

# Managed competition in the Netherlands: an example for others?

Ewout van Ginneken, Willemijn Schäfer and Madelon Kroneman

*Summary: The introduction of managed competition in the Netherlands in 2006 fundamentally changed the roles of patients, insurers, providers and the government. Health insurers are expected to negotiate with providers and purchase efficient care of good quality. Patients are expected to critically assess and select the health insurer and provider of their choice. In this ongoing transition process all players should receive the appropriate tools to fulfil these roles. Important challenges remain: patient information on price and quality should be continuously improved; the risk adjustment system needs continuous refining; quality has to be made visible and measurable; the DBC (Diagnose Behandelings Combinatie) system, comparable to a DRG system, must be reformed; and the negotiation and purchasing process should be optimised and shortened. Other countries planning to introduce a similar system can learn from the Dutch experience. The introduction of managed competition is not merely a simple exercise but a process that requires continuous efforts from all market players.*

*Key words: Health reform, managed competition, health financing, the Netherlands*

Recently, we published the 2010 Health Systems in Transition review for the Netherlands.<sup>1</sup> It is the first attempt to give a full blown description of the Dutch health system after major health reform in 2006. This reform, introduced after almost two decades of preparation, has brought important new regulatory mechanisms and structures to the Dutch health system. The reform can be seen as the realisation of a long-standing political wish to unite the old sickness fund scheme, which covered about two-thirds of the population, and the voluntary private health insurance scheme, for individuals with an income above a certain threshold. As a regulatory mechanism the reform introduced managed competition among actors in health care. Early attempts to unite all health insurance schemes into a single mandatory scheme failed at the beginning of the 1990s, mainly because of strong opposition from health insurers,

employers and physicians. During the 1990s, however, smaller reforms originating from early plans were gradually implemented. This helped pave the way for the final and successful attempt at reform in 2006.

The reform's rationale is threefold:

1. The new system aims to contain rising health expenditures by increasing health system efficiency, i.e. higher quality at lower costs, through the introduction of managed competition.
2. The reform aimed to reduce inequity in the system. Age, income and health status all had a potential influence on insurance form, contribution level and access to health services. Most notably, high-risk individuals with incomes above the threshold and whose only option was to purchase private health insurance were negatively affected by risk selection and

high premiums. Under the new system everybody is insured under the same conditions and all health insurers are obliged to accept all individuals.

3. It was hoped the new system would increase transparency. The old system was characterised by a high level of government intervention, resulting in a fragmented insurance market with complex rules and regulations, especially from the perspective of the individual.

Although the major political parties agreed on the goal of uniting the health insurance scheme, some key aspects of the system were heavily debated political decisions. Basically two models were discussed: (i) a model with community-rated premiums and (ii) a model with income-related contributions, as preferred by the opposition. Furthermore, discussions involved the decision to choose either a system under private law with strong government guarantees or a system under public law with some market mechanisms. In the end the then ruling coalition of Christian Democrats and Liberals adopted the model of community-rated premiums under private law.

---

*Ewout van Ginneken is Senior Researcher in the Department of Health Care Management at the Berlin University of Technology. Willemijn Schäfer is Researcher and Madelon Kroneman Senior Researcher at the Netherlands Institute for Health Services Research (NIVEL), the Netherlands. Email: [W.Schafer@nivel.nl](mailto:W.Schafer@nivel.nl)*

In this review, we examine managed competition in the Netherlands almost five years after its introduction. After a description of the system, some important challenges will be discussed. We conclude with a discussion of the system and its lessons for countries contemplating the introduction of a similar system.

### Main elements of managed competition in the Netherlands

The 2006 Health Insurance Act (*Zorgverzekeringswet, Zvw*) and the Health Care Market Regulation Act (*Wet marktordening gezondheidszorg, Wmg*) were introduced as a legislative framework for managed competition. This fundamentally changed the role of the players in the Dutch health system. The role of the government was envisaged to change from direct control of volumes, prices and productive capacity to safeguarding the process from a distance. Responsibilities have been transferred to insurers, providers and the insured individuals. The government supervises the quality, accessibility and affordability of health care. The health insurers, health care providers and the insured or patients are the market

players. Interactions between these players take place in three markets: the markets for health insurance, health care provision and health care purchasing (see Figure 1). The establishment of new 'watchdog' agencies in the health sector aims to avoid undesired market effects in the new system.

#### Health insurance market

In the health insurance market, individuals are obliged to purchase their basic health insurance from health insurers. Health insurers must compete on price and quality and have to accept all individuals. Health insurers are not allowed to differentiate their premiums according to the risk profile of the applicants (community rating). Tax subsidies, called health care allowances, partly compensate those on lower incomes for their health insurance costs. Basic health insurance covers essential curative care tested against the criteria of demonstrable efficacy, cost-effectiveness and the need for collective financing. The basic health insurance benefit package is determined by the Ministry of Health Welfare and Sport based on the advice of the Health Insurance Board (CVZ). Individuals are

free to choose their health insurer, level of their voluntary deductible (€0–€500), reimbursement or an in-kind policy and switch insurers every year.

If an individual opts for an in-kind policy, choices between providers can be restricted to contracted providers, but financial risk will be absent. If the insured individual nevertheless wants to visit a non-contracted provider, additional out-of-pocket (OOP) payments may apply. When an individual opts for a reimbursement policy, a free choice of provider exists, but also here there is a reimbursement limit that in some cases could lead to additional OOP payments. In addition, a compulsory deductible (currently €170) is applied. However, both the voluntary and the compulsory deductible do not apply to general practitioner care (GP), maternity care and dental care for those under the age of 18. The government committed itself to provide information on health plans in terms of price, quality, and benefits. This should help individuals in making informed choices, which is essential for the proper functioning of the competitive insurance market.

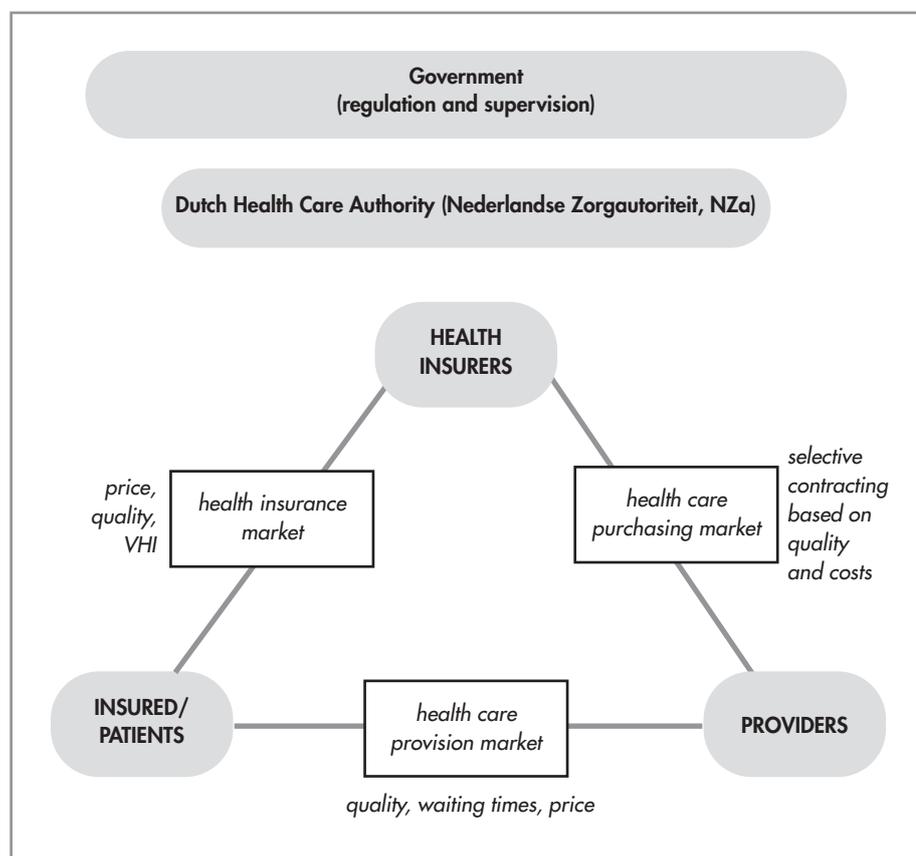
An interesting feature of the Dutch system is the collective contract. Collective contracts are established between groups of insured and the health insurer. Health insurers may offer a maximum 10% reduction on the individual premium. Collective arrangements can be made by several legal bodies such as employers and patient organisations. This system should give the insured more influence ('voice') with the health insurers.<sup>2</sup>

Besides basic health insurance, patients may purchase complementary voluntary health insurance (VHI) from any health insurer. Complementary VHI may only cover health services that are not covered under basic health insurance or the long-term care insurance scheme, regulated by the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten, AWBZ*). Health insurers may use risk-rating and are not obliged to accept individuals for VHI. Consequently, choice on complementary VHI can be limited for patients.

#### Health care purchasing market

In the health care purchasing market health insurers can negotiate with providers on price, volume and quality of care. In this process, insurers are free to use selective contracting. The use of these tools should result in the purchasing of efficient care.

Figure 1. Netherlands health care market interactions



Source: authors' own compilation

The payment mechanisms of the health care providers have also changed to accommodate negotiations and competition. A case-mix related financing system became necessary in which money would follow the patient.

GPs are now paid via a combination of capitation fees and fee-for-service. So far, these fees are negotiated centrally between the National Association of General Practitioners (LHV), Health Insurers Netherlands (*Zorgverzekeraars Nederland*) and the Ministry of Health, Welfare and Sport. However, direct negotiation between insurers and GPs for lower fees is allowed.

For hospital care an elaborate diagnosis-related groups (DRG)-type system called Diagnosis and Treatment Combinations (*Diagnose Behandeling Combinaties, DBCs*) has been in place since 2005. Freely negotiable DBCs can be negotiated between insurers and providers, on price, volume and quality. They are introduced gradually, amongst other reasons to give the health insurers time to build up the necessary expertise and experience to assume their purchasing role. For example, in 2005, freely negotiable DBCs accounted for 7% of annual hospital turnover. In 2010, this percentage stood at 34%. For the remaining DBCs the Dutch Health Care Authority (NZa) establishes the prices; insurers and providers can only negotiate volume and quality.

#### *Health care provision market*

In the health care provision market, providers should compete for patients on the basis of quality of care. The government provides information on quality and waiting times of providers so that individuals can make informed choices. This assumes, however, that individuals are willing or able to make these choices and have a free choice of provider. Yet the latter may be restricted if the individual chose an in-kind basic health insurance plan with selectively contracted providers and if the individual faces access barriers, such as waiting lists or travel distance for certain providers.

#### *Financing of the scheme*

All Dutch residents contribute to this scheme in two ways. First, they pay premiums, directly to the health insurer of their choice. Second, an income-dependent employer contribution is deducted through their payroll and transferred to the Health Insurance Fund (HIF). Children up

to the age of eighteen are covered through one of their parent's health plans. The government makes a payment on their behalf directly into the HIF. The resources from this fund are then allocated among the health insurers according to a sophisticated risk-adjustment scheme, which was inherited from the former sickness fund scheme. A well functioning risk adjustment scheme should make both good and bad risks equally attractive to insurers through adjusted financial compensation. This should guarantee access to affordable care for all citizens and take away the incentive for risk-selection. Risk adjustment is an essential precondition for reaping the benefits of a competitive health insurance market.<sup>3</sup>

#### *Supervision of the scheme*

Competition in health care may lead to undesired market effects. The Health Care NZa, an independent administrative body established in 2006 and funded by the Ministry of Health, Welfare and Sport, is responsible for the supervision of the three health care markets in the Netherlands and the lawful implementation of the Health Insurance Act. The NZa may impose tariff and performance regulation and impose specific sanctions on players that have obtained significant market power.

#### **Four bottlenecks in the Dutch version of managed competition**

Almost five years after its implementation, it has been a steep learning curve for all market players. Many short-term problems needed immediate attention. To name but a few, competition on premiums led to financial problems for many insurers; a wave of mergers resulted in just four insurers having 88% of the market; excessive DBC tariffs led to overfunding of hospitals, which then had to be paid back; GP payments were delayed; GPs received more funding than anticipated; and there remained a pervasive problem with uninsured individuals and defaulters. All of these problems had (and still have) to be dealt with on an ad hoc basis. On a positive note, although the demands on all actors have been high the situation has never become chaotic.

Below, we will not focus on these issues, but rather on some structural problems that still need to be solved for managed competition to work. Particular attention will be paid to those aspects which are crucial for the different market players to fulfil their roles.

#### *Patient information*

Patients are assumed to make informed choices while selecting their health care providers. This requires sufficient and reliable information being readily available for patients. Improvements in this area are needed. Many initiatives have been made to make quality of care more transparent. For example, the government provides information on waiting lists, quality and prices of care through the Internet ([www.kiesbeter.nl](http://www.kiesbeter.nl)). However, this information is far from complete and the information needs differ strongly between patients. Information on performance of the various health care institutions only meets the demands of a limited group of patients with a limited set of health problems.<sup>4</sup> In addition, the NZa concluded that more time would be needed to achieve an efficient provision of information that matches the needs of patients.<sup>5</sup> In addition, patients may have to visit a preferred provider of their insurer or risk making an additional payment OOP. Insured individuals will have to rely on their insurer to contract care of good quality on their behalf. A future issue for debate for the Dutch government will be whether free choice of provider will remain an integral part of the system or that insurers will become agents for the insured.

The health insurance market on the whole seems to function better than the health provision market. Individuals mostly choose their health plan based on easy-to-compare price information. However, the service level of the insurer, largely similar with only four major insurers left, or the quality of purchased care, which is difficult to assess for individuals, play a smaller role.<sup>6</sup> Furthermore 64% of individuals are covered by collective contracts.<sup>7</sup> Since most group contracts are negotiated on premium level, not on the basis of the quality of the contracted care, quality choices in this market do not yet influence the quality of purchased care.<sup>6</sup> As of 2010, the insurance market seems to have stabilised. It was only in 2006, the first year of the new system, that a considerable number of people switched insurer (21%),<sup>8</sup> many of them members of a renegotiated collective contract. In the period 2007–2009, the percentage of people switching health insurers stabilised below 5%,<sup>9</sup> which is the same percentage as under the old (pre-2006) sickness fund scheme.<sup>1</sup>

#### *The negotiation process*

At present, there are several problems that

complicate the active purchasing role of insurers. First, contracting mainly focuses on price and volume, not on quality. Sound performance indicators that health insurers can use to evaluate the quality of providers are lacking. Second, an insufficient supply of health care providers (in numbers and variety) limits the possibilities for health insurers to selectively contract providers. In addition, health insurers fear damage to their public image if a given hospital is not contracted.<sup>10</sup> Not surprisingly, selective contracting of providers is not yet very common.<sup>1,11</sup> Third, the negotiation process between insurers and providers often takes until the summer of a given year, whereas nominal premiums must be set on the 1st January.<sup>1</sup> The former is mostly due to the late public announcement of any legal changes in the insurer's operating environment and the large number of DBCs that have to be negotiated. This complicates the contracting process and the setting of realistic premiums. Moreover, new applicants do not know which care will be contracted and have to make choices on the basis of incomplete information. This may seriously hamper patient mobility.<sup>10</sup>

#### *The payment method for hospitals*

The DBC system for hospital financing is not yet stable and has led to the overfunding of hospitals and increased bureaucracy. For each DBC a price is either negotiated between a hospital and insurer or settled by the NZa. There are problems with the large number of DBCs (about 30,000). This complicates negotiations and the finalisation of contracts. Currently all actors in the field are working on a major revision which should reduce the number of DBCs to 3,000. This should simplify the contracting process. The new system should be implemented in 2012. Furthermore, the DBC system hinders an effective purchasing process. Because DBCs are reimbursed after completion of treatment, the true financial results in a given accounting year will only become clear after a three-year delay.<sup>10</sup> Finally, another important problem with the DBC system is the remuneration of the physician in each DBC. Since this share does not always reflect reality, the incomes of some physicians have increased significantly.

#### *Risk adjustment*

The risk adjustment scheme needs constant refining to eliminate perverse incentives for insurers and to ensure fair competition.<sup>1</sup> At

present, the scheme is not working optimally, in particular, for certain high risk groups there are still failures within the scheme. This may lead to predictable losses among insurers which may in turn increase the incentives for risk selection. Risk selection by health insurers for basic health insurance is difficult, since insurers are obliged to accept all applicants and they cannot raise the premium for individuals. However, there are several other opportunities for cream skimming. For example, complementary VHI can in theory be used as a tool for risk selection. VHI can be sold at a low premium in combination with basic health insurance to attract those insured individuals with expected higher profitability levels. So far, however, this has not led to cream skimming.<sup>10</sup>

#### **Conclusion**

The introduction of managed competition in the Netherlands has attracted a great deal of international attention. Countries contemplating the introduction of a similar system are well advised to follow these developments closely. Introducing managed competition, or more market mechanisms, should not be underestimated. Shifting responsibilities to market players does not mean that there is nothing left for the government to do. The Dutch experience demonstrates that even though complete chaos has not arisen, not everything has turned out in the way that was anticipated. Many problems have had to be solved by ad hoc measures. Furthermore, managed competition is demanding on all players in the system, including the government and its agencies. It clearly shows the need to have a strong institutional structure in place, with enough technological capacity and sufficient regulatory power to manage such an innovative system.

The reform has changed the roles of patients, insurers, providers and the government. Health insurers are expected to negotiate with providers and purchase efficient care of good quality. Patients are expected to critically assess and select the health insurer and provider of their choice. The government presumes that this will increase efficiency and quality in the health care system, as well as make care more demand-driven. However, this reform is still in progress. In this transition process it seems critical that all players receive the appropriate tools to assume these roles. Important challenges remain: patient information on price and quality should be continuously improved; the risk

adjustment system needs continuous refining; quality has to be made visible and measurable; the DBC system must be reformed; and the negotiation and purchasing process should be optimised and shortened. Not until the system is fully implemented, will we be able to evaluate if managed competition has had the intended effects in terms of efficiency and quality.

---

#### REFERENCES

- Schäfer W, Kroneman M, Boerma W et al. The Netherlands: health system review. *Health Systems in Transition* 2010;12(1):1229
- Groenewegen P, de Jong J. Dutch health insurance reform: the new role of collectives. *Eurohealth* 2007;13(2):10–13.
- Van de Ven W, Beck K, Van de Voorde C, Wasem J, Zmora I. Risk adjustment and risk selection in Europe: six year later. *Health Policy* 2007;83(2–3):162–79.
- Berendsen A, de Jong G, Schuling J et al. De informatiebehoefte van de verwezen patient [The information need of the referred patient] *Nederlands Tijdschrift voor Geneeskunde* 2010;154:A1603.
- Dutch Health Care Authority (NZa). *Monitor ziekenhuiszorg 2009* [Hospital care monitor 2009] Utrecht, Dutch Health Care Authority, 2009.
- Friele R. *Evaluatie Wet Marktordening Gezondheidszorg* [Evaluation Health Care Market Regulation Act]. Den Haag: ZonMw, 2009.
- Vektis. *Zorgthermometer 2010: Verzekerden in beweging* [Care thermometer 2010: insured mobility]. Zeist: Vektis, 2010.
- de Jong J, van den Brink-Muinen A, Groenewegen. The Dutch health insurance reform: switching between insurers, a comparison between the general population and the chronically ill and disabled. *BMC Health Services Research* 2008;8:58.
- Vos L, de Jong J. *Percentage overstappers van zorgverzekeraar 3%. Ouderen wisselen nauwelijks van zorgverzekeraar* [Percentage of switchers of health insurers company 3%. Elderly hardly change between health insurers]. Utrecht, Netherlands Institute for Health Services Research (NIVEL), 2009.
- Van de Ven W, Schut F, Hermans H, et al. *Evaluatie Zorgverzekeringwet en Wet op de zorgtoeslag* [Evaluation Health Insurance Act and Health Care Allowance Act]. Den Haag: ZonMw, 2009.
- Verbrugh H. De zorginkoper bij uitstek [The pre-eminent health care purchaser] *Medisch Contact* 2008;63(18):772–75.