Dutch health care reform at the crossroads

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Many health policy watchers follow the experience with health care reform in the Netherlands with great interest. So far, the 2006 health insurance reform (Van de Ven & Schut, 2008) has caught most international attention. This reform ended the traditional dividing line between the sickness fund scheme covering about 67 percent of the population and a heterogeneous set of private insurance schemes covering the rest. The reform introduced a single mandatory scheme (*basisverzekering*) covering all legal residents of the Netherlands. The new scheme is carried out by insurers who may go for profit. To spur competition, every person has the formal right to switch to another insurer and/or policy by the end of the year. Legislation obligates insurers to accept each applicant. Employed persons pay through their employer a state-set contribution (in 2011 set at 7,75% of their income with a maximum of almost 2600 euro per person per year); for self-employed persons the contribution rate is 5,65%). Furthermore, every person pays a flat-rate premium set by each insurer separately. In 2011 these premiums ranged from 1068 euro to 1272 euro per year. The government pays the premium for children under 18. The contributions and the state payment for children flow into a risk equalization scheme.

Each person is free to purchase a complementary health insurance scheme covering health services not included in the basic scheme (e.g. physiotherapy, some forms of dental care, preventive services). There is a great variety of complementary policies, ranging from simple and low-priced to extensive and higher-priced policies. Insurers are not required to accept each applicant. So far, however, risk selection has been quite limited: all insurers have given priority to the preservation and extension of their market share. Whereas the basic scheme is mandatory, complementary insurance is voluntary. Nevertheless, about 89% of the population purchased a complementary scheme in 2011 (Vektis, 2011). Complementary insurance cannot be used for faster access to health care. Figure 1 visualizes the present structure of health insurance in stylized form.

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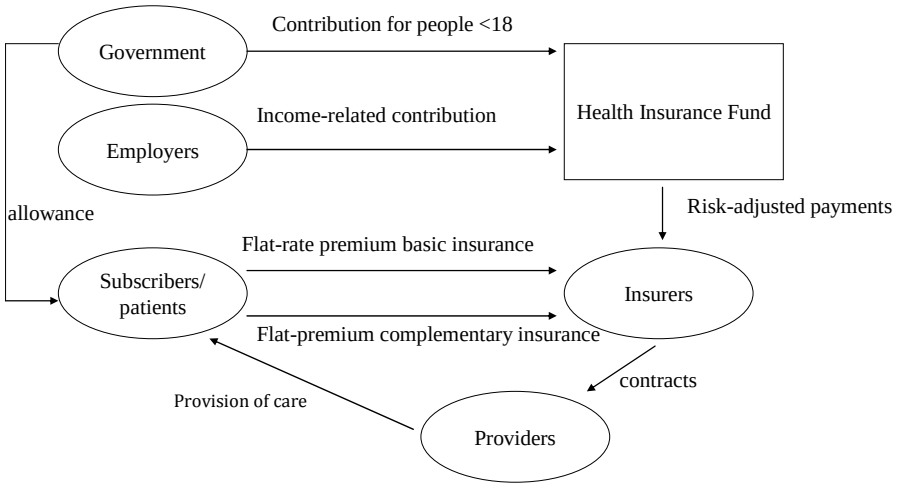
Figure 1. The structure of health insurance since the 2006 reform



The ban on risk selection is one of the key instruments to preserve risk solidarity in basic health insurance. Other instruments are the ban on risk-rating, ex ante risk equalization and the uniform benefit package. The purpose of risk equalization is to compensate health insurers *ex ante* for differences in the risk profile of their insured population. Premium differences should only express differences in efficiency. To guarantee a uniform package, the Minister of Health is in charge of 'package decisions' (for instance, the decision to cover the costs of smoking cessation programs or the decision to remove contraceptives for women aged 21 and older from the list of services covered). Nevertheless, some package variation is possible. For instance, an insured may opt for a benefit-in-kind policy or a reimbursement type of policy. Some insurers also introduced policies with preferred providers. Furthermore, an insured can choose a policy with or without a voluntary deductible. The maximum of the voluntary deductible is fixed (presently 500 euro). The voluntary deductible must be distinguished from the mandatory deductible (in 2011 170 euro per person). GP care, maternity care and dental care for persons under 18 are exempted from the mandatory deductible.

The health insurance reform is intended to bring about a system of *regulated competition* in health care. The essence of regulated competition is to introduce competition while upholding fundamental social values in health care, in particular solidarity in health care financing and universal access to health care. Another aim of the reform was to enhance consumer choice.

Some results of health insurance reform

To what extent can the 2006 health insurance reform be considered a success? The answer depends on the perspective taken. First, one may argue that the reform has reduced complexity. In the pre-reform period, health insurance had a segmented structure due to the dividing line between the sickness fund scheme and private health insurance. Furthermore, it is fair to depict the market of private health insurance as a labyrinth consisting of pure private schemes, a state-regulated scheme and some specific arrangements for public servants. The reform ended the segmented structure of health insurance by introducing a single basic scheme covering all legal residents. Its mandatory character of this scheme is hardly disputed and not perceived as a serious restriction of freedom of choice.

Second, one may argue that the introduction of a single scheme has strengthened solidarity. However, the premium charge (including the employer's part) is still significantly lower for persons on high income (100.000 euro)[2] than for people on low income (10.000); the percentages are about 7% and 25% of income respectively.[3] The premium charge of persons with an income of 20.000 euro is estimated at about 22%, of persons with an income of 40.000 at about 18% and of persons with an income of 60.000 euro at about 12% (Vermeend & Van Boxtel, 2010). How to assess these differences in premium charge is of course a matter of political appreciation. To ensure income solidarity, persons on low income can apply for a state allowance to pay their flat-rate premium. This allowance is included in the estimation of the premium charge.

Third, the reform enhanced freedom of choice because of their yearly switch (exit) option. However, there are good reasons for not overstating the enhancement of freedom of choice. The basic health insurance scheme is mandatory and both insurers and insured have only limited degrees of freedom as regards the composition of the benefits package because of the centralized decision-making model. Furthermore, there are many practical restrictions to consumer choice, such as lack of transparency, high transaction costs of switching and market structure.

A fourth perspective concerns consumer mobility. In 2006 about 18% of the population switched to another insurer, a result almost no expert had foreseen. But in the following years mobility dropped to about 3,6% in 2008/9 and 3,9% in 2010, signaling a 'status

[2] 1 euro equals about 1,4 USD.
[3] These percentages also include the contribution to the exceptional medical expenses scheme covering many forms of long-term care (this scheme is not discussed in this paper).

quo tendency'. Interestingly, however, mobility is estimated to have increased to 5,5% in 2011 (Vektis, 2011). This rise is likely due to the average premium increase of about 10% which motivated many people to reconsider their policy.

How did contributions and flat-rate premiums develop over time? There is no easy answer to this question because of continuous changes in the benefit package of the basic scheme and, more importantly, the switch in 2008 from the no-claim arrangement to a mandatory deductible. Nevertheless, it is important to note that state-set contributions have risen from 6,5% in 2006 to 7.75% in 2011 (for self-employed these percentages are 4,4% and 5,65% respectively). The flat-rate premium, corrected for replacement of the no-claim arrangement with the mandatory deductible, grew by 38% from an average of 795 euro per person in 2006 to an average of about 1100 euro in 2011 (own calculation).

As regards health care expenditures, the results so far do not point to great success. Over the period 2006-2009 HCE rose by 19,4% compared to 16% over the period 2002-2005 (http://statline.cbs.nl) The fraction of *publicly* financed health care in GDP grew from 6,8% in 2002 to 7.1% in 2005 and from 8.5% in 2006 to 9,5% in 2009 (the jump of 1,4% in 2006 is due to the fact that private health insurance was integrated into the basic health insurance scheme). Even more problematic is that the growth of HCE in the years to come s expected to outstrip the growth of GDP by at least 2% a year. This development will put health care under tremendous financial strain.

Since the 2006 reform the number of insurers has significantly dropped from almost 57 to 29 (Vektis, 2010). However, these figures obscure the concentrated structure of the health insurance market because four major companies (Achmea, Uvit, CZ and Menzis) have a common market share of about 90%! 20 out of the 29 insurers belong to one of these companies. In some regions the market structure is very concentrated which may restrict freedom of choice.

If a person fails to purchase a health insurance policy, (s)he is uninsured by implication. The total number of uninsured persons was estimated by the Central Office for Statistics (*Centraal Bureau voor de Statistiek*) at 152.000 (reference May 2009), but this number has fallen to 136.000 (May 2010) (www.cbs.nl). Uninsured persons must be distinguished from insured persons who fail to pay their premium. The total number of defaulters – defined as persons with insurance who failed to pay their premium over a period of at least 6 months – was estimated at 318.000 in December 2009. Using a new definition this number dropped to 244.000 in December 2010 (about 1.9% of the adult population). The Ministry of Health, local government, insurers and other agencies have

intensified their collective effort to track uninsured persons and defaulters. They are fined when tracked.

Further reforms in basic health insurance

The 2006 reform is certainly not the last reform in health insurance. More changes are foreseen for the near future. An important issue is how to respond to the expected growth of health care expenditures. The first and most frequently used strategy is to raise contributions and premiums. The question, however, is to what extent these raises politically acceptable. Some policy analysts call for a more restricted definition of solidarity. In their view, solidarity should remain a cornerstone of health insurance, but it will become unsustainable without a stronger emphasis upon self-responsibility. Therefore, private payments (mandatory deductible, copayments, et cetera) should be raised. However, such raises have always been politically highly controversial, which helps to explain why the fraction of private payments in health care financing (9 à 10%) is still low in the Netherlands compared to most European countries. Politicians at the left side of the political spectrum advocate a bigger share of income-related contributions in health care financing to strengthen solidarity. They are very critical of flat-rate premiums and consider the arrangement to compensate persons with a low income as a costly and unnecessary bureaucracy,

Another strategy is to reduce coverage by removing health services from the benefit package of the basic health insurance scheme. However, delisting is politically controversial as well. Nevertheless, the new government (in office since 2010) announced a substantial package reduction in its Coalition Agreement, termed *Vrijheid en Verantwoordelijkheid* (Freedom and Responsibility).

A fourth strategy is to spur insurers to negotiate low prices for health care in contracting with health care providers. The argument is that powerful incentives to go for the best deal are still lacking because of ex post risk equalization. In 2009, insurers were at risk for about 96% of the costs of ambulatory care and for 47% of the costs of inpatient care (ZonMw, 2009). Ex post risk equalization may motivate health insurers not to go for the best deal, since their expenses for inpatient health care will be (largely) reimbursed anyhow. Another reason is that the revenues of a good deal will be partially skimmed off. Ex post risk equalization has always been intended as a temporary provision to ease the market reform. However, it is still (largely) in place. The new government has announced to abolish ex post risk equalization, but it remains to be seen whether it will be successful.

The strategy to spur insurers to negotiate lower prices fits into a broader strategy of accelerating the liberalization of health care by extending the scope of competition, e.g. in hospital care and pharmaceutical care, and the introduction of for-profit hospital medicine. This strategy will be discussed below. First, some attention is given to two cornerstones of the market reform: selective contracting and patient steering.

Selective contracting and patient steering

Effective market competition in health insurance requires that insurers act as prudent purchasers of health care on behalf of their customers. As agents of their customers, they are assumed to negotiate with provider organizations on the quality and prices of health care. Two important elements of strategic purchasing are patient steering and selective contracting. It is fair to say that both are still in their infancy. So far, insurers have mainly used soft instruments to steer patients, in particular by giving them information on the waiting times of hospitals. Some insurers also use positive incentives by letting off patients to pay the mandatory deductible, if they visit a preferred hospital. Some policies require patients to visit preselected providers for non-acute care. Patient steering by requiring patients to co-pay for health care in a hospital without a contract hardly exists yet.

There are various explanations for the absence of patient steering and selective contracting, including a lack of information and experience, a strong focus upon the preservation and extension of market share, the absence of powerful incentives to go for the best deal and – last but not least – fear of loss of reputation. Health insurers are still struggling with what has been termed the credible commitment problem (Boonen & Schut, 2011).

Interestingly, however, a few insurers recently announced to contract hospitals which meet the quality standards. In 2010 a big insurer (CZ) made public that it would no longer contract four hospitals for breast cancer surgery, because their quality of care, measured by capacity, volume (number of operations) and patient satisfaction, did not meet the minimum standard. CZ's initiative elicited not only admiration among insurers and the advocates of regulated competition ('this is the right way to go'), but also arousal because it was perceived as a significant step that could mark a new era. CZ was also criticized for the fact that it had set its own quality standards for breast cancer surgery. Interestingly, however, its initiative prompted the Society of Surgeons to publish its own list of quality standards for some surgical procedures. The Society clearly wanted to remain in the driving seat as regards the definition and control of quality

standards which it saw as its exclusive area of expertise. In the meantime, another big insurer (Achmea) announced to use these standards in hospital contracting. So, it may well be that selective contracting will come off the ground and that hospitals will be forced to reconsider their portfolio. A fundamental question remains of course, how patients will assess these new developments from the perspective of freedom of choice and access of care.

Developments in GP care, pharmaceutical care and hospital care

Since the 2006 insurance reform GPs are remunerated by means of a yearly capitation payment (52 euro per registered patient), a fee-for-service for a patient visit (9 euro), a fee-for-service for a number of specific diagnostics and routine surgical treatments to innovate and modernize GP care. Furthermore they receive an additional budget for a number of other items. With a few exceptions all tariffs are set by the Netherlands Healthcare Authority (*Nederlandse Zorgautoriteit*).

GPs have never been very supportive of the market reform ('health care is no market'), but from a revenue perspective they did well out of it. The expenditures for GP care jumped from an average of 102 euro per registered patient in 2005 to 119 euro in 2006 (CvZ, 2009). Insurers do not have much leverage to contract with GPs, the more so because of lack of information about the quality of care delivered. Nevertheless, they are seen as crucial in disease management programs for patients with chronic illness (diabetes, COPD, cardiac vascular disease, and so on). One insurer (Menzis) is explicitly focusing on GP care and other forms of primary care by investing in centres for primary care.

As far as pharmaceutical care is concerned, it is interesting to mention the strategy of some insurers to reimburse only the costs of the lowest-priced off-patent drug within the same therapeutic class. Menzis claimed price decreases up to 85%. Recent data (CvZ, 2009) show that in 2008 total expenditures for cholesterol-lowering drugs fell by 13,5% in despite an increase in the number of prescriptions and DDDs (Defined Daily Dose). The growth of total expenditures for outpatient prescription drugs has also been rather modest over the last few years. Over the period 2006-2009 expenditures grew by 10,7% which is significantly less than the growth of 19,4% of total HCE.

So far, market competition by means of free pricing has remained limited in hospital care. Hospital funding consists of two segments. In the A-segment prices are regulated by the Healthcare Authority. The regional market leader of insurers negotiates with each hospital in its region about volume contracts (number of admissions, inpatient

days, and so on). These agreements are binding for all insurers. There is also a state-imposed budget ceiling, which means that cost overruns will be offset in a later year by lower prices. Free pricing only exists in the so-called B segment. In this segment each insurer is expected to negotiate with each hospital on the prices of diagnostic treatment combinations (the Dutch version of case-based payment for inpatient and outpatient hospital care). Both parties may also sign a contract on the volume and quality of hospital care (for instance, maximum waiting period). The government does not set a fixed budget for the B-segment, but practice has proven to be more complicated.

Free-pricing started in 2005 but only for about 10% of hospital revenues. Medical care under the regime of free prices included mainly routine care such as hip and knee replacement, varices, cataract surgery and diabetes care. The B-segment was extended to about 20% in 2008 and about 33% in 2009. The stepwise and cautious extension of the B-segment was not only intended to build up experience with free-pricing (policy learning), but also echoes the continuous need of political compromising. The Minister of Health had always to maneuver carefully to manage a political majority for further extension. Table 1 demonstrates that except for 2007 price increases in the B-segment have been lower than in the A-segment, but the differences are not spectacular.

Table 1 Changes in average hospital prices, 2006-2010 (% growth relative to previous year)

	2006	2007	2008	2009	2010
A segment	0,4	1,3	2,3	2,6	0,3
B-segment 2005 tranche	0	2,1	1,1	1,5	-1,8
B-segment 2008 tranche				1,4	-2,1

Source: NZa (2011)

Unfortunately, only little is known about the volume effect of free-pricing in the B-segment (is the effect of lower prices offset by increased volume?). What is known, however, is that the government reported substantial overruns of the total budget of hospital care which have to be compensated by downward tariff adjustments. Not surprisingly, these overruns were heavily disputed by the hospital sector.

It is evident that market competition in hospital care has remained hybrid and confusing. The scope of free pricing is still restricted. The dual structure of hospital funding not only creates huge administrative complexity, but also implies the co-existence of two different regimes: the regulations and incentives in the A-segment (no free pricing,

collective bargaining and no incentive to produce extra because of the budget ceiling) are different from the regulations and incentives in the B-segment (free pricing, bilateral bargaining, incentive to increase production). Offsetting cost overruns by generic tariff cuts appears a source of great trouble including appeal procedures in court.

The current hybrid situation means, according to the Minister of Health, that 'we are stuck in the middle'. To overcome this situation she announced to accelerate market competition by a significant further liberalization of health care, including an extension of the B-segment to about 70% in 2012! Only hospital services for which free pricing is considered to be unfeasible or undesirable should be funded by means of a fixed budget (e.g. trauma care, some top-clinical care, donor teams, helicopter services). However, the transition to the new situation appears to be very complicated, the more so because it will be combined with a significant reduction of the number of the DTCs. Hospitals and insurers are concerned about the feasibility of the major extension of the B-segment planned and call for a cautious implementation path.

It is important to note, however, that the Minister intends to combine the significant liberalization of hospital care with the continuation of a yearly set fixed budget for hospital care (and other sectors of health care). In other words, she wants to retain her most powerful instrument to reign in health care expenditures. However, liberalization and fixed budgets do not well fit. One may even speak of an attempt to square the circle. The government's policy illustrates that the market reform in Dutch health care can best be understood as a continuous political balancing act between the objective freedom and entrepreneurship on the one hand and the need for central control on the other hand.

The lifting of the ban on for-profit hospital care is another example of this balancing act. For-profit hospital care was forbidden in the pre-market period. The 2006 reform did not change this arrangement. The current government wants to introduce for-profit hospital care. It is seen as an indispensable element of the market reform. Financial agents will only be interested in investing in hospital care, if they expect a return on their investment. However, the introduction of for-profit hospital care is still controversial. Therefore, the Minister of Health opts for what she terms 'regulated for profit hospital care'. How regulation will look like is still unclear, but one may expect that investors cannot acquire a majority position in the supervisory board of hospitals and that the selling of shares by the shareholders will be restricted.

Conclusion

Our analysis of the market reform in Dutch hospital care demonstrates that it has been an unfolding and incrementalistic process. Since 2006 various market-making decisions have been taken, further decisions still have to be taken. It may even be argued that the reform so far is at best only half-way, which raises the question of whether the bottle is half-filled or half-empty (Schut & Van de Ven, 2011; Maarse & Paulus, 2011). Furthermore, it is clear that the shape of the market reform is not the result of rational design, but at best a mixture of rational design and politics. Almost each market-making decision requires bargaining with stakeholders to find an acceptable compromise. How the market reform and the tension between freedom and control will evolve in future, is written in the stars of health care policymaking.

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