primary psychological care in 2010 was circa €132 million, this means per insured person €8.03. In 2008, €5.39 per insured person was expended (CVZ Zorgcijfers 2012). Both total cost and cost per insured person increased. The number of treatment also increased; the National Association of Primary Care Psychologists (Landelijke Vereniging Eerstelijnspsychologen, LVE) estimated a growth of 15% of provided care by psychological primary care providers in 2008, compared to 2007. In addition, the total expenditure on primary psychological care rose as well, due to an increase of administrative burden. CVZ mentions three explanations for the more than average growth of primary psychological care; reinforcement of primary care is government policy, the supply of primary MHC is increasing due to new care providers which leads to a higher demand of MHC and, at last, new ensured care is generally more expensive than average (Van Diggelen, Kroes et al. 2012). Moreover, from *figures 4, 5 and 6* it can be concluded that, although MHC expenditures increased, the production of MHC was growing faster.

DISCUSSION

Evaluation of policy measures

Although main goals from the five policy measures were 'cost control', all policy measures are accompanied with a large MHC expenditure increase. The association between the rising MHC expenditure and the policy measures from 2008 supports the results of previous studies (Van der Horst, F. van Erp et al. 2011; Van Diggelen, Kroes et al. 2012; Jeurissen, Gill - van Kampen et al. 2012). However, these reports do not assign the policy measures as only reason for the increasing MHC expenditures. This means that the effects of policy measures on MHC expenditure are not explicit.

The Dutch Health Authority executes implementation tests for most new policy measures in health care. The NZa monitors and analyses the health care markets, which enables the NZa to react adequate to market behaviour. However, these implementation tests are executed before the policy measures are introduced. Furthermore, the focus of the NZa is not on the overall goals of health care, but on the market behaviour of health care suppliers and health care insurers (NZa 2012).

Consultancy offices and research institutes execute, often under commission of the government, occasionally a research on the implementation of the policy effects. These researches are rarely sector-wide, and are executed soon after the introduction of the policy measure, whereby long term effects are not taken into account. The actual effect of policy measures remains unknown because of a lack of structural evaluation of (new) policy measures. However, in accordance with the research of Van den Berg et al (Van den Berg, Van Dam et al. 2012), the overall goals of health care are not achieved. In particular the affordability of the MHC is under pressure (Nuijen 2010; Van der Horst, F. van Erp et al. 2011; Lokkerbol and Smit 2011; Van Diggelen, Kroes et al. 2012; Jeurissen, Gill - van Kampen et al. 2012).

More demand of MHC

More supply leads to more demand, according to economic theory. In line with Houkes-Hommes (2010), this study showed that more supply of health care leads undoubtedly to more demand of health care. Although the prices of MHC decreased, the continuing rising volume and production of MHC caused increased expenditure. However, it is expected that introduction of co-payments in the MHC will lead to diminished demand of MHC, despite of the grown supply (Lokkerbol and Smit 2011). Jeurissen et al. (2012) emphasizes the effect of co-payments in price elastic goods and services, as the MHC is. Price elastic goods induces moral hazard, copayments will discourage overconsumption (Jeurissen, Gill - van

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Kampen et al. 2012). Besides mentioned reasons for the increase of health care expenditure, frequently named explanations in the literature for growing health care costs are: a growing population, innovations, price inflation, ageing of the population and the so-called Baumol effect (Slobbe, Smit et al. 2011). The Baumol effect can be described as the phenomenon that the wage rates rise more quickly than the labour productivity and therefore the costs increase (Baumol, Blackman et al. 1985).

Invisible hand

All players in the MHC field try to maximize or optimize one's own interests and preferences, which deteriorates the health care system. However, the 'invisible hand' theory of economist Adam Smith, upon whose theory the (managed) competition in health care is based, claims that 'by pursuing his or her own interest, the common interest is served to a higher level' (Smith 2005). Competition in health care has led to competition between the health insurers market and the health care purchasing market, though heavily regulated by the government. Managed competition leads to cost reduction and improves the quality of health care (Maarse 2011). Research of Van den Berg et al, shows that Adam Smith's 'invisible hand' does not exist in the health care market. Although every player in the field of mental health care endeavours for their own interests, the market is too heavily regulated to actually do so. Van den Berg's report shows that when MHC organizations refuse to improve the function of the MHC sector together, the costs will increase further (Van den Berg, Van Dam et al. 2012).

Methodological limitations

For figure 7, statistics from the Cost of Illness Study were used. The figure shows a remarkable growth in MHC expenditures per diagnosis in 2010, compared to 2003. However, until 2006, the diagnosis classification was based on statistics from Zorgis, (care information system), derived from the MHC-sector. From 2007, statistics from DBC's via VEKTIS, derived from health insurers, were used. This resulted in a break in data for the sectors 'other mental disorders' and, as explained in the results, the diagnosis 'alcohol and drugs abuse' (Slobbe, Smit et al. 2011). Statistics before 2006 and after 2006 are difficult to compare, due to this change in data collection. Furthermore, the statistics over period 2008-2012, derived from DBC's, are still preliminary. Although the final statistics are not available, it can be assumed that the MHC expenditure increased largely (Van Diggelen, Kroes et al. 2012). Another limitation is the lack of scientific articles about the effect of policy measures in the MHC in the Netherlands.

CONCLUSION

Research question 1. *How did the expenditures on Mental Health Care (MHC) develop in the past decennium?*

The MHC expenditures increased much faster than all other health care sectors during 2002-2012. Period 2000-2008 was remarkable calm, with one outlier in 2002, due to the policy on eliminating waiting lists, but from 2008, a spectacular rise of MHC expenditure took place. This can be explained by the implementation of DBC's in the curative MHC and the transfer of the curative MHC from the AWBZ to the Zvw. Beside policy, the growing health care expenditures can be clustered in two other themes, namely demand and supply. Due to social changes and active policy to reduce the taboo of MHC, the demand for MHC undiminished increased during the past decennium. In addition, the high referral rate from GP's to MHC led to more demand and therefore to higher costs. The introduction of more competition in the health care sector, starting in 2008, led to more supply of MHC. (Primary) health care providers established themselves in the market and responded to social needs of the population; providing modern and dynamic MHC,

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next to the existing MHC institutions. The production of MHC is more than doubled during the past ten years and even though the prices of the MHC decreased in the same period, the volume increased even faster, which resulted in growing MHC expenditures.

Research question 2: *What are the effects of policy measures during 2002- 2012 on MHC expenditures?*

However, implemented policy measures that the Dutch government took to control the cost development in MHC during period 2002-2012 were accompanied by increased costs. In 2002, the policy on eliminating waiting lists led to an expenditure rise of €240 million. The implementation of the DBC's resulted in a large growth of new and non-budgeted care providers in 2008 – 2009 and the cost of non-budgeted institutions rose from € 10.5 million in 2008 to € 51.7 million in 2009. The costs per DBC in 2009 increased for new care providers with 56%, compared to 2008. Due to the transfer of the curative MHC from the AWBZ to the Zvw, the MHC expenditures grew with € 1.1 billion. The latter is partly an accounting effect. The effect of the introduction of the co-payments on the MHC expenditure on the long term is not visible yet.

Because of the growing MHC supply, the demand of MHC automatically increased. Satisfying the MHC demand led to higher expenditure, and although the price of MHC decreased, the volume of MHC increased. This effect is larger during period 2007-2010 than during period 2003-2007, which can be explained by the (regulated) market competition under primary care suppliers in the MHC. Although market competition leads to more supply, the market is too heavily regulated to perform optimally. At this time, the MHC organizations do not collaborate to improve the MHC together wherefore the MHC expenditure increased and the overall goals of health care are lost out of sight.

The quality of the MHC predominantly increased. The accessibility of the MHC is high, although it slightly decreased during the last decennium. The waiting times in the MHC were for 25 – 33% of the patients longer than the agreed period for waiting lists. Also, the introduction of co-payments may have decreased the accessibility of MHC, as financial, instead of medical considerations, determined the care supply and demand. The affordability of the MHC obviously steeply declined in the past ten years.

In general, the overall goals of the health care, quality, accessibility and in particular the affordability, were not achieved by the policy measures implemented during 2002-2012.

RECOMMENDATIONS

Policy recommendation

Policy measures in the MHC should be scientifically studied to obtain thoughtful answers on issues underlying the policy measures (Plochg, Juttmann et al. 2007). Especially evaluation of policy measures is important to gain insight in the success and effects of the policy measures. The last step of the implementation process should be the evaluation of the policy, shortly after the introduction of the policy measure, and the effects on the long term. To develop relevant, feasible and effective policy, evaluation of policy is essential (Van Hoesel, Leeuw et al. 2005).

Part of the success of goal attainment depends on the formulating the goals (Bovend'Eerd. T.J.H., Botell et al. 2009); the goals of MHC policy measures are not specific. Indeed, the MHC policy measures have multiple goals and are complex. For a successful goal attainment, goals have to be realistic and acceptable, effective instruments to achieve the goals have to be present and the involved organizations and persons have to take their responsibilities to pursue

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the goals (RVZ 2011). The goals of the MHC policy measures do not meet these conditions.

Research recommendation

To gain more insight in the effects of implemented policy measures in the MHC, the policy measures should be evaluated per policy measure, because of their complexity. The government, the MHC providers, the scientific world and the patients have to be involved in the research to obtain a true, fair and comprehensive view of the effect of the policy measure.

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Appendix 1. Policy effect chain

Policy	2002 Modernization of the Exceptional Medical Expenses Act (AWBZ) ; 'Boter bij de vis'-policy	2008 Introduction and implementation of the Diagnosis Treatment Combination (DBC) in the MHC	2008 Transfer of the curative MHC from the AWBZ to the Health Insurance Act (Zvw)
Analysis Goals Of policy	Elimination of waiting lists. Health insurers can spend extra money for health care contracts. Realising extra care is a condition ('boter bij de vis') (VWS 2003). Extra production of care is needed to meet the growing demand of health care, and to eliminate the waiting lists (VWS 2001).	Cost control through more efficiency, better responsiveness and quality, and more transparency of costs (DBC Onderhoud 2012).	Efficiency profit, more consistency in care, cost control (VWS 2003) , (SER 28-03-2008).
Input Instruments	Release the budget maximization, this means that the MHC institutions will be reimbursed by the government for the extra production of care, which was needed to eliminate the waiting lists and waiting time (VWS 2003).	With the DBC-systematic a relation between the diagnosis of the patient and the related costs is established (NZa 2010). The diagnosis is not the same as the health care demand, as diagnosis does not have a predictive value for the treatment the patient is receiving (Van Hoof F., Knispel A. et al. 2009). Through the implementation of the DBC's, the budget systematic is abolished. Since 2006, MHC institutions are in a transition phase and will finally per 01-01-2013 use a new finance system which is based on performance.	Transfer of all the curative MHC from the AWBZ to the Zvw (VWS 2003). This leads to an AWBZ insurance focused on long term care with exceptional medical expenses (VWS 2003).
Throughput Process	Due to an inadequate waiting list registration, there was insufficient information about the waiting lists. However, an increase of 6% new patients, next	The introduction takes place at the same time as the transfer of the curative MHC from the AWBZ to the Zvw. This had financial impact on, in particular, the care suppliers due to the late	The transfer took place at the same moment as the introduction of the DBC's. Both policy measures have major impact on the MHC. The secondary MHC have waiting lists, a small part of the primary

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	to 7% increase of production can be seen (VWS 2003).	start up of DBC declaration for the non-budgeted MHC suppliers and the disbursement for the secondary MHC (De Vos, Kornalijslijper et al. 2009).	MHC. Due to the waiting list, the transfer from primary to secondary care is impeded (De Vos, Kornalijslijper et al. 2009).
Output The extent to which the goals are achieved	<p>The number of waiting patients decreased with 7%, the mean waiting time increased with 22%.</p> <p>Because of an insufficient executed baseline measure, the effects of policy are hard to measure. The MHC expenditure increased with €240,- million in 2003, compared to 2002. The number of waiting patients decreased with 7%, however, the mean waiting time increased with 22% (VWS 2004).</p> <p>A comparison between the production agreements before 2003 and the realised production over 2002, makes it plausible that the production of all health care functions is increased, as expected (VWS 2003).</p>	<p>The implementation of the DBC's has led to a one-off cost rise of €1.4 billion. These costs are caused by investments in ICT and by a higher administrative burden. Also the explosive growth of new and non-budgeted MHC suppliers led to higher costs (Van Diggelen, Kroes et al. 2012), (Jeurissen, Gill - van Kampen et al. 2012).</p> <p>Furthermore, the DBC-systematic does not have budget maximization, so more supply of care leads automatically to more profit. Changing the finance system resulted in perverse incentives, as up- and side coding. For health insurers, the DBC's are insufficient transparent (Van Hoof F., Knispel A. et al. 2009).</p>	<p>There is no flexibility in the two financing systems which leads to less efficiency. The transfer from the Zvw-care and the AWBZ-care is impeded and hinders the extramuralisation. In addition, the transferred part of the AWBZ to the Zvw is larger than it was in the AWBZ.</p> <p>The transfer resulted in a large increase in MHC expenditure (NZa 2011).</p>
Outcome Overall goals of health care	<p>Quality + Expected is that through expanded treatments, more supply and shorter waiting lists, the quality of care is increased.</p> <p>Accessibility - Increase of the waiting time with 22%, decrease of waiting patients with 7%.</p> <p>Affordability -- MHC expenditure rose with €240 million. More supply leads to more demand.</p>	<p>Quality More insight in costs and use of care for care suppliers, but the effect of DBC's on quality of care is unknown (Van Hoof F., Knispel A. et al. 2009)</p> <p>Accessibility + Establishment of many new care suppliers what leads to more accessibility of care (Jeurissen, Gill - van Kampen et al. 2012).</p> <p>Affordability -- No budget maximization, the turnover can be</p>	<p>Quality No flexibility between the two finance systems.</p> <p>Accessibility - The referral is more difficult.</p> <p>Affordability - Because there's no transfer possible between the two systems, an increase of MHC expenditure can be seen.</p>

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		<p>much higher than budgeted (Van Diggelen, Kroes et al. 2012), (Jeurissen, Gill - van Kampen et al. 2012)</p>	
<p>Conditions Based on literature and expert views.</p>	<ul style="list-style-type: none"> ▪ Structural and uniform waiting lists registration is needed for a complete and clear registration of the problem. ▪ More transparency and insight in costs of (supplied) care is needed for more insight in costs prices(VWS 2004), (VWS 2001). 	<ul style="list-style-type: none"> ▪ DBC's contain incentives to produce, but no efficiency incentives. An operations systematic would fit better (Van Hoof F., Knispel A. et al. 2009). ▪ More transparency for health insurers is needed, by mention the diagnosis on every account. ▪ A correct registration of the DBC by health suppliers (NZa 2010). ▪ Shorter transition phase. The budgeted institutions produces according to the production agreements and non-budgeted and new health care suppliers work with DBC's. This leads to skewed ratio's between the care suppliers and impedes market competition (NZa 2011). 	<ul style="list-style-type: none"> ▪ For more efficiency, a less rigid transfer is needed (NZa 2011). ▪ Fostering of better referral from and to primary and secondary MHC is a condition for a connection between curative and long term care. The waiting lists impede the referral (De Vos, Kornalijslijper et al. 2009).

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Policy	2010 Introduction Care Intensity Package (ZZP'S) in the secondary MHC	2012 Introduction of co-payment in the secondary MHC
Analysis		
Goals Of policy	Funding based on personal needs of patients, better distribution of resources, and more insight in care intensity of the patient (VWS 2011).	Foster primary MHC referral, moderation of cost development in MHC (VWS 2012)
Input Instruments	The budget is related to actual production MHC institutions supply. Institutions will be responsible for complete occupation. Negotiations with care agencies ('Zorgkantoren') will be based on integral rates. The ZZP describes precisely how much care per patients need to be supplied (Stark 16-12-2007).	Co-payments in secondary MHC, except for youth, forced care, and crisis care (VWS 2012) For DBC's until 100 minutes a co-payment of €100 has to be paid. For DBC's more than 100 minutes, the co-payment is €200,-. People in crises, or interfere care, are excluded from co-payments. People younger than 18 years and people, who are under forced care, are also excluded. Alternative measures for 2013 and further, will be studied (VWS 2012).
Throughput Process	The transition to care based on personal needs of the patients caused much effort of provider and patient. Care agencies and in the future, health insurers, have an important role to support the care suppliers to provide higher quality of care (VWS 2011)	To ensure access of MHC, the co-payment is before introduction decreased from €275 to €100 per DBC. For 2013, alternative measures will be studied (VWS 2012).
Output The extent to which the goals are achieved	Care suppliers deliver care based upon personal needs of patients and gain more insight in the care intensity. In principle, there is a better distribution of resources, because the actual production of MHC is financed (VWS 2011) However, the cost prices of the ZZP are much higher than the current prices. A discount is applied to hatch budget neutral. This means that MHC institutions will run out of financial resources, if in ZZP arranged care is supplied (Stark 16-12-2007). The NZa determines maximum policy values for the performances within the functions. Care agencies and care suppliers will negotiate about the values. It is assumed that more risk for the care suppliers will lead to more efficiency in care (NZa 2012).	The finally effects of the co-payment are not known by now. Expected is that, in the short term, the policy measure is highly effective to reduce the demand of MHC, and thus the costs of the MHC (Lokkerbol and Smit 2011). The MHC demand is decreased in the first three months of 2012 (LPGGZ 2012). Unknown is the further development. Substitution to other (health care) sectors is expected.
Outcome	Quality	Quality

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Overall goals of health care	<p>More insight in care, but the effect of ZZP's on the quality of care is unknown.</p> <p>Accessibility ZZP indication is complex, but the with a right indication, the ZZP's had no negative or positive effect on the accessibility.</p> <p>Affordability The actual costs of the ZZP's are higher than the current budget. The government adjusted for this, for the care supplier this is detrimental when in ZZP's arranged care is supplied.</p>	<p>There is a risk that financial, instead of medical, considerations determine the care supply and care demand.</p> <p>Accessibility - The health differences between poor and rich people can grow. In other countries with co-payment systematic, this phenomenon is hardly observed.</p> <p>Affordability ++ Co-payment leads to more aware use of care (Lokkerbol and Smit 2011). However, substitution to other sector should be avoided.</p>
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-- = poor - = insufficient +/- = sufficient + = good ++ = very good

<p>Conditions Based on literature and expert views.</p>	<ul style="list-style-type: none"> ▪ Contract areas have to be discussed with the Ministry of VWS and the care agencies. ▪ Less rigid region budgets of care agencies. ▪ More easy and less time-consuming complex indications (VWS 2011) (NZa i.o. (CTZ) 2006). 	<ul style="list-style-type: none"> ▪ Substitution to other health care sector should be avoided. ▪ Patients need to have insight in their health status to make thought-out decisions based on price and health (Lokkerbol and Smit 2011).
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Bijlage 2: Scriptie Annika Bijenhof

Strengthening primary mental health care: effects on the recognition and referral of mental health problems by GPs

Annika M. Bijenhof^{1,2}, prof. dr. J.J. Polder¹, prof. dr. M.W. van Tulder²

1. Department of Public Health Forecasting (VTV), National Institute of Public Health and the Environment (RIVM), Bilthoven, The Netherlands

2. Policy and Organisation of Health Care, Master Health Sciences, VU University, Amsterdam, The Netherlands

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Abstract

Background. General practitioners (GPs) have an important role in the care for patients with mental health problems. Dutch policy measures to strengthen primary mental health care have led to improvement of cooperation between providers by the formation of partnerships between GPs and primary care psychologists, social workers and social psychiatric nurses. Also, the financial barrier to primary care psychologist treatment was removed by the introduction of this type of care in the Dutch public health insurance in 2008. The effects of these measures on the identification and referral of mental health problems by general practices were investigated.

Methods. Data of patients was derived from electronic medical records of 35-79 general practices registered at the Netherlands Information Network of General Practice. The effects of partnerships on recorded mental health problems and referrals to primary and secondary mental health care were analysed in addition to referral trends.

Results. In 2010, only partnerships with social workers were related to an increased number of mental disorders diagnosed within general practices (OR = 1.54; $p = 0.046$). Collaborations with primary care psychologists (OR=1.80; $p=0.025$) or social workers (OR=3.69; $p<0.001$) were associated with increased referral rates to the respective providers. Practices having partnerships with social psychiatric nurses referred less patients to primary mental health care (OR=0.58; $p=0.03$). Multiple partnerships (primary care psychologist and social psychiatric nurse) were associated with more referrals to primary care while secondary care referrals were not significantly affected. During the period 2005-2010, recordings of both diagnoses and referrals showed a rising trend. A significant increase of referrals to the primary care psychologist (OR=3.00; $p<0.001$) occurred in 2008, the year in which the reimbursement of this type of care was introduced.

Conclusion. Dutch policy measures aimed at strengthening primary care in managing mental health problems are only partially reflected in diagnosis and referral rates of GPs. Even though the choice for treatment by GPs or other primary care providers was stimulated slightly by some collaborations, substitution for secondary care providers did not appear to occur. Reimbursement of primary care psychologist treatment most likely led to improved registration of referrals to this provider.

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Introduction

The prevalence of DSM-IV mental disorders remained constant over the past 25 years with 12-month prevalence rates estimated in different countries between 8.4% and 29.1%. [1-4] Most patients with mental health problems are treated in primary care, including a significant part of patients with severe mental disorders. [5-8] Not all persons with mental health problems receive treatment. [5, 9, 10] Nevertheless, It has been suggested that over-treatment of mental disorders exists. Minor mental health problems are often treated by specialized providers and prescriptions of psychiatric drugs occur for mild symptoms or even in the absence of a diagnosis. [7, 11-14]. Over the last decades, the number of patients receiving professional treatment has increased, which coincides with rising costs of the mental health care sector. [4, 9, 15-18]

According to the model of Goldberg and Huxley important filters on the pathway to specialized mental health care are the recognition of mental disorders by primary care providers and their referral behaviour. [19] In several countries, including the Netherlands, this gatekeeper function to mental health care is executed by the GP. GPs are often the first provider of health care contacted by patients with mental health problems. [20] Nearly all Dutch residents are registered at a GP and the care of this provider is covered by the obligatory public health insurance of the country.

The demand for care among patients with mental health problems is growing. As a result, constraints of time and knowledge in treating mental disorders exist among GPs. [21] Moreover, the capacity of secondary care is restricted and costly. As in several other countries, Dutch government policy regarding mental health care has therefore been directed towards the reinforcement of primary care and the gatekeeper function of the GP. [6, 22-24] As part of this policy, cooperation between GPs and other primary care providers as well as consultation from specialized providers was stimulated. [25] Improvement of cooperation between primary care providers was pursued by the creation of partnerships of general practices with social workers and primary care psychologists. A financing arrangement made it possible for social psychiatric nurses to support GPs in the care for patients with mental disorders. Social psychiatric nurses were often detached from specialized providers. [26] In addition, financial constraints to primary care psychologist treatment were reduced by the introduction of this form of care in the Dutch public health insurance in 2008. Specialized mental health care has been covered by the Exceptional Medical Expenses Act since decades in the country.

The effects of the emerged partnerships on management of mental health problems by general practices have not been studied. In this paper, the influence of partnerships with primary care psychologists, social psychiatric nurses and social workers on the identification and referral of mental health problems by GPs will be determined. Cooperation between providers is believed to result in better communication and information transfer, more knowledge of each others capabilities and an improved referral between providers. [27] It is expected that partnerships with providers specialized in mental health care will improve recognition of mental health problems in general practices. Collaborations with primary care psychologists and social workers are expected to stimulate treatment within primary care and social psychiatric nurses treatment within general practices. Also, the introduction of the reimbursement of primary care psychologist treatment will be studied, which is likely to stimulate referrals to this provider. Finally, we will investigate whether the change in mental health care financing had a different impact upon the referral trends of practices with or without partnerships.

The following sub questions will be answered in this study:

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- To what extent is diagnosing for mental disorders by GPs determined by the presence of partnerships with primary care psychologists, social workers or social psychiatric nurses?
- To what extent is referral of patients to non-specialised and specialised mental health care by GPs determined by the presence of partnerships with primary care psychologists, social workers or social psychiatric nurses?
- Did the introduction of the reimbursement of primary care psychologists in 2008 influence referral trends to mental health care between 2005 and 2010 and did partnerships have an influence on these trends?

Methods

Data collection

Data on the diagnoses and referrals of patients in general practices were derived from the medical records of general practices participating in the Netherlands Information Network of General Practice (LINH). GPs participating in the LINH network are representative for the Dutch GPs regarding age, gender, number of working hours per week, urbanization level, geographical distribution and their patient population.[28]

Data on general practice characteristics; urbanisation level and the presence of partnerships with primary care psychologists, social workers and social psychiatric nurses; were derived from the general practices registration of the Netherlands institute for health services research (NIVEL). A partnership exists when either the GP and another primary care provider are practicing at the same location; a partnership contract is in place; when this partnership is presented to the outside or when there is a financed partnership between the providers.

LINH data is organized in separate tables for diagnoses and referrals. For analyses on diagnoses, general practices with reliable registrations of this data type were selected separately for each year (2005-2010). Therefore, the amount of practices included differs per year. For analyses on referral to mental health care, practices that also had reliable registrations on this type of data were selected. General practices of which reliable diagnosis and referral numbers were available in addition to information on partnerships were included in the study (table 1). In addition, a selection was made for patients of 18 years and older.

Diagnoses

Diagnoses were recorded according to the standard for coding symptoms and diagnoses in general practices in the Netherlands, the International Classification for Primary Care (ICPC). [29, 30] ICPC codes for all mental health problems (ICPC codes P01-P99) were included in the study. In addition, the most prevalent diagnoses of anxiety (P01 and P74), depression (P76 and P03), psychotic disorders (P71 and P72), personality disorder (P80), sleeping disorder (P06), emotional distress (P02 and P78) and alcohol and drug abuse (P15, P16, P18, P19) were selected separately for this study. In addition, selections were made for symptoms (P01-P29) and disorders (P70-P99) of mental health problems.

Referrals

Referrals were defined as cases where patients with any psychological diagnosis (p-diagnosis) were referred to primary or secondary mental health care providers. Social workers, primary care psychologists and social psychiatric nurses are considered primary mental health care. The included providers of secondary mental health care are psychiatrists and ambulatory mental health care institutions (RIAGG). Registration of referrals to primary care psychologists, social

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workers, psychiatrists and ambulatory mental health care is obligatory for GPs participating in the LINH network. Referrals to social psychiatric nurses are encouraged but optional.

Statistical analyses

In order to investigate the recognition of mental disorders by GPs, the numbers of unique mental disorder diagnoses (prevalence rates) were determined for 2010. The effects of the presence of partnerships between general practices and other providers on diagnoses and referrals of patients in 2010 were analysed using multivariate multilevel logistic regression analyses with two-level hierarchical structured data of patients within general practices, using R statistical software. The time trend of referrals was determined for the period 2005-2007 compared to 2008-2010, in order to measure the influence of the introduction of the reimbursement of primary care psychologist treatment in 2008.

Models were adjusted for age and gender of patients and urbanisation level of general practices. Analyses were performed for patients of 18 years and older as minors are more often diagnosed and referred by other providers, instead of the GP, for mental health problems. In the models concerning the diagnosis of patients, no linear relation between patient age or patient age squared and the dependent variables existed. Cubic splines were therefore created for the covariate patient age. Hence, it is to complex to present the effect of patient age on the outcomes of the models in numerical effect measures. The model predictions were plotted to make interpretation of the results possible.

	2005	2006	2007	2008	2009	2010
Reliable diagnosis registrations						
N of general practices	54	67	67	70	74	79
N of patients registered	209,087	241,223	241,516	248,371	266,806	285,830
N of adult patients registered	163,465	187,260	188,711	194,707	210,156	226,231
<i>Partnerships of general practices*</i> (%)						
- Primary care psychologist	20	18	16	17	18	20
- Social worker	20	16	15	13	16	16
- Social psychiatric nurse	39	37	39	40	45	47
- Without any partnership	54	54	55	53	47	44
Reliable referral registrations						
N of general practices	35	35	43	41	42	44
N of patients registered	145,044	152,172	154,043	151,545	163,833	166,471
N of adult patients registered	112,877	118,548	120,371	119,269	129,051	131,177
<i>Partnerships of general practices*</i> (%)						
- Primary care psychologist	23	20	14	12	14	18
- Social worker	23	20	12	15	17	20
- Social psychiatric nurse	49	46	42	42	48	50
- Without any partnership	46	49	53	51	45	41

Table 1. Numbers of general practices (and their registered patients) with reliable registrations of diagnoses and referrals for mental disorders/symptoms of the years 2005-2010. The percentages of practices having partnerships with primary care psychologists, social workers or social psychiatric nurses and without any partnership are presented as well. * data on partnerships of LINH practices of 2005-2009 were derived from the situation in 2010 as registrations were only available for the latter year.

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Results

Mental disorder diagnoses

Percentages of patients diagnosed with mental disorders or symptoms are reported in table 2. These numbers reveal that GPs more often diagnosed patients with symptoms of mental health problems (P01-P29) compared to mental disorders (p70-P99). Anxiety, depression, sleeping disorder and emotional distress were the most prevalent mental disorders/symptoms. Over the years, the amount of patients diagnosed with any psychological diagnosis by GPs has increased substantially.

	2005	2006	2007	2008	2009	2010
N of listed patients	163,465	187,260	188,711	194,707	210,156	226,231
<i>Diagnoses</i>						
Any p-diagnosis (P01-P99)	3,180 (8.1)	15,469 (8.3)	19,692 (10.4)	22,222 (11.4)	24,159 (11.5)	26,620 (11.8)
Symptom (P01-P29)	8,992 (5.5)	10,618 (5.6)	13,470 (7.1)	15,412 (7.9)	16,532 (7.9)	18,527 (8.2)
Disorder (P70-P99)	5,699 (3.5)	6,613 (3.5)	8,420 (4.5)	9,172 (4.7)	10,128 (4.8)	10,980 (4.9)
Anxiety (P01, P74)	2,950 (1.8)	3,621 (1.9)	4,460 (2.4)	4,920 (2.5)	5,215 (2.5)	5,543 (2.5)
Depression (P03, P76)	3,621 (2.2)	4,116 (2.2)	5,248 (2.8)	5,537 (2.8)	5,971 (2.8)	6,367 (2.8)
Sleeping disorder (P06)	2,394 (1.5)	2,976 (1.6)	3,949 (2.1)	4,364 (2.2)	4,243 (2.0)	4,785 (2.1)
Psychotic disorders (P71, P72)	198 (0.1)	239 (0.1)	305 (0.2)	329 (0.2)	384 (0.2)	404 (0.2)
Personality disorder (P80)	203 (0.1)	258 (0.1)	393 (0.2)	460 (0.2)	427 (0.2)	539 (0.2)
Emotional distress (P02, P78)	2,324 (1.4)	2,499 (1.3)	2,641 (1.4)	2,948 (1.5)	3,250 (1.5)	3,686 (1.6)
Alcohol/drugs (P15, P16, P18, P19)	582 (0.4)	703 (0.4)	961 (0.5)	1,259 (0.6)	1,335 (0.6)	1,444 (0.6)

Table 2. Absolute numbers of patients diagnosed with mental disorders and specified for symptoms, disorders and several common mental health problems (as percentages of registered patients between parentheses).

Patient characteristics age and gender showed to have a significant effect on the amount of patients diagnosed with mental disorders/symptoms. In 2010, women had a higher chance of being diagnosed with any p-diagnosis (OR = 1.52, $p < 0.001$) than men. Both symptoms (OR = 1.40, $p < 0.001$) and disorders (OR = 1.69, $p < 0.001$) were more often detected among women. In addition, the probability of receiving a diagnosis for a mental health problem fluctuated significantly with age (figure 1). The probability increased between 20 and 55 years of age and after 65 years. The results reveal that elderly dealt relatively more often with mental health problems.

Effect of partnerships on diagnosing

The effect of the presence of partnerships on the identification of mental disorders by GPs are presented in figure 1. General practices having partnerships with social workers diagnosed significantly more patients with mental disorders (OR = 1.54; $p = 0.046$), after correcting for age and gender of patients and urbanization levels of practices. Especially symptoms of mental health problems were more often detected (OR = 1.58; $p = 0.040$) by general practices with this type of partnership. The effect of cooperation with social workers seems to be largest on recordings of diagnoses of patients aged 85 years and over. However, predictions for the very elderly are highly variable when random effects are included in the plots (appendix 1, figure 1) and the average plots therefore provide a less reliable image. Cooperation with a primary care psychologist or social psychiatric nurse did not influence the amount of diagnoses for mental disorders/symptoms made

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by GPs significantly. This suggests that only collaboration with a social worker was related to a rise in the number of mental health problems recognized by the GP.

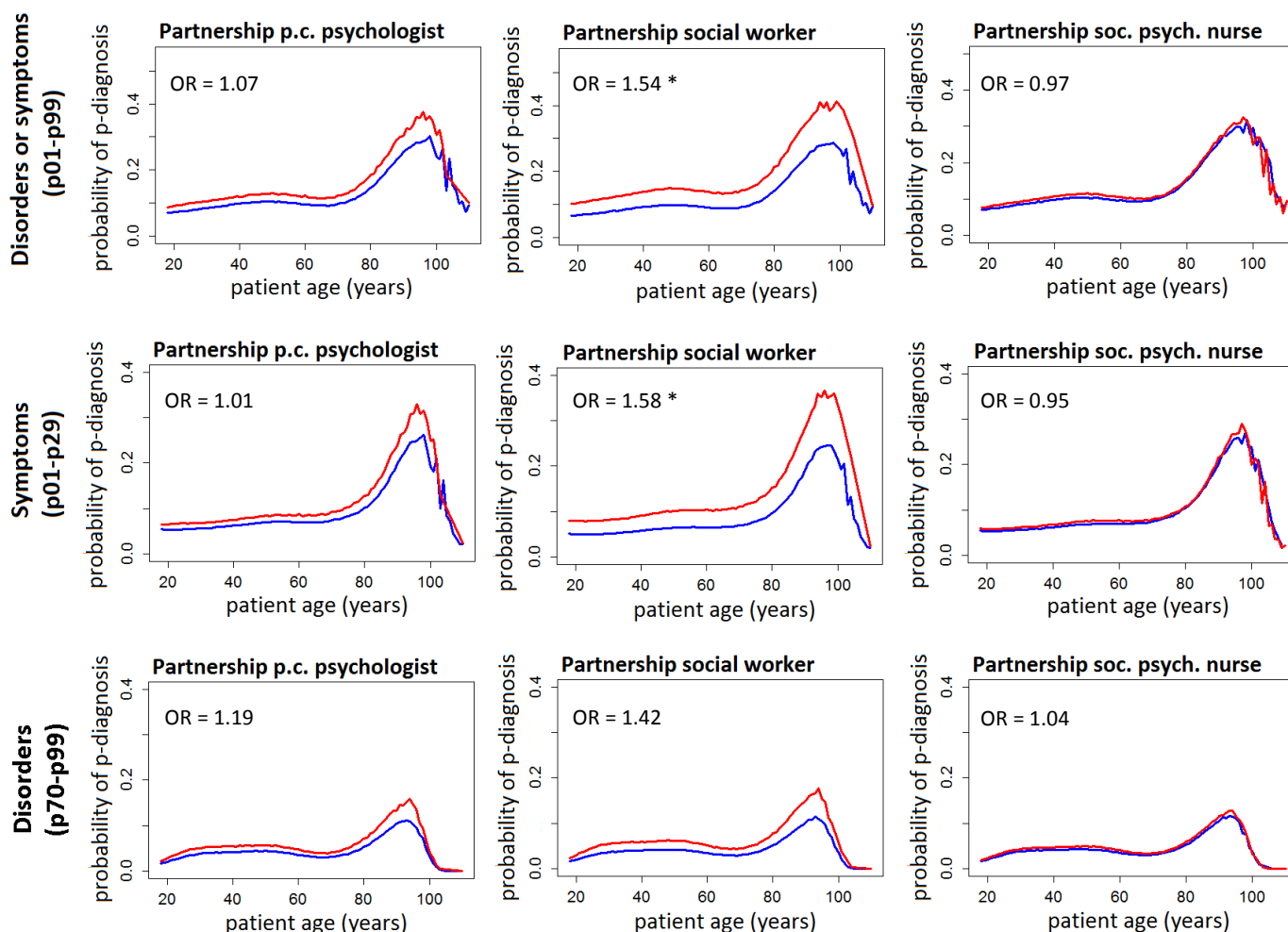


Figure 1. Multivariate multilevel analyses on the effects of partnerships with primary care psychologists, social workers and social psychiatric nurses on the number of psychological diagnoses made by general practices and specified for psychological symptoms and disorders. Predicted probabilities for patients of the average general practice to be diagnosed are presented per patient age year. Odds ratio's (OR) of diagnosis rates of practices with partnerships relative to practices without the specific partnership are presented. Red line = practices with partnership; blue line = practices without partnership. * $p < 0.05$.

Referral to mental health care

The amounts of patients diagnosed with mental disorders/symptoms and referred to primary or secondary mental health care providers in 2010 are presented in table 3. Of the patients with any ICPC p-diagnosis, 8.8% were referred to the mental health care providers included in this study. The primary care psychologist was most often chosen, followed by the psychiatrist. With the exception of personality disorder, referrals to primary care providers occurred more than referrals to the psychiatrist and ambulatory mental health care for mental disorders. Total referral rates were highest for emotional distress and personality disorder.

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	Any p-diagnosis (P01- P99)	Anxiety (P01, P74)	Depression (P76, P03)	Emotional distress (P02, P78)	Sleeping disorders (P06)	Psychotic disorders (P71, P72)	Personality disorder (P80)	Alcohol/drug abuse (P15, P16, P18, P19)
N of patients	16,898	3,669	4,253	2,440	3,061	249	321	881
<i>Referrals</i>								
Any MHC provider	1,842 (10.9)	320 (8.7)	473 (11.1)	334 (14.0)	35 (1.1)	8 (3.2)	52 (16.0)	47 (5.3)
Primary MHC	1,008 (6.0)	193 (5.3)	234 (5.5)	238 (10.0)	23 (0.8)	0 (0)	21 (6.5)	7 (0.8)
P.c. psychologist	908 (5.4)	177 (4.8)	214 (5.0)	205 (8.4)	21 (0.7)	0 (0)	21 (6.5)	6 (0.7)
Social worker	63 (0.4)	8 (0.2)	10 (0.2)	29 (1.2)	2 (0.1)	0 (0)	0 (0)	1 (0.1)
Soc. psych. nurse	47 (0.3)	9 (0.3)	14 (0.3)	12 (0.5)	0 (0)	0 (0)	0 (0)	0 (0)
Secondary MHC	872 (5.2)	135 (3.7)	252 (5.9)	91 (3.7)	12 (0.4)	8 (3.2)	32 (10)	40 (4.5)
Psychiatrist	669 (4.0)	117 (3.2)	206 (4.8)	72 (3.0)	9 (0.3)	8 (3.2)	23 (7.2)	30 (3.4)
Ambulatory MHC	205 (1.0)	18 (0.5)	47 (1.1)	19 (0.8)	3 (0.1)	0 (0)	9 (2.8)	10 (1.1)

Table 3. Absolute numbers of mental disorder diagnoses, and specified for the most common diagnoses, referred to mental health care providers in 2010 (as percentages of diagnosed patients between parentheses).

Age and gender of patients had a significant impact on referral by GPs to mental health care. The probability for patients to be referred to primary or secondary mental health care decreased with age (figure 2 and 3). In addition, women were slightly less often referred to secondary care (OR = 0.78; $p < 0.001$) and more to primary care (OR = 1.22; $p = 0.008$) compared to men (plots not shown).

Effect of partnerships on referral to mental health care

The effects of the existence of partnerships between general practices and the other providers of mental health care on referral are presented in figure 2. Collaboration with a primary care psychologist did not seem to affect referral rates of GPs to the total of mental health care providers. However, the probability of referral increased significantly when practices had an additional partnership with a social psychiatric nurse. Multiple partnerships apparently had a stronger effect on referral numbers. Surprisingly, practices having only a partnership with a social psychiatric nurse referred fewer patients (OR = 0.57; $p=0.019$), suggesting that these GPs more often treated patients with mental health problems within their practices. Partnerships with social workers did not seem to influence the amount of referrals to mental health care.

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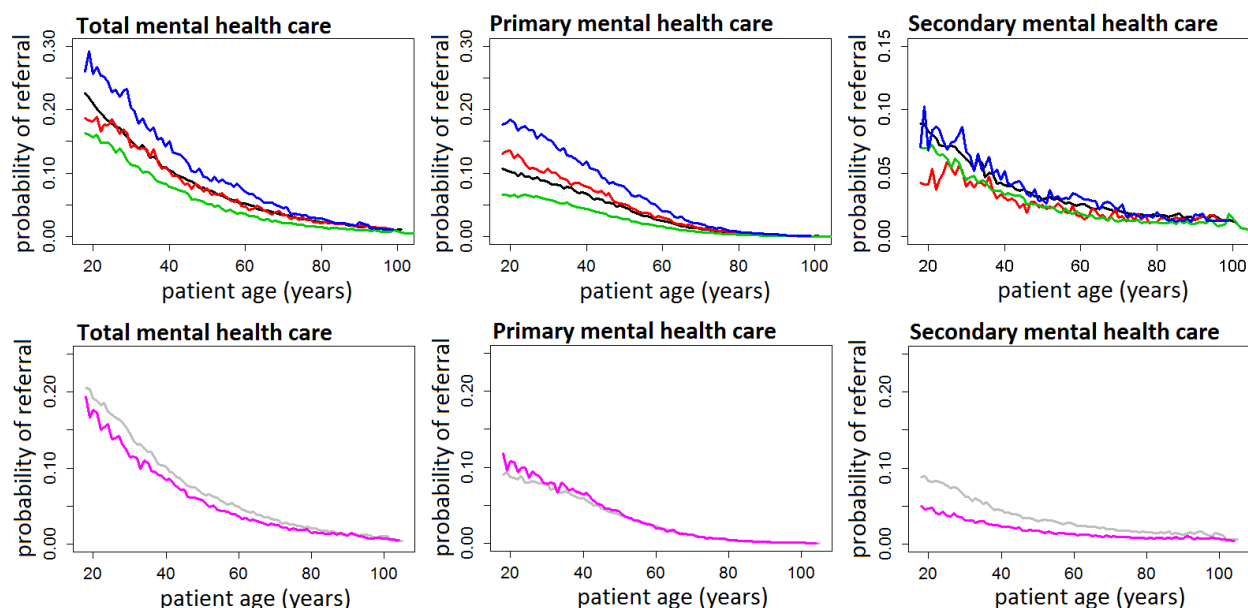


Figure 2. Multivariate multilevel analyses on the effect of partnerships with primary care psychologists (PCP; red), social psychiatric nurses (SPN; green), both these providers (blue) and social workers (SW; pink) on referral to mental health care and specified for primary and secondary mental health care. Total mental health care: OR PCP=0.67, $p=0.32$; OR SPN=0.57, $p=0.02$; OR PCP \times SPN=3.15, $p=0.03$; OR SW=1.06, $p=0.81$. Primary mental health care: OR PCP =1.01, $p=1.00$; OR SPN =0.58, $p=0.03$; OR PCP \times SPN=3.01, $p=0.05$; OR SW=1.49, $p=0.14$. Secondary mental health care: OR PCP=0.40, $p=0.08$; OR SPN=0.56, $p=0.06$; OR PCP \times SPN=4.16, $p=0.04$; OR SW=0.63, $p=0.17$. P-values of 0.05 and lower are considered statistically significant. Black line = practices without PCP and SPN partnerships; gray line = practice without SW partnership.

Effect of partnerships on referral to primary care

Partnerships with social psychiatric nurses were significantly related with lower referral rates to primary mental health care (OR=0.58; $p=0.03$). General practices that had partnerships with primary care psychologists more often referred patients with mental health problems to this provider (OR=1.80; $p=0.025$). The same effect was seen for GPs collaborating with social workers; significantly higher referral numbers to the social worker were found for these practices (OR=3.69; $p<0.001$). Moreover, general practices having a partnership with both the primary care psychologist and the social psychiatric nurse referred significantly more patients with mental health problems to primary mental health care.

Effect of partnerships on referral to secondary care

A trend towards a reduction in referral rates to specialized providers was found when partnerships with primary care psychologists (OR=0.40; $p=0.082$) or social psychiatric nurses (OR=0.56, $p=0.062$) were in place. Practices cooperating with social workers seemed to refer fewer patients to secondary mental health care, but after correcting for patient and general practice characteristics, this result did not prove to be statistically significant (OR=0.63; $p=0.14$). Multiple partnerships did not affect referral numbers either.

Referral trends

Referral trends to secondary and primary mental health care and specified for the primary care psychologist, between 2005 and 2010, are presented in figure 3. Analyses revealed that the mean of patients with mental disorders being referred to primary mental health care increased significantly in 2008 (OR=4.56;

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$p < 0.001$). This rise was mainly caused by elevated referral numbers to primary care psychologists in this year ($OR = 3.00$; $p < 0.001$). Most likely, this result is related to the introduction of primary care psychologist treatment in the Dutch public health insurance in 2008. During the whole period, referral numbers to specialized providers did not change significantly. In addition, referral trends were similar for general practices having partnerships with primary care psychologists, social workers and/or social psychiatric nurses and practices that were not cooperating (data not shown).

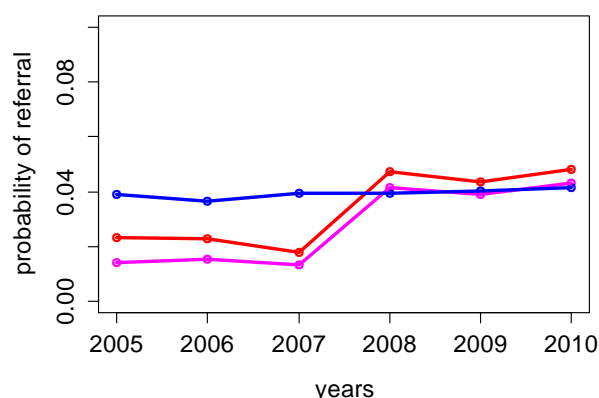


Figure 3. Time trend analyses of referral trends to primary care (red), secondary care (blue) and specifically for the primary care psychologist (purple). Dots represent the aggregated mean of patients with any psychological diagnosis who were referred. The lines visualize the probabilities of referral for patients of the average practice, estimated with multivariate multilevel regression analyses. Significant increases of referrals to primary care ($OR = 4.56$; $p < 0.001$) and the primary care psychologist ($OR = 3.00$; $p < 0.001$) were seen in the year 2008.

Discussion

Most patients with mental health problems are treated in primary care. As the chance of getting a mental health problem increases with age, these disorders are most prevalent among adults. As in most other countries, Dutch adults with mental health problems have contact with their GP before they consult other providers of mental health care.[20, 31] GPs therefore play an important role in the pathway to mental health care for patients with mental health problems. During the last decade, several policy measures have been taken by the Dutch government in order to strengthen primary care and the role of the GP as a gatekeeper. The measures may have led to changes in the recognition and referral of mental disorder by GPs.

Recognition of mental health problems

Over the years, the proportion of patients diagnosed with mental disorders in Dutch general practices has increased. General practices having partnerships with other providers of mental health care diagnosed more patients with mental disorders in 2010. However, it is not particularly plausible to subscribe the increase in diagnosed mental disorders to increased cooperation between providers as only partnerships with social workers seemed to have a significant effect on these numbers. The number of practices collaborating with social workers is small. Hence, this trend is probably mainly related to an increased help seeking for mental health problems among the Dutch population. Due to reduced

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stigma in society on mental disorders, an increase in the demand for professional help for health issues and aging populations, adults may increasingly consult their GP for psychological problems.[15, 32, 33]

General practices having a partnership with a social worker mainly diagnosed more symptoms of mental disorders (p01-p29) like nervous/tense feelings, stress and concentration/memory problems. Earlier studies in the Netherlands indicated that GPs cooperating with social workers have a higher self-perceived involvement in the care for patients with psychosocial problems.[20] This increased involvement may be a result of enhanced knowledge and skills among GPs or an increased awareness of less severe psychological problems. However, it is important to note that besides the GP, social workers are the only provider of primary mental health care often visited on the patients' own initiative.[25] The increased number of diagnoses may therefore be a result of social workers cooperating with GPs referring more patients back to the GP for further diagnosis.

Referral of mental health problems

Social psychiatric nurses support GPs in their care for patients with mental health problems.[26] Referral numbers of general practices only cooperating with the social psychiatric nurse indeed confirm that patients with mental disorders/symptoms are less often referred to other providers. Earlier studies in the Netherlands suggested that the increasing workload among GPs reflected itself in enhanced referral rates to mental health care.[34] Most likely, the social psychiatric nurse adds knowledge and time to the general practice that the GP lacks in order to treat patients themselves. The reduction in referrals was mainly caused by a decline of referrals to primary care as only a trend towards a reduction was detected for specialized care referrals. This is surprising as social psychiatric nurses are often detached from specialized providers and therefore primarily enhance contact with secondary care.[26] The finding may indicate that primarily patients with less severe mental health problems can be treated within general practices when GPs are supported in their work. Consequently, collaborations with social psychiatric nurses probably have a minimal effect on the aimed reduction of specialized mental health care, but may still save health care costs by lowering the use of primary care. Earlier studies on collaborative care in the Netherlands demonstrated that fewer referrals did not affect the efficiency of patient care while costs can be reduced.[35]

GPs cooperating with primary care psychologists or social workers more often chose for the care from these providers respectively. Partnerships are therefore likely to lead to a better understanding of the knowledge and capabilities of other health care providers resulting in more referrals. Studies in Canada and England illustrated that cooperation can lead to enhanced referral between providers because of improved communication. In addition, a lower use of other mental health care services was found. [21, 36] In our study, only partnerships with primary care psychologists were associated with a trend towards a reduction of referrals to secondary care. This is not surprising as total referral rates to primary care were not increased by single partnerships either.

Referral numbers to primary mental health care increased when practices collaborated with both social psychiatric nurses and primary care psychologists. Partnerships with multiple other providers may indicate a higher level of collaboration. The intensity of relationships with other providers has been suggested to correlate to referral rates.[36] Most likely, the intensity of cooperation differed between the two groups of practices (with and without an additional partnership with a primary care psychologist) leading to different effects on referral. Remarkably, secondary care referrals were not affected by this combination of partnerships. Thus, while only multiple partnerships increased referral trends to primary care, the pursued policy aim of substituting specialized providers did apparently not occur.

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Reimbursement of the primary care psychologist

In 2008, primary care psychologist treatment was introduced in the Dutch public health insurance. In the same year, a rise in the amount of referrals to primary mental health care occurred, mainly caused by an increase in referrals to the primary care psychologist. It is therefore expected that before 2008, the costs of the primary care psychologist formed a barrier for referral to this provider. Studies in Canada, where GPs also have a strong gatekeeper role, showed that health care costs were indeed identified as the largest barrier in referring patients with mental health problems to psychologists. [21] In this country, care from psychologists was not covered by the public health insurance either. Surprisingly, estimations of patient numbers treated by primary care psychologists in the Netherlands do not seem to reflect the rise in referrals from GPs. A constant rising trend of patients treated by primary care psychologists was seen since 2005. [37] This indicates that the introduction of primary care psychologists in the insurance package mainly affected the amount of registrations made for referrals by GPs. Before 2008, GPs may have more often advised patients to see a primary care psychologist, as a referral letter was not obligatory and made little difference for the patient regarding costs. This might also explain why a substitution for secondary mental health care was not detected. Nevertheless, it has to be noted that numbers of patients treated by primary care psychologists are estimations as not all psychologists are registered in the studied network.

Strengths and limitations

Our study provides insight into the effects of cooperation between GPs and other providers of general mental health care. Although health care systems are never identical and therefore generalizing results to other countries should be done with caution, the results are useful for countries in which GPs also function as strong gatekeepers. Analyses of the referral trends provide insight into the effect of the introduction of primary care psychologist treatment in the public health insurance. However, in order to determine if this policy measure can actually explain the time trend a more complicated study design (e.g. longitudinal multilevel analyses with three level hierarchical structured data) would be required. Also, as other major policy measures were introduced in 2008 as well, it will remain difficult to determine the impact of solely the reimbursement of the primary care psychologist. Nevertheless, our results give indications which are useful for countries where primary and secondary mental health care are financed in similar ways.

GPs and patients registered at the LINH database are representative for the Dutch population regarding age and gender. In addition, GPs are trained in coding. For each year, general practices were selected which met the quality criteria for registration. Nevertheless, mainly referral registrations to mental health care providers have to be interpreted with caution. Although instructed to be registered, referrals to primary care providers are often considered recommendations by GPs and might therefore be underreported. Moreover, it is important to notice that only the psychiatrist and ambulatory mental health care were included as providers of secondary mental health care in this study. The psychotherapist, psychologist and addiction institutions were left out because of unavailability of data. Especially the psychotherapist is an important provider of secondary mental health care as 3.8% of mental health problems was referred to this provider in 2008.[11] Conclusions regarding secondary mental health care therefore only concern the two included providers.

Conclusion

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The studied policy measures aimed at strengthening primary mental health care appear to have a small impact. Cooperation with social workers seemed to enhance the identification of primarily less severe mental health problems. Apparently, the intensity of cooperation with primary care psychologists and social psychiatric nurses is not sufficient enough to increase detection of mental disorders significantly. Overall, the increasing amounts of diagnoses made by GPs in general is probably related for the most part to a growing demand for professional help for mental health problems. However, it is important to notice that not all adults with mental health problems are in need of care from professionals as these can be transient.[7] For depression, a reasonable chance of recovery within three months exists and therefore a 'watchful waiting' approach has been recommended by several guidelines.[38, 39] It is therefore essential that GPs are able to identify patients whose problems will persist or deteriorate when adequate care is not provided. Further studies on the type of patients diagnosed by GPs within Dutch general practices are needed in order to determine if collaborations contribute to adequate diagnosing.

The social psychiatric nurse is likely to strengthen general practitioners in their care for patients with mental disorders as lower referral numbers were found. However, mainly referrals to primary care were affected. Primary care psychologists and social workers were associated with increased referral rates to the respective providers. However, only a combined cooperation with primary care psychologists and social psychiatric nurses increased referrals to the total of primary care providers. Reimbursement of primary care psychologist treatment affected primary care referrals by stimulating the choice for the primary care psychologist. Moreover, substitution for secondary care was not induced by any of the measures. Primary care most likely needs to be further enhanced in order to affect the demand for specialized care. Waiting lists for providers of specialized care might explain this lack of effect. Nevertheless, the quality of care may have been improved by any of the collaborations. Unfortunately, referral numbers do not give insight into the correctness of referral. Additional research on the severity of the mental disorders/symptoms referred to either primary or secondary mental health care providers is needed.

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Appendix

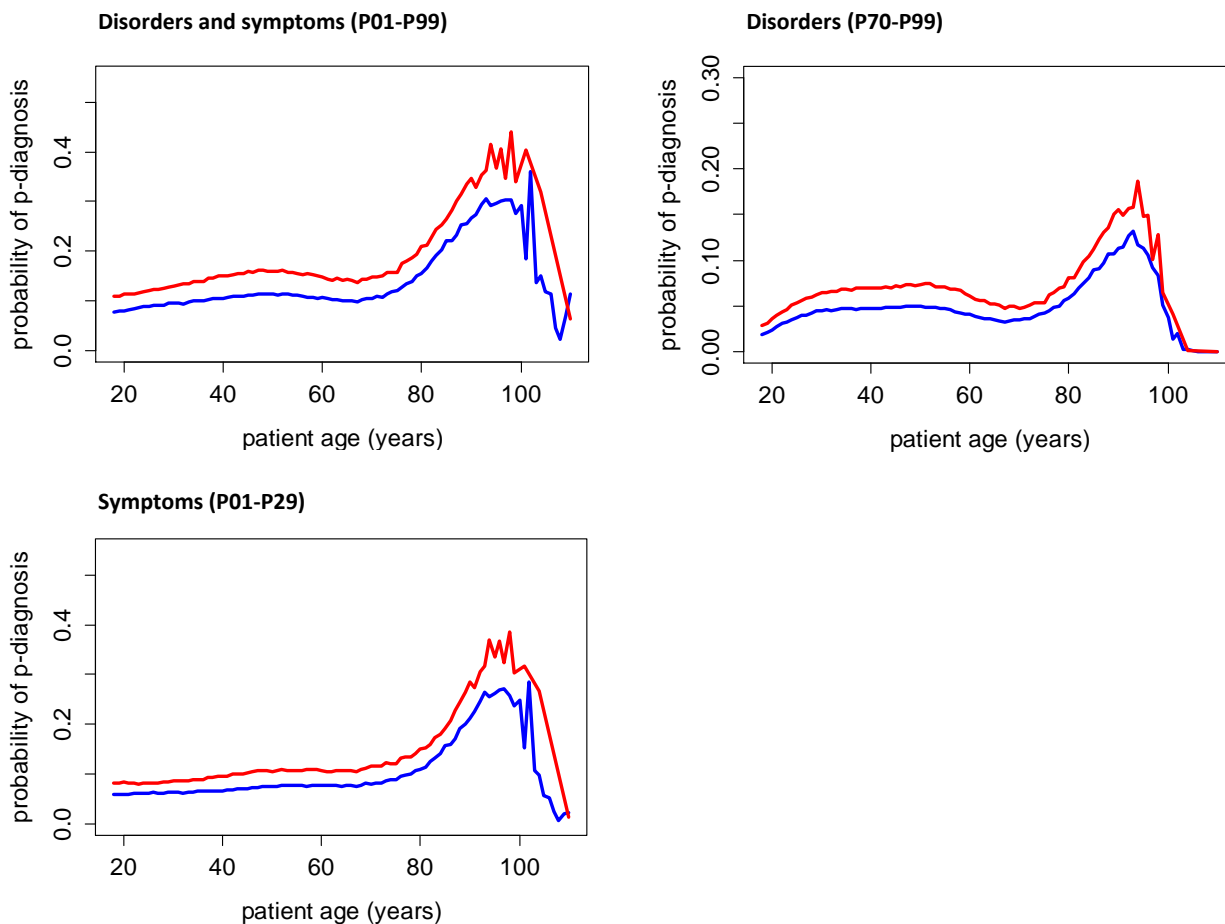


Figure 1. Plots of multivariate multilevel analyses of the effects of partnerships with social workers on the number of psychological diagnoses made by general practices and specified for psychological symptoms and disorders. Probabilities predicted by the models including random effects (random intercept for general practice) are shown, for diagnoses per patient age year. Red line = practices with partnership; blue line = practices without partnership.