
# Moving towards trusted healthcare

## Open letter for the curative healthcare sector

June 2015

NBA

Koninklijke Nederlandse
Beroepsorganisatie
van Accountants

NBA

The NBA's membership comprises a broad, diverse occupational group of over 20,000 professionals working in public accountancy practice, at government agencies, as internal accountants or in organisational management. Integrity, objectivity, professional competence and due care, confidentiality and professional behaviour are fundamental principles for every accountant. The NBA assists accountants in fulfilling their crucial role in society, now and in the future.

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Dear Mrs Lodders,

We have written this letter because we want to draw your attention to healthcare-related governance, accountability and auditing, particularly in the curative healthcare sector. This sector includes hospitals, university medical centres (UMC's) and independent treatment centres (ZBC's), hereinafter collectively referred to as institutions. Many of our observations also apply to the long-term healthcare sector and healthcare which is subject to the Wet maatschappelijke ondersteuning (Social Support Act - WMO) and the Jeugdwet (Youth Care Act).

The curative healthcare sector has changed drastically over the past two years. The transition from budget-based funding to service-based funding using integral prices has significantly increased the administrative burden faced by institutions. Administrative streamlining of medical transactions, via the DBC and DOT systems, has caused great debate in the sector about interpretations of laws and regulations and the legitimacy of expense claims. In light of austerity measures and pressure to control costs, society appears to be losing confidence in the sector and the policies being implemented by the government.

Royal Netherlands Institute of Chartered Accountants

NBA

Almost four years ago, the NBA wrote a public management letter entitled New perspectives for Dutch Healthcare. The situation highlighted at that time continues to be relevant today, as the friction between public interests (regulation) and private interests (market forces) remains unchanged. The sector is heavily regulated, and features countless parties who often think about their own specific jurisdictions rather than the care supply chain as a whole. Intervention by the government primarily focuses on finances, with particular emphasis on legitimating expenditure and controlling macro budgets.

However, the healthcare sector urgently needs deregulation, simplification and lower administrative workload for its institutions. This will require effective management by the Minister of Public health, Welfare and Sport (VWS) as well as efficient supply chain accountability, based on trust.

Considering our social role and our knowledge of the sector, we would like to express our views about how more trust and fewer rules can be created in the healthcare sector. However, we will in no way question the macro policy objectives of the government, which include keeping the healthcare system affordable and respecting the principles of regulated market forces. Our contribution is aimed at conveying three signals, which we have specified further in this letter in the form of concrete recommendations:

1. Unclear governance requires better management.
2. More rules will have an adverse effect.
3. The chain of accountability is not efficient enough.

Yours faithfully,

Drs. Huub Wieleman RA
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Mr. Charlotte Insinger MBA
Member NBA Identification Board

# Sector in transition

Besides being socially relevant, the healthcare sector is an important part of the Dutch economy and is one of the largest cost items in the Government budget. The Healthcare Budget Framework (BZK) is expected to account for 71.3 billion Euros in the Ministry of VWS's 2015 budget[1]. Of this amount, 44.4 billion Euros is intended for curative healthcare. Despite implemented measures and agreements made with the sector, costs are expected to increase to 51.8 billion Euros in 2018. The Macro Management Instrument (MBI) is one of the tools available to the Minister of VWS if the BZK is exceeded. In this case, the overshoot will be spread across all institutions. The overspend for 2013 has been provisionally estimated at 242 million Euros, but the Minister has put off the decision - about possibly implementing the MBI - until 2016.

Ever increasing healthcare costs can be attributed to several factors. Greater prosperity is accompanied by a specific set of diseases, such as obesity, high blood pressure and diabetes. People are living longer and good healthcare and an ageing population have increased the number of senior citizens. And healthcare costs are higher during these extra years of life. New medical developments are making treatment more expensive. It is no longer a case of whether costs will increase, but how effectively the increase can be managed. In addition, demand for long-term care is not equally distributed in the Netherlands. Whereas the Randstad is subject to an over-concentration of medical centres, hospitals in declining regions are unable to survive without additional financial support. This is placing pressure on the availability of healthcare in these regions.

It is extremely important to have a cost-efficient healthcare system. The government is constantly looking for new ways to manage costs associated with healthcare. The last major intervention in the curative healthcare sector involved switching to service-based funding with integral prices. This means a central role has been assigned to healthcare insurers, who must use service-related agreements to make sure institutions do not declare excessive costs. This transition has caused many headaches in the past two years and has been accompanied by extra workload in terms of administration, accountability and inspection. The audits for annual accounts 2012 and 2013 became so complicated that the NBA was forced to send annual Audit Alerts[2] to its members. In the end, the impact could - for the most part - be remedied via the recovery plan launched by the Minister of VWS as well as an expensive additional turnover investigation performed by institutions. However, a similar programme is also being implemented for the annual account for 2014.

In terms of 2015 and thereafter, the Minister has decided to focus on cost management by improving quality[3], whereby an impressive number of measures is being implemented. However, the quality control programme has resulted in new instructions, guidelines, protocols and supervisory measures. This could easily result in even great administrative and auditing workload for institutions.

The healthcare system is still characterised by system-based thinking, and solutions are still being sought in the form of rules, frameworks, audits and supervision. This may be a legitimate approach from a cost management perspective, but it should not hinder accessibility to and quality of care, and should not result in too many overheads. There must also be room for people-oriented thin-

1 Source: http://www.rijksbegroting.nl/2015/voorbereiding/begroting,kst199401_25.html.
2 NBA Alert 28 (reporting year 2012) and 31 (reporting year 2013).
3 Letter 6 February 2015. Title Quality reaps rewards (reference 723296-133115-Z).

king, greater trust in the professionalism of care providers and greater focus on patient care.

This barrage of developments means institutions have great need for clear governance, fewer administrative rules and efficient accountability. These three themes have been specified in greater detail in the pages that follow. Focus has been placed on 2016 and thereafter; a temporary solution will have to be devised for 2015.

# Signal 1 | Unclear governance requires better management

*In recent years, a very complicated governance structure has been established for institutions. Besides the Ministry of VWS, an important role is also played by the NZa, ZIN, IGZ and the ACM. Institutions also have to deal with healthcare insurers, sector organisations and patient associations. As part of the Wmo and the Youth Care Act, institutions also have to consider numerous municipalities and care regions, which are all able to define their own specific policies[4].*

Many stakeholders share responsibility for healthcare. They often operate based on their own specific visions and normally attempt to achieve their own goals. This creates ambiguity about the scope of each party's role, position and mandate. For instance, each healthcare insurer will make a different choice about where care will be acquired. This means institutions can be confronted by a wide range of policies, each with their own remuneration conditions. This leads to complicated administrative processes, with the likelihood of major audits years down the line. Other parties have remained absent from important discussions for too long or only decided to explain laws and regulations later down the line. For instance, ZIN only provided clarity about effectiveness and appropriate use very late in the day and NZa only used an allowed/forbidden list to provide transparency about its rules once a great deal of discussion had already taken place. Rules and authorities are not always compatible with each other. Examples include incompatibility between calendar year and damage year; different calculation systems for work in progress (OHW) and the failure to fully complete the Function-oriented Budget (FB) system.

Many problems are being repaired on an ad-hoc basis within managerial meetings. This primarily involves looking for consensus, without specific management or enforceable actions. Experience shows that there first needs to be a lot of pressure before coordinated solutions are found, as proven by the national recovery plan.

The main thing the healthcare sector needs is clear governance. And people's roles and mandates must also be clear - whether it involves institutions, healthcare insurers, sector organisations or institutions like the NZa, ZIN, ACM and IGZ. Supervisory bodies should not have to monitor their own rules, fund managers must show due care when requesting information and healthcare insurers shouldn't be trying to reduce their own workload on the back of complex public rules.

On the other hand, institutions must also establish their own effective internal governance. For instance, the introduction of integral prices has resulted in often complicated constructions to retain the fiscal status of medical specialist - so-called specialised medical companies. In this case, the quality of patient care is taking a back seat to the traditional earnings model of people who work as specialists. Such constructions should not be introduced at the expense of institutional manageability or the effectiveness of internal supervision. Finally, it will be in their best interests if institutions are transparent when it comes to the distribution of profit and private financing.

4 See letter from the NBA Healthcare Platform to the VNG on 7 January 2014. Title 'Decentralisation in a social setting.

## RECOMMENDATION 1: Arrange governance and take control

1. Improve governance with regards to regulation and supervision. Clearly map out system-based ownerships as well as the supervision and auditing chain. Each party's responsibility and mandate must be clear, as must links between everyone's tasks and potential overlap or gaps. In this case, try to limit or integrate the number of responsible parties.

2. As the Minister of VWS, continue to assume leadership until the system functions effectively and, if necessary, read the riot act to parties that refuse to participate. Remain alert to signals from the sector. Encourage parties to trust each other and to establish feasible agreements.

3. As an institution, try to be the most efficient and transparent organisation possible. Ensure there is harmony between the interests of institutions and those of medical specialists. Make sure there is an effective internal management and supervision structure and be transparent about management fees and payments to private financiers.

# Signal 2 | More rules will have an adverse effect

*Institutions are being forced to comply with many rules when it comes to registration. It is extremely difficult to correctly adhere to this multitude of rules, whereby there is a risk of errors being seen as fraudulent behaviour by the outside world. This complexity can primarily be attributed to the number of specific criteria when registering, for example, day treatments, nursing days, outpatient visits, medicines and IC surcharges. They can relate to how patients come into contact with doctors, where in the hospital a treatment will take place, indicators for which medicine is administered, times when patients are taken into hospital, etc.*

Although these criteria may be completely transparent as far as policy-makers are concerned, such detailed rules result in considerable administrative workload for institutions. Institutions need to incorporate checks into primary registration processes, register information to demonstrate compliance with the rules and make sure sufficient internal controls are implemented to test compliance. In turn, external accountants must examine these processes as part of audits carried out on the annual reports of institutions. This begs the question whether finances, which are spent complying with excessive bureaucratic rules, have actually been put to the best possible use. And whether such detailed funding regimes and service descriptions are compatible with a healthcare system subject to certain market forces.

Each new law or regulation makes the healthcare system more complicated, which often leads to inconsistencies and disruptions in existing systems and procedures. Transitional arrangements and stipulations when switching from old to new systems simply reinforce this effect, as demonstrated in the annual account for 2013. This is not only harms implementation of registration and automation-related rules, but also makes it more difficult to check accountability. Due to a pile up of rules and systems, system complexity has become a huge obstacle, whereby the consequences of changes can sometimes be overlooked. Few parties have a clear insight into the structure of, and interaction in, this complex maze of regulations. In addition, more rules will inevitably result in greater likelihood of errors, discussions and disputes, which will in-turn lead to more auditing and supervision requirements. And the actual aim of all these rules, namely to improve the quality of healthcare, is at risk of being overlooked.

The problems highlighted above create a great deal of uncertainty about the accuracy and legitimacy of revenues, and this does not benefit the sector as a whole. It is difficult for institutions to get a good insight into their own turnover because major corrections can still be implemented later down the line by healthcare insurers or the government in the shape of the MBI. This means the management information available to institutions is subject to great uncertainty. Risks for banks and financiers are also increasing, which is being reflected in higher costs for borrowed capital and less access to new sources of funding. This is resulting in fewer opportunities for investment which could help to improve quality and innovation.

## RECOMMENDATION 2: Place greater focus on feasibility and coordination

1. Improve checks for feasibility, costs, accountability and auditability when formulating new rules. When doing so, call upon experts and experienced professionals at sector organisations, institutions and accountants. Always check if there are conflicts with existing laws and regulations, and modify them if necessary.

2. Rules must not come into effective retrospectively and shouldn't require clarification or interpretation at a later time. Adopt one particular moment a year for rules to be changed. When doing so, aim for regulatory pacification, whereby rules are determined long in advance and remain in effect for a long period of time.

3. Avoid the piling up of audits. Ensure uniform agreements about important audits, so institutions are not audited by different healthcare insurers, in a different manner, with different benchmarks. Try to integrate audits and make them uniform.

# Signal 3 | The chain of accountability is not efficient enough

*Institutions are facing information requests from a wide range of parties. Besides the Healthcare Annual Document and compliance with DigiMV for the Ministry of VWS, this involves, for example, cost price indications and market share indications for the NZa, annual reporting of invoiced DBC's, OHW statements for healthcare insurers and information for the national DBC Information System (DIS). In addition, institutions receive countless ad-hoc requests for information.*

All this information must be registered, audited and issued, often in different formats, and possibly accompanied by an auditor's report. But it is still surprising how often unsafe Excel spreadsheets are used, while the government is doing a great deal to promote the supply of information via Standard Business Reporting (SBR). The above-mentioned examples of uncoordinated supply of information inevitably result in unnecessary administrative workload, errors and duplication of work at institutions.

In terms of communication between institutions and healthcare insurers, it does not help when both parties speak a different language. Institutions perform registration and accountability activities based on calendar years, while healthcare insurers operate on the basis of damage years[5]. In addition, healthcare insurers can also implement individual requirements when registering and justifying actions, whereby institutions may need to perform various tasks to provide the required information. And the situation is even more complicated for institutions when it comes to the Wmo and the Youth Care Act, because each municipality or care region is entitled to impose its own accountability requirements.

In a climate where great focus is being placed on cost management and quality improvement, it is important for administration and auditing-related costs to be kept to a minimum for institutions.

Uniformity and automation in information requests could help to significantly reduce administrative workload. This was also one of the objectives when the Healthcare Annual Document was introduced. However, it was unable to prevent various authorities from continuing to request their own specific information.

It is thus important for the Minister of VWS to take control in this matter, and to work closely with sector organisations, institutions and accountants. Information requests can continue to be as diverse as they are now, as this is more or less standard practice in today's healthcare system. However, it is important for everyone to speak the same language, to use the same frameworks and models and for information systems to be compatible with each other.

In this case, there are two important initiatives. SBR, which makes it possible to use the same information for various automated reports sent to different users. System based approach (SBA), whereby institutions and healthcare providers address each other about their mutual responsibility for reliable and relevant information exchange and appropriate behaviour within existing laws and regulations. By placing emphasis on the reliability of information, it may even be possible reduce the number of audits carried out on supplied information (this initiative is already being tested on a limited scale).

5 See document issued by the NBA Healthcare Platform July 2014. Title 'Damage year versus calendar year.

## RECOMMENDATION 3: Implement system based approach throughout the sector

1. Use modern techniques like SBR to focus on making information uniform, streamlined and automatic. Replace PDF's and Excel files by sharing information files. As Minister of VWS, assume a leading role and work together with the sector.

2. Encourage the introduction of system based apporoach on a much broader scale. When doing so, facilitate the development of uniform frameworks and the certification of information systems. Reward institutions with fewer auditing and supervision activities if they have used horizontal supervision to demonstrate appropriate control.

3. Coordinate national, centrally imposed service descriptions and invoicing rules with parties in the sector before they are actually introduced. When doing so, focus on measuring quality and result-oriented parameters.

# Credits

**Sharing Knowledge**
In the NBA Knowledge Sharing policy programme the expertise of accountants is collectively applied to signal risks early in social sectors or relevant themes. In doing so the emphasis is on governance, operations, reporting and audit.

The NBA has used this open letter to identify three signals for the curative sector. This sector is the fourteenth topic to be selected by the Identification Board of the NBA. The Coziek Sector Commission's Cure work group collected material used for the letter and discussed it. The Identification Board then gauged the signals from a social perspective¬. Coordination and final editing was provided by the Sharing Knowledge programme team.

**Further information**
An open letter is one of the publication types issued by the Sharing Knowledge policy programme, in addition to public management letters and discussion reports. The NBA has previously published public management letters on: Insurance (2010), Long-term Care (2010), Commercial Property (2011), Greenhouse Horticulture (2011), Municipalities (2012), Charities (2012), VET colleges (2013), Transport and Logistics (2013), Risk management (2013), Life Sciences (2014) and Banks (2014). Further publications include an open letter on Pensions (2011) and a discussion report about Tone at the top (2012). All publications are public and are intended for a broad audience.

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