

Health care reform in the Netherlands

by

Rudy Douven, Esther Mot, Marc Pomp,

CPB Netherlands Bureau for Economic Policy Analysis

For many years, Dutch health insurance for basic care services consisted of a two-pillar system. One pillar consisted of the social health insurance system for people in the lower income brackets, and the other pillar was the voluntary private health insurance system for people with higher incomes. In 2006, the Dutch government implemented radical market reforms and the two pillars fused into one mandatory national health insurance system executed by private insurers. The key idea of the market reforms is to increase efficiency by promoting more competition on the health insurance market as well as on the health care provider market.

The first ideas of a single national health insurance system with elements of managed competition were already proposed in 1987 by the Dekker Commission (Dekker Commission, 1987). According to this report central government planning should be replaced by a system in which competing health insurers act as prudent buyers of care on behalf of their members. Although it took almost twenty years before the actual reforms were implemented, many incremental changes already took place before the 2006 reforms. Examples of these changes are the introduction of nominal premiums and a risk equalization system in the social health insurance.

The Dutch health care reform

Introducing competition into the health care market is not without risks, as it may threaten solidarity and quality. Also, if providers and insurers have significant market power then costs may rise. To preserve solidarity the government introduced a basic benefit package that is mandatory for all Dutch citizens. All citizens have freedom of choice in choosing their health insurer, who is obliged to accept all applicants during annual open enrolment periods. Moreover health insurers are obliged to charge each applicant the same nominal premium (community rating). These restrictions on the premium create predictable losses for health insurers on enrollees with predictably high medical expenditures. Therefore the Dutch government implemented a risk equalization system that compensates health insurers for predictable differences in their medical expenditures. The development of the risk equalization system started in 1991 in the social insurance system and has subsequently been further improved.

Figure 1 illustrates the scheme for the Dutch health care financing system. All citizens, except children under 18, must pay an income dependent contribution, levied by the tax collector, to the Health Insurance Fund (HIF). The HIF also receives contributions from the government (for example for expenditure on children under eighteen). In the right part of the figure the health insurance fund reimburses this money, after applying risk equalization, to the health insurers. In the lower part of the figure all consumers pay also a nominal premium directly to their health insurer. The idea being that consumers discipline health insurers by voting with their feet if they are not satisfied with the performance of their health insurer. While the financing system in figure 1 was also present in the social health insurance system before the reforms, the size of the nominal premium was much smaller than the size of the income dependent contribution. Under the new health care system the law requires that 50% of all expenditures must be paid by income dependent contributions and 50% by nominal premiums. This implied a significant rise of the

nominal premium for people in the lower income brackets from about 350 euros in 2005 to about 1050 euros in 2006. A high nominal premium should make people more aware or cost-conscious of the high health care costs. The increase in nominal premiums resulted in a loss of spending power of the lower income groups and therefore the government now compensates more than 5 million citizens with monthly income-dependent subsidies.

Raising efficiency in the health care market is not an easy task. Health insurers need not only incentives but also tools to produce more efficiently. To create as many incentives as possible the Dutch government opted for a privately organised health insurance system that falls within the scope of the Third Non-Life Insurance Directive of the European Commission's competition law. Competing health insurers obtained various tools to attract consumers. With respect to the basic benefit package they compete on price, and are allowed to offer premium discounts for group contracts (the discount is capped at 10% of a similar individual contract) and for people who opt for a voluntary deductible that may vary between 100 and 500 euro per year. These deductibles are on top of a mandatory no-claim rebate of 255 euro per year for the entire population. Health insurers can also compete with different supplementary insurance packages, service levels and different types of preferred provider networks. Especially this latter tool should encourage health insurers to bargain favourable contracts with health care providers. The idea is that this will stimulate efficiency in the provision of health care services since health insurers will steer their enrollees only to efficient health care providers that produce decent quality. Of course this can only work if information about quality of care is readily available. At the moment reliable quality information is lacking but the government, as well as private organizations, are currently undertaking large efforts to speed up this information.

Though liberalisation of the provider market lags behind the insurance market, many changes already took place to promote competition. Legal barriers for new entry have been lowered and in the past few years many independent clinics entered the market. The introduction of a new hospital administration system, based on cost per treatment, facilitates health insurers and hospitals to negotiate about hospital services. To become accustomed with this negotiation process hospitals and insurers may since 2005, negotiate on volume, price and quality of about 10% of hospital services. The other 90% of hospital services is still regulated, but the government intends to liberalise hospital services further, and in the future hospitals and insurers should negotiate on 70% of hospital services.

A first evaluation after one year of experience

The first remarkable result of the reform is that health insurers started a premium war. The threat that many customers would change from health insurer had a profound impact on their premium setting. In particular, premiums of group contracts were offered below the break-even price. It is estimated that health insurers lost between 375 and 950 million euros on the provision of the basic benefit package (Douven en Schut, 2006). These losses can still be managed by most health insurers since they (especially the larger ones) have substantial financial reserves.

A second unexpected result was that about 20% of the Dutch population switched from health insurer. Such a high degree of switching was never seen before. Through the reforms, combined with massive media coverage of premium differences, the population seemed to have become much more aware about their possibilities to switch health plans. Many people switched from an individual contract in 2005 to a group contract in 2006. There was a wide choice of group

contracts and most health plans offered large premium discounts for group contracts (on average about 6,5% lower than individual contracts). These group contracts were not only employment-based but were offered also to other groups, sometimes with a large number of potential insured such as the major labour unions, national sport federations and a large cooperative bank. Group contracts were even offered to interest associations for the elderly and several groups of chronic patients (e.g. diabetes and rheumatoid arthritis). These contracts are feasible because health insurers are compensated for predictable expenditures by the risk equalization scheme.

The reforms provoked a lot of reactions at the health insurance market. One health insurer announced losses for providing health insurance and started to cut down on employees and administration costs. Another activity to cut costs is risk-selection. Some insurers may have exploited the deficiencies in the risk adjustment system by obtaining favourable group contracts. Another potential tool for risk-selection is supplementary insurance. However, health insurers announced that in 2006, and also in 2007, they would accept all applicants for supplementary insurance. Health insurers announced mergers that meanwhile have been approved by the Dutch competition authority. After these mergers, about 90% of the population will be insured by six large insurance concerns, while the other 10% will be insured by seven small regionally oriented health insurers (Schut, 2006).

The real test of the reforms is still to come

The real test of the reforms will be in the efficient provision of health services. This could come about if health insurers use their newly acquired opportunities for selective contracting. However, until now they hardly seemed to have used these opportunities. A first explanation is that the incentives to negotiate with hospitals are not very strong. First of all, only 10% of hospital services is freely negotiable and, secondly, hospital expenditure differences between health insurers cannot become larger than about 50 euros per premium payer. This latter policy rule is introduced to prevent insurers from running risks on high or low hospital expenditures that may arise because of temporary deficiencies in the new hospital administration system. A second more fundamental problem is that there is still not enough quality information available, and a cheap bargain may indicate low (real or expected) quality. A third reason may be that health insurers do not have enough bargaining power to obtain favourable contracts with hospitals. Hospitals not only have more information about costs and quality of their services but they also may exert market power, especially in those regions where the number of hospitals is small. A fourth explanation may be that health insurers find it difficult to steer enrollees to preferred health care providers, since enrollees that contract a preferred provider network are still allowed, albeit at the cost of extra expenses, to choose a health care provider outside the network.

However, at the moment it is much too early to draw any firm conclusions about efficiency. The reforms are just under way and better information about the quality of health care still has to be collected. Health insurers and providers also need time to adjust to the new situation, and furthermore not all policies to increase the incentives for selective contracting and managing care are yet implemented.

Rising expenditures

At the start of the new millennium the global budget, which produced growing waiting lists, was suspended. This policy led to declining waiting lists and growing health care expenditures. The rising expenditures puts more pressure on the Dutch reforms. If the Dutch reforms are successful

then increases in efficiency will lower the upward pressure on health care prices. Indeed, in 2006 some efficiency may have occurred in the hospital sector where liberalised hospital prices increased by one percentage point less than the price of GDP. Successful reforms and rising health care expenditures can go hand in hand since this combination may indicate more efficiency, production and quality of health care services. However, the government will need to explain rising expenditures credibly to the population since they may interpret rising expenditures as a sign of failing reforms and a lack of efficiency.

References

Dekker Commission (1987), *Willingness to change*, The Hague: Dekker Commission (in Dutch).

Douven R., and E. Schut (2006), *Premium competition among health insurers*, ESB, 91, pages 272-275 (in Dutch).

Schut, E. (2006), *Competition in health one year later*, ESB-Dossier: Market in action, December 2006, pages 20-24 (in Dutch).

Figure 1

