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Contents

How sustainable is a market-based approach to the German health system?

Ulla Schmidt

On 7 February 2005, Ulla Schmidt, the German Federal Minister for Health and Social Security delivered a speech at the London School of Economics and Political Science. This article is a slightly abridged version of Minister Schmidt's speech.*

For a long time in Germany regulatory policy discussions on the health system tended to focus on a legal or social policy perspective. Stimulated by the developments in the US and the UK, health economics then evolved into an independent academic discipline. Within that discipline, there is a conflict between advocates of a market-economy orientation in the health system and supporters of traditional self-government. The idea of a health system under state governance, such as the British National Health Service, has never found much support in Germany.

When trying to approach the issue of 'market orientation in health care' on a political level, there are two main lessons I have learnt through experience:

1. Whoever calls for more market orientation will usually not want to have that principle applied to him or herself. This is true both for political parties and for players involved in the health system.

2. Whoever claims to be committed to deregulation will often end up making proposals that by far exceed the volume and intensity of existing regulations.

This practical experience leaves a lasting impression on my reflections on the sustainability of market-economy-based approaches to the health system.

The task of health policy in Germany and everywhere else is to find concrete solutions for real problems. And these solutions often elude attempts at categorization or classification. Leaving headlines, targets or catchphrases aside, it is more than problematic to find a coherent philosophy for regulating health systems and to implement it. This is not to say I support political arbitrariness, but I would like to outline a realistic perception of past reforms in the German health system and future prospects.

There is a marked and undeniable trend towards more competition in the health system but I would be loath to call that a coherent market-oriented approach. In contrast to past debates, competition is no longer discussed as an ideological bone of contention in the German health system but is used as a very functional means to foster innovation, to enhance the effectiveness of the insurance system and health care provision, and to allocate resources more efficiently.

Since the introduction of the social market-economy after the Second World War, there has been widespread consensus in Germany that a market economy (and competition as the key element) needs a stable regulatory framework. This is especially relevant with regard to the peculiarities of the health system.

I have many doubts whether market orientation alone can guarantee sustainability of a health system. If insurance is not mandatory, as is the case in the US, its kind and *scope* is often linked to employment. Insurance policies then also have a right to restrict benefits in cases of severe illness. This means that in such systems, being ill becomes an existential risk in life that can financially ruin even well-

* *The lecture was organized by the LSE German Society as part of the German Symposium.*

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to-do members of the middle class.

In preserving health and providing care in case of illness, the market forces of supply and demand therefore must not be given free rein, especially in the individual relationship between patient and doctor. This also applies to the kind and scope of protection against risk. Otherwise the question of whether or not someone is protected sufficiently against potential risks would depend exclusively on their financial capacities and their ability to act with foresight. Many young and healthy people would be tempted to neglect such provisions. In old age or in the case of illness, however, they would be left with no opportunity whatsoever of obtaining adequate insurance at an affordable price. That is why the essence of what is medically necessary should not be left at the disposal of the individual. This is true both for the scope of insurance on the demand side and the design of services offered on the supply side.

Please do not get me wrong: I think it is a very good idea to give people freedom of choice and options for individual arrangements within the health system. In the 2003 health reform, we have considerably extended the options available to insurance members, patients, insurers and care providers. This is valid even beyond the borders of our own country, within the European Union.

However, this is not the same as saying that we would accept a transformation of the solidarity-based system of statutory health insurance into a genuine market model. A future in which the individual citizen would be at the mercy of the market power of insurance funds and care providers, where it is hardly possible to monitor for quality control or value for money and where comprehensive health priorities cannot be implemented, seems thoroughly undesirable from our point of view. The free movement of goods and services within the European Union and the rulings of the European Court of Justice on 'utilization of health care services abroad' will do nothing to change this. Health is not merchandise like any other and it never will be.

This fundamental decision in favour of maintaining the cornerstones of the German solidarity-based health system does not, however, mean that we reject regulatory elements based on a market economy or competition. Traditionally, the role of the legislator in Germany has been restricted to establishing framework conditions. This framework is then given a concrete shape to be applied in a uniform way to all actors at a medium level – usually formed by associations, health insurance funds and health care providers.

The power of associations was limited by our reform in favour of initiatives by individual health insurance funds and health-care providers. These now have the possibility to make arrangements that deviate from collective contracts if certain health policy objectives are met. To name just a few key aims in this context: better integration of outpatient and inpatient care which have been kept rigorously separate in Germany; upgrading treatment by family doctors; improving the quality of treatment; and treatment of chronic diseases based on guidelines.

On top of that, we have created financial incentives in the form of budgetary allocations for new forms of health care provision. These new forms are made attractive for insurance members by granting bonuses in the form of discounted co-payments or other services. Special incentives are also provided to stimulate a rational use of services and healthy lifestyles. These elements exemplify a restructuring of the system with the objective of improving the quality of health care and to channel resources to where they can be used more effectively and efficiently. That is why the question for concrete health policy in Germany is not 'More market or more intervention?' but 'How much market and how much intervention?'

The relationship between the market and intervention will always have to be brought into balance anew. And politics will always have to correct undesired trends. This knowledge, of course, also influences the answer to the question of the sustainability of market-oriented, or to be more precise, competition-oriented approaches. From our point of view, sustainability means first and foremost that we have to evaluate continuously whether developments have materialized as predicted.

Considering my own experience, I am not too sure that market-based approaches will prevail in solving the problem of sustainable financing of health expenditure. That is why it is all the more important to consider alternative forms of financing. Forms of financing that:

- treat all citizens equally;
- maintain the concepts of solidarity, subsidiarity and individual responsibility;
- take into account all forms of income in calculating contribution rates; and
- intensifies competition between statutory and private health insurance.

As you may know, in Germany contributions to social insurance are equally shared by employers and employees, deducted from wages. These non-wage labour costs are putting a strain on the price of labour in the international competition to attract business. Therefore, we also need to discuss how companies will contribute to health system financing in the future. Allow me to draw your attention to the fact that in the statutory health system, which has an annual budget of €140 billion, we have refinanced and generated savings in 2004 of €10 billion due to our reform. This helps health insurance funds consolidate their finances and makes life easier for companies. But it is part of the so-called 'German disease' that people do not acknowledge this progress.

I have a great interest in making companies continue their commitment to the health of employees and limit health expenditure. The latter is particularly relevant in reducing costs in the area of what is medically necessary. I am also aware however, that health care is an important branch of industry, with the potential of becoming a significant growth market in the future. On the other hand, it is clear that without certain limitations, health expenditure would rise beyond control without generating corresponding benefits for patients. This can be demonstrated by the example of the pharmaceuticals market, where it is easier

for companies to present a new variety of a successful product after a patent has run out rather than launching a genuine innovation on the market since in Germany every approved medical product is automatically reimbursed by the statutory health insurance. A monitoring of profits, as is customary in the United Kingdom, does not take place.

The consequence has been that the costs for drugs under patent have doubled during the past 10 years to nearly €19 billion. This is not what market elements in health care should look like. That is why we have extended the system of 'maximum reimbursement amounts' to include pharmaceuticals under patent protection that offer no therapeutic improvement for patients. Contrary to what is described in the international press, this system is not an intervention in free market pricing but a limitation of reimbursement by health insurance funds. According to our experience, this concept virtually initiates competition for genuine innovation.

Market incentives and administrative rules have to be adapted continuously to changing settings. Developments in medical science, in pharmacology, in medical technology and changes in the demographic, social and economic environment will further increase pressure for rationalization in health care.

The key factors in expenditure development are not exclusions, limitations and co-payments. According to a very simple rule of thumb, 20% of all citizens account for 80% of all expenditure and the majority of costs arise in an insurance member's last year of life. If you want to avoid an ethically questionable rationing of the health care system along the lines of what is possible in financial terms, and refrain from merely shifting the burden to future generations, you will not be able to escape thinking about a rational use of resources, along with a sustainable financial policy in health care. In this area, market-oriented and competitive approaches have not yet been used to their full extent. One example is the success of the €10 doctor's fee charged for the first consultation every quarter. The number of doctor's visits (to specialists in particular) and expenditure for pharmaceuticals were reduced by 10%.

Without wanting to lose myself in detail, I do advocate a relationship between health insurance funds and health care providers that is characterized more clearly by competition. When talking about sustainability, the issue of prevention should not be left out. Investing in health is a prerequisite for avoiding disease and limiting financial burdens. Last week, I introduced a draft law, which for the first time ever obligates all players to concerted action and pools all initiatives targeted at reaching national objectives. Sustainability thus has a dimension that is specific to health policy.

Allow me to summarise what I have said: the debate about regulatory alignment in health care does provide some orientation in the health policy discourse. Its usefulness in solving practical problems, however, is limited.

Health care will always be subject to the conflict between competition and regulation. Considering enormous social, demographic and economic change and increasing possibilities in the field of diagnostics and therapy, everything will depend on our ability to develop pragmatic approaches to regulation, ensuring high-quality health care for the citizens of our country at affordable prices.

The trend is turning towards a greater significance for the individual level rather than for collective contracts and state regulation. As a consequence, there will be more intense competition on the supply side, both between health care insurance funds and health-care providers.

In order to avoid unwanted effects in the health care system, which is only subject to market forces to a limited extent, there must be a coherent political framework, allowing for swift corrective action if necessary. Only if we succeed in avoiding adverse incentives and selection, can market-oriented and competition-based approaches contribute to sustainable health and financial policy.

The politics of health care financing reform in Germany

Kai Mosebach

Health care reforms in Germany are embedded in the corporatist structure of the health care system and the federalist structure of the political system. Due to the distribution of power both institutional contexts require a consensus process to make health care reforms work. In the summer of 2003, political and economic pressures, as well as high public expectations, gave rise to negotiations between the political parties in government at both the *Bund* (federal level) and the *Länder* (state level). The Social Democrats (SDP), Greens and Christian Democrats (CDU, including the Bavarian Christian-Social Union, CSU) agreed to pass the *Statutory Health Insurance Modernization Act* (SHIM Act), which came into force on 1 January, 2004. But soon after the Federal Assembly (Bundestag) and Federal Council (Bundesrat) passed this reform act, further debates over different health care policy options surfaced during the implementation process, thereby anticipating the politics of health care financing reform.

Policy goals of the SHIM Act

After the surprising victory of the 'red-green' government coalition in the federal

parliamentary elections of September 2002, public opinion polls and a powerful media expected the federal government to initiate a comprehensive health care reform that would end inefficient health service provision and adapt the German social security system to the pressures of globalization.

In the middle of debating the first draft of the health care reform act in June 2003, the social policy agenda of the SDP was shaken by Chancellor Gerhard Schroeder's *Agenda 2010*, which aimed to make the German welfare state more internationally competitive.[1] On health care policy, *Agenda 2010* stressed the importance of balancing solidarity with self-responsibility and making health care delivery more efficient. Therefore, the overall policy goal of the consensus negotiations was to lower wage costs by reducing the statutory health insurance contribution rate.

Led by federal health minister Ulla Schmidt (SDP) and the health minister of the previous conservative-liberal federal government, Horst Seehofer (CSU), these policy measures were not, however, limited to economic objectives. The SHIM Act consisted of a policy mix of new cost-sharing mechanisms as well as measures to streamline the benefits package and make health care service provision more efficient, effective and responsive to the needs of patients.

The politics of policy formulation and implementation

The SHIM Act introduced a new system of cost-sharing consisting of a flat-rate user charge (€10) and an additional co-payments per service (mostly 10% of the costs of the utilized service and a capped maximum [€10] for each single service or day of treatment). The flat-rate user charge has to be paid at least once quarterly on the first contact with a general practitioner (GP). Further visits to the same GP or to a referred specialist, as well as visits associated with prevention or disease management programmes, do not incur the charge. Compared to 2003, visits to statutory health insurance (SHI) physicians subsequently dropped by 4.6% in the first quarter of 2004.[2]

Furthermore, the Act withdrew previous social hardship exemptions and set a ceiling on individuals' out-of-pocket co-payments (excluding children under 18 years) at 2% of yearly gross income (1% for the chronically ill).

The new cost-sharing system led to severe problems. Homeless people and long-term care inpatients, who are financed from public assistance schemes, could not find enough money to pay the required user charges in advance. In response, a new law was introduced obliging public assistance bodies to grant interest-free loans to long-term care inpatients, to be repaid over the year. Nevertheless, the burden of cost-sharing mostly will affect the chronically ill with low gross incomes. According to a recent study, the burden of cost-sharing would rise in parallel with each age group above 65, groups which have are rising share of the chronically ill and low old-age pensions.[3]

The reduction of the SHI benefits package was not only heavily debated between the governing parties and the opposing conservative parties, but also caused continuing divides within the parties. The SHIM Act originally excluded dentures, non-prescription drugs (mostly alternative medicines), some medical aids (spectacles), transportation services and some cash benefits (for example, death benefit), from the benefits package and was expected to reduce SHI health care expenditure by approximately €2.5 billion per year (1.9% of total SHI health care expenditure in 2002).

However, due to political pressure from the public, patients' organizations and internal partisan discussions, the 'red-green' government partly revised the exclusion of non-prescriptive drugs and reinstated some non-prescriptive drugs into the benefits package. Moreover, the dentures exclusion will be withdrawn altogether as neither the SDP/Greens, nor the statutory sickness funds are keen on this exclusion, fearing that making people purchase flat-rate supplementary insurance to cover dentures might prejudice other reforms on health care financing. Following a political compromise between the government and the conservative opposition parties, employees will now pay for dentures coverage through their health insurance contributions (a rise of approximately 0.9%) without employer contributions.

The reform introduced several measures to improve the efficiency and effectiveness of health care service provision. On the macro-level it established the *Institute for Quality and Efficiency in the Health Care System* (IQWiG), a German version of the National Institute for Clinical Excellence (NICE) in the UK. On the meso-level the law offered several opportunities to health-care providers and sickness funds to make health-care provision more efficient by strengthening gatekeeping, managed care and selective contracting. To that end, sickness funds have to establish gatekeeping structures and should set incentives for its contributing members to use them (for example, by reducing co-payments).

Concerning integrated care, sickness funds can contract with health care providers across sectors under one contract with a sickness fund. Integrated care is a German version of the concept of managed care, which aims to overcome the regulatory split of the German health care system into ambulatory and hospital care, with its duplication of specialists in each sector. Under the SHIM Act, sickness funds can contract provider services without the formal approval of the Association of SHI Physicians. Thus, selective contracting of provision is made possible.

However, the Association of SHI Physicians is still mainly responsible for delivering an adequate level of ambulatory care through block contracts. Therefore, the growth of integrated care will depend on its comparative advantage against the traditional model of block contracts for both sickness funds and health-care providers. To foster its growth, integrated care will be financed with an additional 1% of the sickness funds' resources for primary, secondary and tertiary care from 2004 to 2006. On the micro-level, SHI physicians will be obliged to meet defined quality standards in primary care and secondary care.

Citizen insurance versus flat-rate insurance

Health care financing is a major issue in German health care politics. After promoting structural change in health care provision, health policy stakeholders are debating competing options on how to fundamentally change the financing of health care in Germany.

In 2002, the red-green government established an expert commission to examine ways to adapt the statutory insurance system to the challenges of demographic change, technological innovation and globalization (the so-called Ruerup Commission). Reflecting the goals of *Agenda 2010*, the commission started from the premise that income-related statutory insurance contributions should not be permitted to rise steeply as this would undermine the international competitiveness of the German economy. However, due to its wide range of members with different views, the Commission did not recommend a single approach and in the summer of 2003 proposed two alternative models for controlling the contributions' growth rate.

The first option proposes universal *citizen insurance* achieved through enlarging the scope of the SHI scheme to cover all income types and levels and all citizens. This would end the provision of substitutive private health insurance (PHI) purchased by high-income earners who can voluntarily opt-out of SHI.

The other policy alternative was the establishment of a *flat-rate insurance* scheme which would require individuals to purchase a basic health insurance package from a public provider, with insured people paying the same flat rate. This option would shift the redistribution mechanism of SHI to the tax system which would subsidize poor households to obtain insurance cover. Beyond this redistribution aspect, this policy option accepts the continuation of substitutive PHI.

The redistributive effects of both policy alternatives have been assessed: while the citizen insurance option would burden higher income groups the most, the flat-rate insurance option would diminish the insurance burden of higher income groups.[4] In the end, the Commission concluded that the ultimate decision had to be made by politicians.

The political front lines also are not clear-cut. The SDP and the Greens decided to endorse the citizen insurance option. However, both parties' versions differ in some respect from the model proposed in the Ruerup Commission and these are still being debated.

Due to internal tensions over housing policy the SDP has insisted that only interest income, in addition to salaries and wages, should be counted when calculating SHI contributions. Moreover, it is not clear how the many legal and political objections to integrating the current voluntary substitutive PHI scheme into SHI can be overcome.

The Greens are offering a policy that is closer to the Ruerup Commission's citizen insurance proposal. They have stuck to its model of subjecting all types of income (not only capital income and salaries) to SHI contributions. However, they have questioned the right to co-insurance (coverage for dependents) of unemployed spouses or cohabitants, arguing that if people in this category do not raise children or take care of the elderly, then co-insurance status should be withdrawn. Instead, the Greens favour both partners in a long-term relationship to each pay a SHI contribution.

The Christian Democrats prefer the flat-rate insurance option. The Herzog Commission – a counterpart to the government's Ruerup Commission – chaired by the former German President, Roman Herzog, has recommended that a capital funded flat-rate insurance scheme should replace the current SHI system in 2013 when a build-up of capital funds will be completed. Similar to the Ruerup Commission's flat rate insurance model this policy shifts the redistribution of income to the tax system, leaving only the redistribution of insurance risks and the co-insurance of children within the SHI scheme. According to the Herzog Commission's calculations the redistributive pool of funds will require an annual state subsidy of €27.3 billion accounting for 12.5% of total health expenditure and 22% of SHI health expenditure in 2001.[5]

In the short term (2003–2013), like the Greens, the Herzog Commission has questioned the co-insurance status of unemployed spouses if they do not raise children or undertake elderly care. Additional proposals include the introduction of defined health insurance contributions for employers and limiting the benefits package.

In contrast to its sister party, the Bavarian CSU has been very sceptical about flat-rate health insurance. Although a member of the Herzog Commission, the former German health minister and chairman of the trade-unionist wing of his party, Horst Seehofer (CSU), criticized the conclusions of the Herzog Commission.

Seehofer has questioned the financial foundations of the flat-rate-insurance option, and in particular has argued that additional tax subsidies are not compatible with the CDU's tax policy proposals which seek to limit citizens' tax burden, which if implemented, would also have an impact on available tax revenues. Additionally, flat-rate insurance would affect lower income households as well as families, thereby contradicting the CSU's social policies geared towards subsidizing families in need. On the other hand, the CSU has also criticized the subjection of additional types of income (capital income, interest income and the rental income of small and medium households) in the Ruerup citizen insurance model.

Finally, the Liberals argue for a privatization of the SHI sickness funds and the introduction of risk-adjusted premiums. Under these proposals, health care insurance should be mandatory and the allocation of insurance premiums should be accompanied by redistributive funds out of taxes, similar to the CDU model. However, the Liberals have not discussed their model as thoroughly as the other parties, nor have their proposals been evaluated for their financial implications.

What could be the outcome of all this? Given the distribution of power in the

Bundesrat the introduction of citizen insurance is a less realistic option than a flat-rate insurance scheme. The same holds for the proposals of the Liberals. Therefore, the consensual solution that may emerge might involve a hybrid of both policies proposed by the conservative parties.

In fact, on 15 November 2004 both conservative parties (CDU and CSU) agreed to put forward an income-adjusted flat-rate insurance contribution (€169). This combines a maximum individual income-adjusted rate paid by the employee (7% of the employee's gross income with a maximum payment of €109) with an income-related, defined contribution rate paid by the employer (6.5% of the employee's gross income).

Overall, each member would contribute €169 per month: representing the ratio of total health care expenditure to the number of members insured under SHI. The employer's contribution would remain uncapped.

If the total of the employer's and employee's payments exceeds the target of €169, the excess would be pooled in a government-run Employers' Solidarity Fund. However, if the target payment is not reached, revenue would be taken from the Employers' Solidarity Fund to make up the difference. Therefore, lower income groups would pay lower health insurance contributions.

Seehofer (CSU) still criticized this proposal as too bureaucratic and financially unfeasible. Having upset many politicians in the CSU and CDU, Seehofer finally resigned on 25 November 2004 as deputy leader of the joint CDU/CSU parliamentary group in the Federal Assembly.

Finally, it is also not clear how the CDU/CSU's policies might affect voluntary substitutive PHI. While the proposals of the Herzog Commission might lead to a fusion of SHI and substitutive PHI within a flat-rate-insurance scheme in the future, the recent proposal by CDU/CSU seems to reflect the current situation where SHI co-exists with PHI. Consequently, the debates are still running and the jury is still out.

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The health care system and reform in the Netherlands

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The Dutch health care system is not only complex to describe, but is also constantly undergoing debate and discussion on the possible integration or separation of its different parts. Three different sets of insurance, governed by different bodies, exist: (1) a national health insurance for 'exceptional medical expenses'; (2) compulsory sickness funds for persons under a certain income and private, mostly voluntary health insurance; and (3) voluntary supplementary health insurance. The second set, separated into compulsory insurance for those under a certain income and a rather large segment for private insurance, has noticeable repercussions on the funding side with regard to equity, and has been the impetus for various reform initiatives over the last 15 years that are still being debated.[1]

Actors and organization

The Ministry of Health, Welfare and Sport (VWS) defines policies to ensure the well-being of the population, and with this aim, it established the social health insurance schemes under the *Exceptional Medical Expenses Act* (AWBZ) and the *Sickness Fund Act* (ZFW).

Simplified, the AWBZ covers long-term care and high-cost treatment. With very few exceptions, everyone living in the Netherlands is covered by this act, which is responsible for approximately 40% of health expenditure. The cost of insurance is covered by percentage contributions and government funds. The employed have contributions deducted from their earnings, others who are liable for tax/social security contributions are issued with an assessment for percentage contributions and no contributions are made by those with no taxable income.

The costs of normal, necessary medical care are largely covered by sickness fund insurance, private medical insurance or a health insurance scheme for public servants (these three components make up approximately 50% of health

expenditure). The most important insurance scheme, covering 63% of the population, is that administrated by the ZFW. This comprises those with salaries under €32 600 (2004) and all social security recipients. Revenue to operate the ZFW comes from employer/employee contributions (both percentage and flat-rate), a government grant, and a private sector contribution, all of which (with the exception of the flat-rate contribution) are channelled through a central fund managed by the *Health Care Insurance Board* (CVZ).

There are currently 22 sickness funds which are supposed to compete country-wide for members. The CVZ manages the actual implementation of the AWBZ and ZFW regulations including the central funds of the two systems. The *Supervisory Board for Health Care Insurance* (CTU) supervises individual executive agencies and the overall implementation of the ZFW and the AWBZ. It is mandatory for the sickness funds to contract all accredited institutions, although they do not need to contract with all individual providers. This is done through a consultation process between the representative organizations of health insurers and providers, which then has to be approved by the CVZ.

Private health insurance (covering 30% of the population) can be provided by two different categories of tariffs: the standard policy provided under the Health Insurance Access Act (WTZ) and other forms of policies. Standard policies are funded from premiums and WTZ surcharges paid by the privately insured (who, in addition, pay a so-called MOOZ* charge as a transfer into the ZFW central fund). While no one is obliged to take out the standard policy, all insurance companies are required to offer it, and people meeting the statutory criteria may apply.

* The MOOZ (*Over-representation of Elderly Health Insurance Act Beneficiaries Joint Financing Act*) is a surcharge that private policyholders pay as a contribution towards the sickness fund insurance as long as the elderly are over-represented within the sickness fund scheme.

The Pensions and Insurance Supervisory Authority (PVK), a body established under the Insurance Business Supervision Act, supervises private medical insurance. However the standard policy scheme under the WTZ is supervised by the Ministry of Health, Welfare and Sport.

There has been an increasing shift in the Netherlands from government to the private sector (*delegation* or *functional decentralization*), as well as a transfer of competencies from central to provincial/local governments (*devolution* or *territorial decentralization*), and this can be illustrated through the increased influence of local and provincial governments in planning.

Financial resource allocation

Since 1991, sickness funds have been subject to a 'double budgeting system'. On the one hand, each sickness fund receives a budget from the CVZ (approved by the Minister) by means of risk-related capitation payments, the difference between the allocated budget and expenditure being covered partly by the flat-rate contributions which each fund determines itself. The risk adjustment system is based on a number of factors and has been modified over time. On the other hand, sickness funds negotiate budgets with providers, as well as the quality, quantity and, to some extent, price of services. This system should give the funds the flexibility and incentive to purchase care as effectively as possible, and also encourage market competition. The CVZ adjusts for part of the difference between the total budget allocated to sickness funds and actual expenditure, relating to the ability of the sickness funds to influence the level of costs (the recalculation percentage). In 2002, the percentage of full risk for the sickness funds had reached 41%, up from 3% in 1995 – and it is estimated that the risk will rise to 53% in 2004.

Health care delivery system

Primary health care is well developed and is provided mainly by family physicians (GPs), the central gatekeepers and dominant figures in the system. Each patient is supposed to be on a GP patient list and must be referred to specialist physicians or a hospital by their GP. The impact of gatekeeping is illustrated by the low referral rate (primary care constitutes two out of three ambulatory care contacts). GPs maintain independent and largely individual practices in each community. They are paid on a per capita basis for patients insured under the ZFW and on a fee-for-service basis for those privately insured.

Secondary and tertiary care is mainly provided by medical specialists in hospitals with both outpatient and inpatient facilities. Over 90% of hospitals are private, non-profit facilities, the remainder being public university hospitals. Hospitals have increased their capacity through mergers or expansion despite the required decrease in beds in each region. Since 1980, this has lowered the number of acute care beds by over one-third to 3.1 beds/1000, a value well below the EU15 average. The Netherlands is the only social health insurance system with waiting lists for certain specialist and long-term care treatments, albeit shorter than in most tax-financed systems.

Since 1998, there has been a function-directed overall budget system in hospitals. Financing is through the fees charged by the hospital to insurers or patients. Since 2000, payment has been performance-related, and this is the first step towards changing the hospital payment system to a DRG-type Diagnosis Treatment Combinations system (to be introduced in 2005), both of which where instigated because of disincentives in the old budgeting system and therefore to stimulate efficient processes in hospitals. Medical specialists in outpatient departments of hospitals are also paid by this new system.

Health care reforms

Health insurance has moved back and forth between efforts to either unite the different insurance schemes into one or to retain the existing separations.[2]

The Dekker report, published in 1987, prompted a government response which recommended removing the divisions between cover under the ZFW, private

insurance and the insurance schemes (public servants), and moving to single a national insurance scheme providing basic cover for everyone. The idea was to have an income-related premium with a small flat-rate component and people would be able to take out supplementary private insurance for care not included in the basic package. The changes were to be phased in from 1989, with the gradual disappearance of the distinction between sickness funds, private insurance and public servant schemes.

This attempt to unite all social and private health insurance schemes into a single mandatory scheme – now under the Simons Plan, which included key components of the Dekker report – failed in the early 1990s, mainly due to strong opposition from health insurers, employers and physicians.

During the 1990s, however, many incremental reforms were implemented. Important reforms helped pave the way for health insurance for the whole population, such as the Health Insurance System Act of 1992 which transferred cover for certain services (for example, pharmaceuticals) to the AWBZ (these were transferred back a few years later). Other reforms include introducing open enrolment and dissolving sickness funds' regional monopolies, which increased patients' choice of third-party payer. On the other hand, mergers among both insurers and hospitals have decreased patients' choice. Interestingly, many of the smaller reforms introduced during the 1990s were part of the original Dekker and Simons Plans.

Looking at reforms over the last decade, a shift of responsibility for purchasing care from government to insurers can be observed as a consistent trend. A second trend is towards more competition among providers of care. A third trend is the progressive way of thinking about a combination of market and non-market elements in health care.

At last, it looks like health care reform will be successful in the Netherlands. A huge obstacle was overcome on 22 December 2004, when the House of Representatives – without the support of the biggest opposition party, the Social Democrats – passed legislation that introduces a compulsory standard insurance policy for everyone (Health Insurance Act) and a compensation scheme (Health Care Allowance Act), scheduled to come into effect on 1 January, 2006. Both the health insurance and health care allowance now only need to be accepted in the Senate. Accordingly, statutory health insurance under the ZFW will be united with private health insurance into a single scheme. Sickness funds will then operate on a for-profit basis with flat-rate contributions. Apparently, the new scheme also complies with the EU third non-life directive since private health insurance companies have the obligation to contract and charge non-risk based flat-rate contributions, and therefore act in the interest of the common good.[3]

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