National Health Insurance in the Netherlands, since 2006; a 100-year history

11th Caribbean Conference on National Health Financing Initiatives

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Invitation

The conference organizers invited me to give a presentation about:

1. Evolution of social health insurance in The Netherlands focusing on changes and adjustments over time;
2. Main features of current system;
3. Expected future challenges and likely coping strategies;
4. Lessons of experience for Caribbean countries.

Agenda

1. 1900-1941: three-tier system;
2. 1941-2006: two-tier system;
3. Need for a Third-Party Purchaser; **WHO?**
4. Towards NHI in NL;
5. 2006: one-tier system, National Health Insurance (NHI);
6. Evaluation Dutch healthcare reforms;
7. Preconditions regulated competition;
8. Conclusions and lessons.

Russia

The NETHERLANDS

U.K.

GERMANY

FRANCE

1. 1900-1941: a three-tier system

- **Poor** people: public provision of care, free of charge;
- **Low/Middle** income: voluntary membership of sickness funds (private initiative, no government regulation);
- **Highest** income: private, fee-for-service health care.
- Until 1941 no government regulation of health insurance.

Price discrimination by doctors

- Doctors accepted a **low** capitation fee for sickness fund members if sickness fund would only accept members up to a certain wealth/income level;
- For high-income patients doctors asked a **high** private fee for each item of service.

Sickness funds, 1900-1941

- 100's of local sickness funds: not-for-profit "mutualities" working in local communities;
- Benefits in kind;
- Each sickness fund sets its own premium;
- Community rated premium;
- Membership: 10% in 1900 up to 40% in 1940.

Many (N)HI-proposals since 1900

- In the last century many proposals for mandatory (national) health insurance have been launched;
- Reasons for failures:
  - Resistance from the doctors;
  - Resistance from the private health insurers;
  - Too large income redistribution;
  - Too large public health expenses;
  - Different political opinions;
  - …..

2. 1941-2006: Two-tier system

Sickness Fund Act (1941):

- **Mandatory** sickness fund membership for employees up to a certain income level;
- Income-related premium to Central Fund;
- Ideally: risk-equalized payments from Central Fund to sickness funds;
- For the time being: 100%-cost-based payments to sickness funds.

Sickness funds prior to 1941

Sickness funds are **financially autonomous** insurance-organizations

Sickness funds 1941-1991

Sickness funds are administrative organizations **without any financial risk.**

1941-2006: a two-tier system

- **Mandatory** sickness fund insurance (SFI) for lower-income people (2/3 population);
  about 50 regional sickness funds.
- **Voluntary** private health insurance (PHI) for high-income people (1/3 population): increasing problems with risk-rating and risk-selection (Act on Access to PHI, 1986).

Differences public-private HI

Differences public-private health **insurance**:

1. Differences in premium;
2. NO differences in use of medical providers, medical treatment or waiting lists;
3. Differences in prices of providers: high prices for privately insured;
4. Gov't regulation forced convergence of prices (**necessary for NHI!**).

From 1970 cost containment by gov't

From 1970 / 1980 increasingly more and more-detailed government regulation:

- Price controls; (including a gradual reduction of the huge differences in doctor's fee between SFI and PHI);
- Capacity planning & controls;
- Cost = Price * capacity;
- Macro-budget;

All with respect to private doctors, pharmacists and hospitals.

3. Need for a Third-Party Purchaser

The individual consumer is generally not a good purchaser of health care because of:

- Information asymmetry patient-doctor (→ supply-induced demand);
- Vulnerable position when you need care;
- Moral hazard (i.e. the use or provision of additional health care due to insurance).

Therefore, there is a need for a Third-Party Purchaser of care (on behalf of the consumer).

WHO?

Third-party Purchaser: WHO?

- Government: central, province, region (e.g. regional health authorities); e.g. in England, Spain, Italy, Sweden,…
- Sickness funds, (not-)for-profit insurers, …e.g. in the Netherlands, Germany, Switzerland, Israel, …
- Combination of government and sickness funds/insurers: as in many countries;
- ……

Tools for improving efficiency

Government: mostly legislation and other regulations with respect to prices, budgets, hospital planning, manpower planning, investments, certificate of need, etc.

Insurers: private contracts with the providers, selective contracting, negotiations about price and quality, etc.

International experience

In many OECD-countries three consecutive waves of health care reforms can be discerned:

1. Universal coverage and equal access;
2. Controls, rationing, and expenditure caps;
3. Incentives and competition/market.

David Cutler, Equality, Efficiency, and Market Fundamentals: The Dynamics of International Medical-Care Reform, *Journal of Economic Literature* 2002(40) 881-906.

The Netherlands: three waves

1. Universal coverage and equal access:
   - **1941: Sickness Fund Act**
   - **1968: AWBZ (Exceptonal Medical Expenditures Act)**
2. Controls, rationing, and expenditure caps:
   - **1971: Hospital Facilities Act**
   - **1982: Health Care Tariffs Act**
   - **1985: Health Care Facilities Act**
3. Incentives and competition:
   - **1988: "Dekker Reforms"**
   - **2006: National Health Insurance Act**

4. Towards NHI in NL

Dekker-reform proposals (1987):

- Regulated competition:
  - among insurers;
  - among providers of care;
- Compulsory health insurance for everyone.

Core of the reforms

The core of the reforms is that:

- **Risk-bearing insurers will be the prudent buyer of care on behalf on their members;**
- Government will deregulate existing price- and capacity-controls;
- Government will "set the rules of the game" to achieve public goals.

Sickness funds 1991-2005

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Risk Equalization Fund (REF)

income-related contribution

REF-payments based on risk adjusters

Consumer

Sickness Fund

community-rated premium

As it was intended in 1941….! Compare slide 11!

Problems private health insurance

- Risk rating and risk selection;
- Increasing problems of affordability of private health insurance;
- Many elderly and chronically ill people locked in into their ‘old product’;
- Young, low-risk people switch to the cheap new products;
- Self regulation: too weak;
- Government regulation.

Cost containment

- Price- and capacity-controls together with a macro-budget appear to be quite successful tools for cost containment by government in the period 1970-2000;
- From 2000 very strong cost increases!!

Health care costs as % GDP

1950	3.2 %
1960	4.3%
1970	7.2%
1980	7.8%
1990	8.0%
2000	8.2%
2004	> 10%

Towards regulated competition

Government declaration of policy (May 2003):

"The central planning by government has failed and will be replaced by regulated competition ***as soon as justifiable****"*.

Government on the one hand stresses the urgent need for reform and on the other hand indicates that not all preconditions for regulated competition are yet fulfilled.

Convergence of public & private HI

After 20 years of convergence the differences between mandatory **public** and voluntary **private** health insurance diminished:

- Medical prices equal for publicly and privately insured;
- Mergers between public and private insurers;
- Public HI market more competitive;

Ready for NHI: **public or private?**

5. 2006: one-tier system (NHI)

National Health Insurance Act (2006):

- Mandate for everyone in the Netherlands to buy individual **private** health insurance;
- Standard benefits package, broad coverage: described in terms of functions of care (flexibility!);
- Mandatory deductible: €385 (in 2016) per adult.
- Selective contracting & vertical integration allowed;
- Open enrolment & community rating;
- Risk equalization.

Risk Equalization Fund (REF)

Gov't contribution (18-)

(5%)

(50%)

Income-related contribution

REF-payment based on risk adjusters

(45%)

premium (18+)

Two thirds of all households receive an income-related care allowance (at most € 1896 per household per year, in 2016)

Consumer choice

- Annual consumer choice of insurer and choice of insurance contract:
  - in kind, or reimbursement, or a combination;
  - preferred provider arrangement;
  - voluntary higher deductible: at most 'plus €500' per person (18+) per year;
  - premium rebate (<10%) for groups.
- Voluntary supplementary insurance.

Criteria for basic benefits package

The basic benefits package should contain all care that is:

1. necessary, and
2. effective, and
3. cost-effective,
4. and that cannot be left to the individual's own responsibility or own account.

(Dunning-Committee on Choices in Healthcare)

Annual-premium range

Minimum premium-2016: €1.030

Average premium-2016: €1.180

Maximum premium-2016: €1.370

The annual-premium range
(the maximum premium minus the minimum premium for basic health insurance without a voluntary deductible):

- in 2016: €340;
- 2008-2015: between €277 and €340.

Regulated Competition

- Competition among <u>*health insurers*</u>: consumers have a periodic choice among health insurers and insurance products;
- Competition among <u>*providers of care*</u>: insurers and providers may selectively contract with each other;
- Not a free market; regulation to achieve society's goals.

Why no free market?

Due to the specific characteristics of healthcare (uncertainty, information asymmetry and externalities):

- ***unregulated*** healthcare markets result in inefficiencies (e.g. supply-induced demand);
- ***unregulated*** insurance markets make health insurance unaffordable for many people (due to risk rating and risk selection).

Insurer as purchaser of care

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Insurer

Insurance policy

contract

Private contracts!

Consumer

Provider of care

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Insurers' duty of care

- Insurers have a so-called 'duty of care': they must guarantee the delivery of care;
- The care must be delivered within acceptable maximum waiting times ('national norms');
- Insurers compete (also) on waiting times.
- If an insurer does not fulfill its contractual obligations, the insured can successfully go to court.

6. Evaluation Health Insurance Act

- The Dutch reforms started 25 years ago (Proposals 'Dekker-Committee');
- The Netherlands is the first country in the world that is consistently implementing the model of regulated competition in healthcare nation-wide.
- Is the 'Dutch experiment' successful?

Evaluation Health Insurance Act

- Evaluation of Health Insurance Act (dec09):
  On balance positive,
  despite some serious problems.
- No serious proposals (political parties, interest groups) for a return to the former system with a distinction between sickness fund and private health insurance.

Source: 'Evaluatie Zorgverzekeringswet en Wet op de zorgtoeslag', Den Haag, ZonMw, september 2009

See: http://www.zonmw.nl/nl/publicaties/detail/evaluatie-zorgverzekeringswet-en-wet-op-de-zorgtoeslag-1/?no_cache=1&cHash=e5b71da6107aad3ec72e6428d781092f

Positive effects NL healthcare

- Good system of cross-subsidies ('solidarity');
- Standard benefits package available for everyone, without health-related premium;
- Annual choice of insurer/contract;
- Increasing information about price and quality of insurers and providers of care;
- Strong price competition among risk-bearing insurers;

Positive effects NL healthcare

- Increasing insurers' activities in purchasing care;
- Some insurers reimburse only the cheapest medicine of medicines that are therapeutically interchangeable;
- Tendering generic drugs resulted in price reductions up to 90%;
- Insurers succeeded in controlling price and volume of care; now quality is on top of the agenda.

Quality of care

- Quality of care is becoming more and more an issue in the negotiations between insurers and hospitals, much more than a few years ago.
- In late-2010 one insurer announced: ***"We will no longer contract with hospitals A, B, C, D, E and F for certain cancer treatments because their quality of care is not high enough for our members."***

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7. Preconditions regulated competition

In addition to **general** (textbook) preconditions to let markets function effectively (e.g. a non-corrupt government, a system of property rights, an independent judiciary, a well functioning banking system, adequate solvency requirements for insurers, a well functioning system of general taxation, and good communication systems), also some **specific** necessary preconditions (due to the specific character of healthcare) can be distinguished that are not naturally fulfilled in competitive healthcare markets.

Necessary preconditions

Ten specific **necessary preconditions** for achieving efficiency and affordability under regulated competition in healthcare.

Source: Van de Ven, WPMM, K.Beck, F.Buchner, E. Schokkaert, FT Schut, A. Shmueli, J Wasem, 2013, *Preconditions for efficiency and affordability in competitive healthcare markets: Are they fulfilled in Belgium, Germany, Israel, the Netherlands and Switzerland?* Health Policy 109(3) 226– 245.

Ten specific preconditions

1. Free consumer choice of insurer
2. Consumer information and market transparency
3. Risk-bearing buyers and sellers
4. Contestable markets
5. Freedom to contract and integrate
6. Effective competition regulation
7. No incentives for risk selection
8. No opportunities for free riding
9. Effective supervision on minimum-quality
10. Guaranteed access to basic care.

1. Free consumer choice of insurer

- A free periodic consumer choice of insurer and insurance products covering a basic benefits package.
- No high switching costs, such as search costs, filling out forms, or losing supplementary insurance.
- Insurers are not allowed to refuse applicants for any basic health insurance product they offer.

2. Consumer information & transparency

- Sufficient public information on the price and quality. This information must be relevant, valid, reliable, objective, transparent and easily understandable.
- A manageable number of medical products and insurance products with a standardized benefits package to make value-for-money comparisons possible.

3. Risk-bearing buyers and sellers

- The buyers and sellers are individually risk-bearing (i.e. price- and cost-sensitive), both on the insurance market and on the healthcare provision market.
- Providers of care bear the full risk of running their practices, including the capital costs.

4. Contestable markets

- The provider and insurer markets are contestable (Baumol, 1982) as much as possible, i.e. there are no unnecessary barriers to enter or exit the market.

- E.g. no financial support by government to failing hospitals.
  (because that reduces the competitive advantage of efficient competitors that otherwise might have increased their market share).

5. Freedom to contract / integrate

The individual insurers and individual providers of care have freedom to (selectively) contract and negotiate the content of contracts (e.g., prices, quality, capacity and services), and to reduce the contracting costs by internalizing them through vertical integration.
(Williamson, 1971)

Selective contracting

Selective (differentiated) contracting is expected:

- to increase quality (keeping price equal);
- to reduce the price (keeping quality equal);
- to increase dynamic efficiency (innovation);
- to increase the providers' responsiveness to consumers' preferences, e. g. opening hours, waiting times, respectful treatment, coordinated care.

6. Effective competition regulation

Effective competition regulation to prevent anticompetitive mergers and cartels, and to prevent abuse of dominant positions.

(This precondition is complementary to -but not a substitute for- precondition 4 ‘contestable markets’.)

7. No incentives for risk selection

Cross-subsidies in the competitive health insurance market are organized *without* providing insurers with incentives for risk selection.

(Cross-subsidies should also not reduce the insurers' financial risk; see precondition 3)

8. No opportunities for free riding

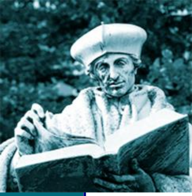
- No opportunities for free riding. (Free riders are individuals who avoid paying cross-subsidies.)
- Free riders increase the payments by the non-free-riders, and thereby reduce the willingness to cross-subsidize.

9. Effective supervision on minimum-quality

- The consumer in healthcare must be effectively protected against quackery and substandard quality care (because of her vulnerable position, e.g. information asymmetry, supply induced demand).
- Also consumer protection in other industries (e.g. airline industry and food).

10. Guaranteed access to basic care

- A guaranteed access for each consumer to sufficient good healthcare facilities at reasonable travel time without undue waiting times.
- This guarantee may be given by government, insurers, employers or another ‘third party’.



The Netherlands: preconditions fulfilled?

Precondition (maximum is *****)	1990	2006	2014
1. Free consumer choice of insurer	NO	***	***
2. Consumer information and transparency	NO	*	***
3. Risk-bearing buyers and sellers	NO	**	****
4. Contestable markets	NO	*	***
5. Freedom to contract and integrate	NO	*	****
6. Effective competition regulation	NO	***	***
7. Cross-subsidies without risk selection	-	***	***
8. Cross-subsidies without free riding	-	**	****
9. Effective supervision on minimum-quality	****	****	****
10. Guaranteed access to basic care	***	****	*****

Preconditions are not (yet) fulfilled

- Because regulated competition in healthcare is complex (preconditions!) its implementation will take considerable time, and the short-term effects may be limited, or even negative.
- Policy makers may then wrongly conclude that the regulated competition in health care does not work, rather than conclude that **important preconditions have not (yet) been fulfilled**.

Conclusions

The Netherlands made substantial progress in the last decades in fulfilling the preconditions for regulated competition, although there still is an ‘unfinished agenda’:

- adequate risk equalization (!);
- transparent consumer information;
- effective enforcement competition regulations;

8. Conclusions & lessons

1. One-tier system in the NL, a 100-year history:

   - 1900-1941: fragmented, unregulated three tier system; many NHI -proposals;
   - 1941: Sickness Fund Act;
   - 1941-2006: extension of both the number of SF-insured and the SF-benefits;
   - 2006: mandatory Social Private Health Insurance for all.

Conclusions & lessons

2. In the last century, in the NL: equal access dominated efficiency.
3. There is a need for a third-party purchaser of care.
4. Think carefully about: **WHO** is the third-party purchaser of care? (Gov't, insurer?; yes/no choice among insurers?)

Conclusions & lessons

5. No free market; regulated competition;
6. Regulated competition in healthcare: very complex, both technically (e.g. preconditions) and politically.
7. It is crucial that there is a powerful authority that can enforce the preconditions for regulated competition (i.e. can 'manage' the competition).

Conclusions & Lessons

8. The Netherlands made substantial progress in the last decades in fulfilling the preconditions for regulated competition, although after 25 years there still is an 'unfinished agenda':
   - adequate risk equalization (!);
   - transparent consumer information;
   - effective enforcement competition regulations.

Challenges

- Are insurers capable of being a prudent buyer of care on behalf of their insured?
- If **NOT**, what then is the rationale of a competitive insurance market with all problems of risk selection?
- Is government prepared to give up its traditional tools (i.e.global budgets) for cost containment?
- After 25 years the Dutch health care reform is still work-in-progress.

No realistic alternative

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Although some political parties argue against competition in healthcare(-insurance) and advocate a return to the former sickness fund system (with central government regulation), my conclusion is that **'in the Netherlands there is no realistic, politically viable alternative'** (see also slide 26!).

For this conclusion see also:'Evaluatie Zorgverzekeringswet en Wet op de zorgtoeslag', Den Haag, ZonMw, september 2009

See: http://www.zonmw.nl/nl/publicaties/detail/evaluatie-zorgverzekeringswet-en-wet-op-de-zorgtoeslag-1/?no_cache=1&cHash=e5b71da6107aad3ec72e6428d781092f

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1. Evolution of social health insurance in The Netherlands focusing on changes and adjustments over time;
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I hope I succeeded in doing so.
Thank you for your attention.