The Netherlands: reform of the health system based on competition and privatisation

Sylvie Cohu, Diane Lequet-Slama, Pierre Volovitch

Dans Revue française des affaires sociales 2006/6, pages 207 à 226
Éditions La Documentation française

ISSN 0035-2985
DOI 10.3917/rfas.en606.0207

Article disponible en ligne à l'adresse

Découvrir le sommaire de ce numéro, suivre la revue par email, s'abonner...
Flashez ce QR Code pour accéder à la page de ce numéro sur Cairn.info.
The Netherlands: reform of the health system based on competition and privatisation

Sylvie Cohu, Diane Lequet-Slama and Pierre Volovitch*

Introduction

According to OECD data, the Netherlands dedicated 9.8% of its GDP to health in 2003, as opposed to 8% in 1990, which ranks it among the EU leaders in this respect, just below France, where health expenditure represented 10.1% of GDP in the same year.

To promote the need for health reform, Dutch leaders highlighted the increase in spending, which had risen sharply over the past 15 years, despite the strict policy of spending regulation developed during the 1990s by the so-called “purple” coalition. From 1994 to 2000, this policy led to major reductions in the number of hospital beds and the number of practitioners. Control of spending and health care rates even led to waiting lists. Another subject for concern for those in charge was that the relative shortage of GPs, who act as gatekeepers for specialist and inpatient care, also generated waiting lists.

For the Dutch authorities, one of the main problems in their health care system was the lack of efficiency. The main objective of reform would be to produce more care, and therefore reduce waiting periods, without, however, increasing supply, but rather through better organisation and increased productivity. From this stemmed the decision to establish competitive mechanisms in the Dutch health insurance system. After the strict policy of the 1990s, which was very unpopular with the public, it was inconceivable to return to a policy of budgetary control and control of health care provision regulated in a centralised manner.

After describing the health insurance system in the Netherlands by underlining the characteristics that are conducive to a competition-based reform, we will analyse, in the second section, the new reform and the various mechanisms accompanying it: “risk equalisation” among insurers, standard health baskets, new setting of tariffs for treatment and raising users’

* S. Cohu and D. Lequet-Slama: International Research Supervisors at the centre of research, studies and statistics (DREES) at the French Ministry of Employment and Solidarity. P. Volovitch: Researcher at the IRES (Institute of Economic and Social Research)– France.
1 A coalition of left-wing and right-wing political parties, which excluded the Christian Democrats for the first time since 1917.
awareness of prices. In the third section, we will focus on debates that have taken place in the Netherlands regarding this reform, and finally, in the last section, we will look at questions that remain concerning the success and viability of this system, which is based entirely on competition and the privatisation of health insurance.

■ Favourable conditions for a competition-based reform

Several characteristics of the Dutch health system have made a competition-based reform possible.

The first is that “high-risk” patients, which represent a very small proportion of the population but which consume a very large portion of health care expenditure, have been under specific legislation and universal public health coverage (AWBZ – Exceptional Medical Expenses Act) since 1968. In fact, for a small fraction of the population, i.e. the elderly, the disabled or the chronically ill, the high-risk element makes it difficult for them to obtain insurance on a private market, where insurance premiums are linked precisely to risk. Initial reflection on the reform (Dekker-Simmons Plan) foresaw that competition would apply to the whole health insurance system, including the AWBZ. The difficulty in integrating the coverage of high-risk patients into a competition-based system was one of the elements that led to the non-application of the Dekker-Simmons Plan (see Box 1).

Health insurance in the Netherlands is traditionally composed of three “compartments” (see table below): universal public insurance for high risks (AWBZ), “general curative care” insurance and finally supplementary health insurance. Until the end of 2005, the second compartment was composed of mandatory public health coverage (ZFW) for approximately two thirds of the population whose income was under a certain threshold (€33,000 per year in 2005) and voluntary private insurance for those whose income was above the threshold set by the law. The third compartment is made up of supplementary insurance that is completely voluntary, and represents a small fraction of overall health care expenditure (3%), insofar as the majority of care is covered by the first two compartments. Ninety per cent of the population has taken out supplementary insurance. In this segment, the coverage levels, premium rates and deductibles vary greatly from one insurer to another.
In 2003, health expenses covered by the AWBZ represented 42.5% of all health expenditure, those covered by social insurance (ZFW) represented 36% and those financed by private insurance represented 15%. Six point five per cent of expenditures were out-of-pocket expenditures paid by households.\(^1\)

Competition has existed in the second compartment of the Dutch health care system for a long time. It was understandable for private insurance schemes that covered the population whose income was above the threshold. But from the early 1990s on, competition could also exist between public sickness funds. In fact, those insured by the social insurance system (ZFW) could freely choose their sickness fund and could change insurer each year. From 1992 onwards, public sickness funds, which up to then had regional jurisdiction, were allowed to define their own catchment areas.

Another characteristic conducive to the reform was the existence of risk equalisation systems between public health funds from 1992 onwards, in order to prevent health insurers from selecting their clients. This selection, which was profitable from a financial point of view, generated huge inequalities.

For people covered by private health insurance who were having difficulties in finding affordable insurers because of their age and health status, in 1986 the government imposed standard cover (WTZ) on private insurers. The WTZ basket of goods and services and its tariffs were set by local authorities. The premiums of this insurance were partly financed by a required contribution by all the privately insured. This

\(^1\) Source: Begroting VW 2004 Ziektekostenverzekeringen.
money was then redistributed among insurance companies through a compensation system.

The risk equalisation system also applied between private insurance and public health insurance funds (ZFW). To offset the fact that mandatory health funds cover a population that is older on average than the population covered by insurance companies, the privately insured pay a second premium surcharge (MOOZ). Finally, compensation between public health insurance funds was through a “central pool” which received the totality of contributions paid by employers on behalf of their employees, or by individual entrepreneurs. This pool spread the risk by redistributing payments received to different sickness funds in relation to the characteristics of the population covered by each fund.

Finally, the last characteristic of the Dutch health care system that could only favour the implementation of a reform based on introducing market mechanisms in health care is the fact that the private sector had always been present in providing health care, even though it mainly concerned private not-for-profit care. Ninety per cent of hospital beds are in fact, private not-for-profit beds.

On a broader basis, the fact that Dutch politics are based on consultation and consensus, often known as the polder model (Wierinck 2005), meant that an important reform could be adopted after negotiations lasting about 20 years.

■ 2005: A reform inspired by the Dekker Plan

A reform that came a long way

The idea of introducing competition between all insurers had, in fact, been stated in the framework of the draft Dekker reform in 1986. This draft reform recommended ending differences between public and private insurers, allowing patients to freely choose their insurers and setting up care networks managed by insurers. Mandatory insurance covering a health basket of goods and services representing approximately 85% of all health expenditure was to be defined legally. The two insurance segments – insurance for “exceptional medical expenses” (AWBZ) and normal care (ZFW) – were to be revised and merged into one type of insurance regu-

---

1 MOOZ: Medefinanciering oververtegenwoordiging oudere ziekenfondsverzekeraars – a scheme that ensures the joint financing of sickness funds which have an over-representation among the elderly. As for the WTZ scheme, people over 64 who are covered by private insurance do not have to pay this premium surcharge to the MOOZ scheme.
The Netherlands: reform of the health system based on competition and privatisation

Box 1: Short historic overview of Dutch health insurance up to the 2005 reform

- In the Netherlands, health insurance funds date back to the guilds of the Middle Ages. Members of a guild were covered for the payment of their medical expenses through mutual-benefit care funds.
- In the mid-19th century, an original form of health insurance appeared. In some large cities, health insurance systems were set up by doctors who agreed to negotiate coverage with mutual-benefit insurance companies, for the poorest section of the population, at tariffs lower than those charged to the rest of the population. Under the influence of trade unions, health insurance funds spread throughout the country. In the early 20th century, as medical science was developing, the question of populations that were too rich to benefit from “doctor funds” but too poor to have access to care was raised. Insurers discovered a new market: the first individual health insurance schemes appeared in the Netherlands in 1906.
- Despite a series of government projects, before World War II the Netherlands did not have a public health insurance system. In 1941, German occupying forces made membership of a health insurance fund mandatory for employees and their families (Ziekenfonds). Based on the Bismarkian model, an income ceiling for membership was determined by law, and the contribution, which was based on the employee’s income, was deducted at source. Insurance companies continued to offer private insurance to citizens whose income was above the ceiling. After the war, the mixed, or dual, system was definitively implemented by a law brought into force in 1966.
- In 1968, the Exceptional Medical Expenses Act (AWBZ) was adopted. This law provides for mandatory insurance for “high-risk” patients such as the elderly, the handicapped and those suffering from mental disorders.
- In 1987 the Dekker-Simmons commission proposed a complete reform of the Dutch health insurance system based on the introduction of market mechanisms into the system. In reality, the proposals of the Dekker-Simmons commission were only very partially implemented in the 1990s, with, in particular, a series of measures to introduce competition in the second compartment of public insurance.
- In 2005, the Parliament voted in a reform that was nonetheless inspired by the Dekker Plan.

lated by the market. The Dekker proposals, which were modified by the Simmons Plan, anticipated transition stages before the complete application of the reform. In 1992, revision of the law on health care tariffs allowed insurers to negotiate tariffs that were lower than official tariffs with care providers. In reality, even though certain measures towards competition had been taken, the suppression of differences between public health funds and private insurance as well as the merging of AWBZ and ZFW never really happened.

For certain experts (Helderman et al. 2004), the failure of the Dekker-Simmons reform was partly due to the fact that the necessary preconditions for a competition-based reform were not met: creation of an appropriate risk equalisation method, product evaluation, DRG payments and measurement of care quality and relevant information for patients.
In its 2004 report on health insurance reform, the Dutch Social and Economic Council, the SER (Sociaal Economische Raad)\(^1\) – whose opinion is particularly significant for the government – considered that the current bottlenecks in the health care system needed to be urgently addressed and that future challenges needed to be urgently met. It recommended the introduction of general insurance for curative care, mandatory for all and funded on the principle of solidarity between high- and low-income earners and solidarity regarding risk (between the young and the elderly, the healthy and the ill). As it concerned the Exceptional Medical Expenses Act (AWBZ), the SER offered its support as a universal social insurance provider, but by centring this support more on serious health risks and long-term coverage. The report authors also advised political leaders to move progressively from current control of supply, prices and budgets to a system based on regulation through demand, competition and the market.

In 2005, the government voted in an act that restructured the whole health care and health insurance system (Health Insurance Act and Health Care Allowance Act). This act came into effect on 1 January 2006.

The difference in the second compartment of health insurance was eliminated by the new reform, which introduced a single mandatory scheme for all residents. The government decided to opt for risk coverage by private insurance companies, while maintaining the social nature of the health insurance system.

In this compartment, the insured can freely choose his/her insurer. A complex “risk equalisation” system has been set up between health insurers. The system for financing hospitals is being modified in stages, moving from an overall budget to a system of DRG reimbursements, to allow competition between hospitals, which had previously been very limited.

The insured person pays a flat rate for normal care.\(^2\) However, the employer’s share is calculated in relation to the employee’s income.\(^3\) The stated objective is that in the long term, funding will be provided by the

\(^1\) The SER, which was founded in 1950, is a tripartite body composed of employers’ organisations representatives, trade unions and one third of government-appointed experts and “crown members”. It is involved in the preparation of all government social and economic policies through consultation carried out at a very early stage of the decision process. Even though, since 1995, consultation with the SER is no longer obligatory, and despite recent efforts to keep its distance from the SER, the government cannot avoid submitting all important projects to this body and must take its advice into consideration, especially when it is unanimous.

\(^2\) Health coverage for minors is free of charge, contrary to the previous system for those privately insured, whose premium depended on the number of people covered, children included. The cost of this coverage will be borne by the government.

\(^3\) The amounts from this contribution are paid into a central pool that distributes them among health insurers in proportion to the number of people covered, while taking the rules of risk equalisation into account.
employer and the insured employee on a 50/50 basis. The basis for calculating the premium is in keeping with the competition introduction process. Each insurer will freely set the amount of the premium, which should be identical for all of its insured clients, for the same health basket, whatever the person’s age or health status. Insurers cannot refuse to insure a client, whatever his or her risk profile might be. They must offer a basic insurance without extra benefits. The premiums naturally vary according to different insurers. There is only one exception allowed regarding this rule for equal premiums for all under the same insurer: the case of collective insurance by employers for all their employees. The reduction however, cannot exceed 10%.

The insurer is expected to generate competition between care providers so as to obtain the best price. The insurer can create a care network with providers under contract or working directly with the insurance provider. In this case, in order to be covered, the insured party can only be treated within the insurer’s network. But the insurer can also chose the single-payer model rather than that of “health entrepreneur”, by reimbursing its clients’ health care expenses. In such a model, the insurer is not obliged to reimburse more than the average rate of market-based tariffs that are “considered to be reasonable tariffs.”

This does not mean that the reform process is fully completed. Other bills should come into play regarding the segment of health insurance for exceptional medical expenses (AWBZ) and the law on social care services obliging municipalities to contribute in providing care for handicapped and dependent persons. The reform that came into effect in 2006 does not eliminate the AWBZ, which is not part of competitive mechanisms, but its content is limited to major risks considered by authorities as non-insurable, i.e. serious and chronic illness. Short-term psychiatric coverage has been moved to the second compartment of the health care system. From 2007 onwards, municipalities will also bear the cost of homes for the elderly and home helpers for the elderly and handicapped. The increase in the “personal budget” for dependent and handicapped persons, who can freely choose their service providers with the help of the sum allocated to them, is considered by some experts as being part of the market-driven policy that should improve the quality-price ratio of the service provided.

The main principle of this reform is to guarantee a health insurance system that is financially sustainable and accessible to all residents. But supporters of this system also wish to decrease the control of central government on the health system in favour of a well-supervised market-regulated system. On this point, it is surprising to see that no less than seven national agencies in charge of supervision and monitoring the new mechanism have been set up. Furthermore, incentives have been put in place to make insurers and the insured aware of health care costs.
For some experts, the 2005 reform is the re-emergence of the Dekker Plan, which “like a phoenix has risen from its ashes” (Van de Ven and Van de Gritten 2005). It is based on four main pillars: risk equalisation, raising users’ awareness of prices, a new form of rate-setting for hospitals, and finally, the definition of a standard health basket on a national level.

---

**Box 2: A theoretical outline as a basis for the 2005 reform**

As early as the beginning of the 1960s, following the founding work of J. K. Arrow, the issue of compatibility between market mechanisms and management of the health care system was raised from an economic theory point of view. The Dutch reform is largely based on these theories.

Creating an unorganised competition-based health care system comes up against “information asymmetry” between the demander (the patient) and the supplier (the professional or the health care structure). As professionals make their income from their activity, the risk of creating “supplier-induced demand” is very real. From these early beginnings, some economists have drawn the conclusion that competition in a health insurance system cannot therefore be in the form of a patient freely choosing a professional who would freely set his prices. Even more so when the large concentration of health expenditure, at a given time, for a very small proportion of the population, implies a significant increase in cross-subsidisation of the cost.

In light of these constraints, economists consider that competition can be introduced once health insurers have become “health care operators”. “Health care operators” who finance the expenditure of several patients can provide cross-subsidisation of the risk, which is necessary due to the concentration of expenditure for a small number of insured people. As a collective player, in liaison with professionals and health care structures, the operator can, in principle, reduce “information asymmetry”.

The theoretical outline calls on three main players: the insurer, the insured and the health care provider. The health care operator’s profits will come from the difference between premiums paid in by the insured and payments made to health care professionals and structures. Given the information that the “health care operator” can obtain on the cost and quality of care, this player should in theory, be able to negotiate prices. Professionals or health care structures, when placed in a competitive situation with other professionals or structures, should take the demands of “health care operators” regarding both prices and quality into consideration, if they want to ensure an income when signing contracts with these operators. The insured person and potential patient can choose between several “health care operators”. This choice is based on prices, but also on health and quality issues. The quality criterion is theoretically necessary to attract clients who can choose but also change their health care operator. In order to attract clients, the insurer cannot therefore focus on prices as a sole objective.

To move from this theoretical diagram to the implementation of a real reform, Dutch authorities have pragmatically created several mechanisms aimed at “leveling the playing field” for “health care operators” who are now in competition, restoring a certain price-sensitivity for insured people, while upholding the principles of solidarity-based collective funding and establishing a rate-setting means for hospitals in order for them to become competitive.
A relatively sophisticated risk equalisation system between insurers

Given the very large differences in the levels of spending between insured people, in relation to their age, sex and social status, one of the first issues to be resolved when implementing a competition-based health insurance system is that of “risk selection”, which would enable insurers to reduce their financial risk when choosing their clients. As Wynand Van de Ven has highlighted, the most effective strategy for reducing this risk consists in implementing a perfected compensation system “based on the health status of the insured” (Van de Ven 2004).

The objective of risk equalisation is not only to take into consideration the number of insured people, but also their social and economic characteristics when calculating the financial provisions attributed to each fund or insurer. In this way, for example, knowing that the average expenditure of an elderly person is higher than that of a younger person, risk equalisation will consist in increasing the provision attributed to the insurer who covers a higher number of elderly people. The main problem in this framework is in determining the criteria to be used and the weighting given to each (see Box 3).

The objective of compensation is not to equalise financial situations between different funds, but to compensate the differences in risk borne by insurers. It limits insurers’ interest in selecting clients and could encourage them to try to increase their profits by negotiating with health care providers, which, according to some experts, does not necessarily prevent indirect selection. As observed by the OECD, measures taken “to prevent insurers from trying to attract healthier populations, who are less costly to insure”, such as, for example, “banning discrimination in enrolment and implementing an experience-based system of risk compensation between insurers” reduce “incentives for insurers to manage costs and also require complex regulatory interventions” (OECD 2004a).

The 2005 bill unifies and improves the risk compensation mechanisms that will be subjected to continuous evaluation. During the transition period, the Dutch authorities came up against the difficulty of moving from a risk-compensation system, based on the retrospective reimbursement of sickness funds, to a prospective system, based on payment by the insured, adjusted in relation to certain characteristics of that person (see Box 3).

This risk equalisation operation is not carried out uniformly for all costs. A distinction is made between the different cost elements, by taking into account the fact that insurers have more or less power over these types of cost. The following costs are thus differentiated: ambulatory care costs, the variable costs of hospitalisation directly linked to care provision, costs
linked to specialist care, and finally, fixed hospital costs. Risk equalisation is carried out separately for each of these groups of costs. Nonetheless, although risk equalisation is very sophisticated, it is still imperfect and therefore the incentive to select risks continues for insurers.

**Box 3: Risk equalisation in the Dutch system**

Risk equalisation is carried out in five successive operations:

- Risk adjustment
- Consideration of “historic” costs
- Changes in the insured population
- “Isolated” costs
- Share of the risk borne by the insurer

These five operations apply in a differentiated manner to the four cost groups: ambulatory care costs, the variable costs of hospitalisation (directly linked to care provision), costs linked to specialist care, and finally, fixed hospital costs (with no direct links to care provision).

The **first phase** consists in taking into consideration the population covered by health insurers. Over the years, a certain number of criteria have successively been introduced.

- Age and sex: 19 age groups, 38 groups in total (1993).
- The type of insurance – here insured people are differentiated as being active, work-related accident victims, beneficiaries of social assistance, unemployed, or elderly (1995/1999). This criterion is subdivided into four age groups. Twenty groups in total.
- A regional criterion that takes into consideration the level of urbanisation, the regional variation of the health status and accessibility to care (1995/2002). Five groups.
- Groups of pharmaceutical costs (2002).

By using all of these criteria, an initial value for risk adjustment subvention (RAS I) is calculated.

In the **second phase**, and only in two cost groups, insurer’s expenditure for years t-1, t-2 and t-3 are taken into account for 30% of the total adjustment subvention.

$$\text{RAS II} = 0.7 \times (\text{RAS I}) + 0.3 \times \text{“historic” costs}.$$  

The first and second phases allow for an ex ante calculation of the risk adjustment subvention. The ex post calculation comprises the three remaining phases:

- In the **third phase**, a change in the composition of the population covered by the health insurer during the year is taken into account. For the first three cost groups it is the change in the population covered in number but also the changes in all criteria in phase I that are taken into account. For fixed hospital costs, only the variation in the number of people covered is taken into account.

- The **fourth phase** only concerns the first two cost groups. Here it concerns leaving exceptionally “large” individual expenditure out of the adjustment subvention equation and “isolating” them. When the annual expenditure of an insured person is above a certain threshold \(^{(1)}\) the central fund pays the sickness fund 90% of this expenditure.

- Finally, in the **fifth phase**, a rate that takes into account the scope of each health insurer to act on each cost group is applied. In this way, even though the risk borne by each insurer for the payment of ambulatory care costs is
100% of the adjusted cost, fixed hospital costs are spread among the insurers in such a way that they really only bear 5% of the costs. This mechanism is evolvable. It depends however on the availability of data and on political choices concerning risk spreading. Projects for developing the equalisation mechanism concern the introduction of new criteria, particularly for diagnosis-based cost groups, the disappearance of “historic costs” and consideration of the progressive move to activity-based tariffs for financing hospitals. In the long term, the fifth phase of calculation should disappear.

(1) As an example, €4,538 in 2001 – average spending in 2001 was €2,270.

**Raising users’ awareness of prices**

The reform retains the principle of collective financing of health insurance expenditure and seeks to ensure the fairness of financing through tax measures. It allows insured people to freely choose their insurer in relation to price, coverage and the care network offered, and the insurer is meant to become a “care operator.” Insured people now pay a premium that is not income-based but rather based on the policy package and the insurer chosen. Only employers continue to pay a contribution in proportion to the salary paid to their employees.

In order to raise users’ awareness of the real cost of care, the new law allows insured people to freely choose their amount of out-of-pocket expenditure and abandons the principle of contributions entirely based on income. The insured will therefore have the choice, as part of health insurance covering the “basic” health basket, between different levels of excess, or deductible (the remaining amount that is borne by the insured), the amount of the premium being modified in relation to the level of excess chosen. Nonetheless, in the logic of organised competition, the law determines a ceiling for the excess: it cannot exceed the sum of €500.

For the majority of the Dutch, this reform has led to a significant increase in their contribution. According to the Dutch Ministry of Health, Welfare and Sport (Ministerie van Volksgezondheid, Welzijn en Sport 2006) the nominal fee will average €1,100 per adult per year, whereas a person currently insured by a public health fund (ZFW) pays €390 per year on average. Privately insured persons, on the other hand, will come up trumps as their average premium was €2,000 per year on average in 2005.

Special tax provisions will reduce the non-redistributive effects of non-income based premiums. Low-income households (less than €25,000 per year for individuals and less than €40,000 for couples) will benefit from fiscal compensation for health paid by tax revenue. This will amount to €420 maximum for individuals and €1,200 maximum for couples. The financial loss is significant for all categories of insured people, with the exception of parents of children under 18 who were previously covered.
by private health insurance and who now no longer pay a premium for their children.

In addition, a bonus of €255 is granted to those who have not used the health care system during the year. Opponents of this measure have highlighted the risk of users deferring care. These users could in fact generate extra spending, raising the question of the general practitioner’s “gate-keeping” role. A compromise solution has therefore been found by maintaining the reduction of the user’s premium if he or she consults his GP.

Towards controlled medicalisation:
the new rate-setting of hospitals and doctors

Hospital funding will now depend on the hospital’s activity, allowing competition between establishments, at least in theory. Health insurers can, very progressively, contract out a growing part of their activity to hospitals and private clinics. The number of private clinics is on the increase. Initially, clinics were authorised to set up with the sole objective of reducing waiting lists. They are only allowed to perform certain medical interventions.

Hospitals benefit from strengthened financial autonomy and can, under certain conditions, negotiate their tariffs with insurers playing the role of health care operators. The authorities, in compliance with a progressive reform strategy, authorise the setting up of care structures that provide curative care not requiring a stay of more than 24 hours in hospital. These “new hospitals” are free to set their tariffs and can be for-profit structures. The authorities want to use the growth of this type of structure to transform hospital management methods.

For specialised care, the public authorities’ aim to achieve real competition between health care providers is based on reform of the system for remunerating specialists and hospitals on the basis of DBCs (Diagnostic and Treatment Combination), introduced on a step-by-step basis. Almost all specialists practise in hospitals, whether they are individual service providers at the hospital or part of a professional association. As Marie Wierink states, “their relative scarcity gives them a dominant position in tariff negotiations with hospitals.” (Wierink 2004)

The budget per DBC diagnostic includes all hospital expenses linked to a certain diagnostic as well as specialist’s fees. DBCs cover the whole chain of health care, from the first consultation to readaptation, intervention and treatment. For each DBC a local tariff is determined. All DBCs (about 600) were to have been introduced before 1 February 2005. A fixed segment, A, covering at least 90% of hospital care, is financed by tariffs set by DBC.
For the variable segment, B, (10% maximum of hospital care), insurers have been able to negotiate volume and prices with hospitals since 2003. From 2006 onwards, the variable portion will be progressively increased. One hundred DBCs concerning medical interventions where the waiting lists were the longest were prioritised in order to allow insurers to intervene in negotiations and to force structures to become more efficient.

The objective of this new type of remuneration of hospital and specialist treatment is to have a better knowledge of the volume and costs of health care demand, in order to improve the efficiency of hospitals and specialists.

**A standard basket of goods and services defined at a national level**

In the Netherlands, the existence of several well-marked health compartments meant that it soon became necessary to study the contents of a health basket covered by each of the compartments. The demarcation of goods and services covered by the different segments is voted by the Parliament on the health minister’s proposal. The health minister’s proposal is based on expert advice.

The health basket is defined each year on the basis of four criteria determined in 1991 by the Committee on Choices in Health Care, better known as the Dunning Committee, named after its chairman: the need for care, effectiveness, efficiency and responsibility. In order to determine the services necessary, three service groups have been differentiated: services for all members of the community that guarantee the normal running of society, services for all members of society to ensure that they remain capable of participating in social activity, and finally, services whose need is determined by the severity of the illness and by the number of patients suffering from it. Expensive treatment with a low success rate is considered to be the individual’s responsibility and is therefore not part of the services covered collectively.

The contents of a standard basket are quite extensive but certain limits have been introduced in recent years concerning dental care and prostheses for persons over 18. Jurisprudence is often called on to resolve cases of litigation. Doctors and insurers are the main deciders regarding interpretation of the contents and what should be covered or not. Today, in the new reform, the responsibility of defining the basket of goods and services is divided between several consultative committees as well as administrative bodies, and it is difficult to know who will actually make the final decision. For the DBC hospital rate-setting system, a foundation acting on behalf of different players in the health system (specialists, hospitals, insurers, patients) will be responsible for the system’s development and evolution.
Debates regarding the 2005 reform

The drawing up of the reform met with broad consensus. Consumer associations, which are especially powerful in the Netherlands, globally supported a reform in which they saw the possibility of increased choice for the insured, and pledged to implement information programmes that will help to determine more appropriate insurance packages based on certain characteristics (sex, age, medical history). Trade unions had serious reservations regarding the possible reduction of coverage for long-term and expensive care (AWBZ) – an area of major employment issues (assistance to persons in need) – and on the transfer of certain aspects of social and domestic care to municipal services. One of their main concerns in the drawing-up phase of the reform regarded tax measures that would be taken to reduce the non-redistributive effects of nominal premiums.

When the Parliament adopted the reform, consensus went up in smoke, mostly because for the majority of the Dutch population this reform led to a significant increase in their contribution.

But the most radical opposition appeared within the medical body and especially among general practitioners. For the entire population, access to care is through a general practitioner who acts as the gatekeeper of the health care system. Before the reform, GPs were remunerated on a capitation basis for patients covered by public health insurance (ZFW) and per consultation for patients covered by private health insurance. By merging the second health insurance compartment, public and private insurance funds came under the same rules, which therefore posed a problem regarding the remuneration system of GPs.

On several occasions, GPs demonstrated their opposition to the reorganisation of care that the reform involved. In 2005, making the most of their position of strength, Dutch GPs took strike action that was largely supported, enabling them to obtain, in July, significant improvements in anticipated remuneration levels and, above all, guarantees regarding future tariff negotiations between doctors and health insurers. Indeed, contrary to the initial project, which involved selective negotiations between an individual insurer and an individual doctor, the public authorities accepted the principle of collective negotiations between the organisation representing doctors and the joint representation of insurers. Before the reform, insurers already had the right, in theory, to sign selective conventions and to negotiate different tariffs with GPs; but in reality, the Council of Sickness Funds had shown that this option had never been used.

Applying a reform whose objective is to create competition between health care providers, and doctors in particular, through the establishment of a single set of national negotiations, seems contradictory to say the least. The
cause of this situation was the relative shortage of GPs, which made the introduction of competitive mechanisms in a limited-offer situation difficult.

However, although the balance seemed to be tipped in favour of doctors mid-year 2005, the situation radically changed in 2006. Health insurers concerned about higher-than-planned requests to change insurance company (25% of transfer requests instead of an estimated 10%), felt that in such conditions, they could not take part in negotiations with doctors and decided themselves what tariffs to apply. In response to protests from health professionals’ organisations, the Netherlands Competition Authority said that there had been no abuse of a dominant position.

Another reason for doctors’ concern was the interest shown by public authorities in redefining the allocation of tasks between doctors and nurses.

The transition period is particularly difficult for insured persons and insurance companies. Insurance companies have lowered their tariffs so much that the Central Bank has expressed its concern for the future. As for insured people, a large proportion of them seem to be disconcerted and lost in the arcane intricacies of a complex reform.

The issue of the evolution of relations between doctors and insurers/health care operators is not yet settled either. The capability of insurers to sign selective contracts with professionals is undoubtedly vital for the future of the Dutch reform.

■ Some questions regarding the future

Competition and solidarity

The integration of the “private” component of the second health insurance compartment into a single system will make part of the population that was not initially included enter a collective and mandatory system. This is one of the paradoxes of the Dutch situation: privatisation of the system leads to a higher level of socialisation of spending.

This integration is however, not without ambiguity. In the former system, families covered by the private element of the second compartment paid insurance premiums based on the size of the family. In the new system, children under 18 are covered free of charge, financed by government payments to the sickness funds. Families formerly covered by the private element of the second compartment have seen their insurance expenditure significantly reduced. Strangely, this advantage granted to better-off families is little mentioned in debates regarding the reform.
Furthermore, the debate on offsetting negative financial effects of the reform on certain population categories through fiscal mechanisms (non-redistributive effects of a fixed-rate premium paid by households) is not yet over, but is the subject of political discussions the outcome of which is not yet known.

**What choices for patients?**

The establishment of insurers acting as health care operators means that when users choose their insurers, this will also lead to the choice of a particular “health care network” – that of professionals who have signed agreements with the operator. Will the patient have the necessary information to make such a choice? Dutch authorities are aware that insured people need access to clear information so that competition can work. As the OECD underlines in a study on private health insurance, “the extent of the choice offered within the PHI market is somewhat obscured by a lack of information enabling people to easily compare PHI products and private health insurers” (Colombo and Tapay 2004). Consumer associations are currently implementing information programmes to help people make their choices. The first of these programmes came up against vigorous protests from insurers who question the criteria used by the consumer associations.

Apart from the possibility of choice, there is also the issue of patient mobility. In the past, the possibility for patients covered by social insurance funds to change fund did not lead to many people transferring. In Switzerland, despite large variations in tariffs proposed by insurers, insured people do not often use their right to change insurance company. A little less than 4% of the population moves from one insurance company to another each year. Conversely, the possibility granted to Germans covered by social insurance to change insurance fund has led to a relatively high level of transfers and a significant decrease in the number of funds. (Cohu *et al.* 2005). The initial figures available for the Netherlands show that competition between insurers has been based mainly on the cost of premiums, and that mobility has been higher than forecast, concerning more than a quarter of insured people, as mentioned above. What will happen when the reform is at “cruising speed?”

**The future of non-basket services**

The Dutch health insurance system, just as any other health insurance system, does not offer coverage for all health care and services offered by professionals. A part of health care is not covered, or is only covered by voluntary supplementary health insurance within the third compartment.
Insurers in the second compartment, which has now been merged, also offer voluntary supplementary insurance packages that can enable them to select patients through the options offered. Types of cover (prices and types of care) are one of the elements of competition between insurers within the second compartment. If what is covered within the third compartment is, and remains, relatively unimportant, the impact of this type of cover on the whole system will remain limited. But if the basic basket of goods covered in the second compartment were to be significantly reduced, then the impact of this extra level, in which there is unorganised competition, could become a deciding factor. Dutch authorities, aware of the danger of selection in this way, have offered insured people the possibility of taking out basic insurance with one insurer and supplementary insurance with another. But as has been observed in other countries, such as Switzerland, for example, it seems that the main check on mobility has in fact been supplementary insurance, which is normally taken out with the same insurer as the mandatory insurance.

**Will insurers really become “health care operators”?**

The future of the reform largely depends on the capacity of insurers to become real “health care operators.” As Dominique Polton and Lise Rochaix underline, “not only must insurers be able to manage care, they must also know how to do it. Managing the organisation of health care is a complex activity that involves the mobilisation of expertise and specialist competence in order to establish medical frames of reference and health care protocols and implement incentives and controls …” (Polton and Rochaix 2004). Following on from what these authors have said, we should bear in mind that the basic work of insurers consists in evaluating risks and pricing them and not in managing care. As seen earlier, despite being open to competition, the public health insurance funds (ZFW) did not become “health care operators.”

On the issue of insurers’ capacity to become “health care operators”, the implementation of the reform has brought to light a situation that was not foreseen during the debates that preceded the reform. In order to reduce the amount of premiums and to facilitate insurers’ management, public authorities had anticipated a possible 10% decrease in premiums, in the case of collective membership, by a football club, for example, or any other type of association. This clause was very successful and was particularly used by associations for sick persons. The reform hoped to promote two-way negotiations between insurers, who did not necessarily have competence in health care, and professionals who had the monopoly of this competence, at least initially. Three-party negotiations are starting to appear between insurers who have the financial means, professionals who
have the know-how, and a third player, associations of sick persons, which can provide the insurer-health care operators with collective expertise in the field of health care. Is this configuration likely to help turn insurers into health care operators?

Furthermore, competition between health insurers can only be effective if there are enough of them. The reforms in the 1990s have already led to a significant reduction in the number of health insurers, the merging of the two segments in the second compartment of health insurance does not necessarily increase choice for insured people, as sickness funds and private health insurers often belong to the same groups. The six largest groups currently hold 70% of the market (Van der Putten 2005). It is therefore important for the Netherlands Competition Authority to control the situation in the health insurance market.

Success of the reform will also depend on insured people’s choice of insurance policies. Indeed, if the insured mainly choose insurance policies providing reimbursement for health care rather than access to the insurer’s health care network, the insurer will have relatively little room for manoeuvre. In Switzerland, for example, users prefer insurance policies providing reimbursement rather than those offering access to a health care network.

The solution is even more difficult to find given that another paradox of the reform lies in the fact that it is undoubtedly through the constitution of health care networks and choice of practitioners under contract that insurers can practise greater risk selection.

For some experts, the Dutch reform sets “a dangerous precedent in Europe” as it weakens supporters “of the specificity of the health care sector in relation to market services” (Les brèves de l’assurance maladie 2005).

Finally, one should ask if, even though the European Commission has recognised the compatibility of this new form of health insurance with European legislation regarding competition, the European Court of Justice is not liable to sanction the relatively strict rules governing competition in the Dutch system. Under such an assumption, what would remain of “social insurance” in the Dutch health system?
Bibliography


LES BREVES DE L’ASSURANCE MALADIE (2005), no. 26, June, Brussels, Union Nationale des Mutuelles.


OECD (2004b), *Pays-Bas, economic study*, chap. IV « Le système de santé ».


VAN DER PUTTEN R. (2005), « Pays-Bas, la réforme du système d’assurance maladie en améliorera l’efficacité en améliorant la concurrence », EcoWeek, no. 16.


