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TILEC Discussion Paper

Changes and Challenges of the New Health Care Reform in the Netherlands: What Should the Dutch Be Aware Of?

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Abstract: In this paper we examine the recent change of health care policy reform in the Netherlands, which introduced elements of market competition into the system with the goals of strengthening solidarity, guaranteeing an equitable and cost-efficient health care market, and preserving individuals' freedom of choice concerning health care providers. We draw a parallel with the Swiss health care system, which relies on ten years of experience with managed competition in health care, and highlight the difficulties emerging from a set-up that does not always guarantee a competitive environment.
The lesson that the Dutch should learn is that competition can only work if there is a substantial liberalization on the procurement market (more room for selectively contracting providers of care) and if sufficient incentives to stimulate an increased role of the consumer are present.

JEL classification: I11, I18, I19, H51.
Keywords: Health care reform, market competition, consumer-driven health care, the Netherlands, Switzerland.

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1. Introduction

Health care continues to be one of the hottest topics on the political agendas of many Western countries. The dynamic feature of the health care system propels search for new solutions and arrangements in order to cope with several well-known strains, such as cost explosion, long waiting lists, inefficiencies, and public dissatisfaction.

Over the past century, reforms in the health care sector in many developed countries have experienced three different waves: The first wave aimed at ensuring equal access and universal coverage to the whole population; the second wave focused on controls, rationing and expenditure caps; and the third wave promoted decentralization and the introduction of competition and incentives (Cutler, 2002).

Each country contemplating reforms in the organization of its health care system faces a series of important questions: Should the health system be left to market forces or is public action required? And if so, what level of public regulation and intervention is best for a well performing health care system? By taking a broad look at the situation in 19 different European countries Saltman and Figueras (1998) show that four broad themes have influenced organization and behavior within nearly all Western European health care systems:

- The role of the state and the market: A number of countries combined both market-style incentives, such as negotiated contracts and patient choice (consumer sovereignty), with continued public sector ownership and operation of facilities. The most well-known example is the introduction of *quasi-markets* in the United Kingdom.[1] Other cases are Sweden, Italy, Spain, and Finland.
- Decentralization: This concept has come to the fore as a means to revamp the performances of a health care system. Funding and/or managing responsibilities shifted from the center to sub-levels of Government (i.e. to regions in Italy, or to the Autonomous Communities in Spain), with the goal of achieving an efficiently performing health care system that involves a bigger community in oversight and decision-making processes, which help creating tailor-made health policies.[2] The classic example of decentralized health care system is Switzerland where the independence of each canton has basically generated a situation in which 26 comprehensive health care delivery systems coexist and operate, and are all more or less self-governing.
- Empowerment of patients and patients' rights.
- Role of public health: This includes health promotion and disease prevention policies.

The Dutch health care system has not been immune to these waves of changes: As Schut and Van de Ven (2005) argue, during the 1980-2000 period Dutch health care policy was marked by a combination of cost-containment policies alongside a pursuit of market-oriented reforms. The Dutch health care system is different, if not more complex, from those of many European countries:

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[1] The essence of the quasi-market was decentralized decision-making, with local actors making all the relevant decisions about the allocation of resources in line with their own priorities. The government's task in this framework was limited to ensuring equitable budget allocation to purchasers, the market mechanism alongside sufficed in achieving the objectives.
The founding principle was a clear distinction between purchasers and providers (hospitals and secondary care suppliers), which were quasi-independent entities or trusts, and managed their own budgets, financed from contracts with purchasers. The real innovation was therefore in the fact that they did not receive funds directly from the central government. Competition existed among providers, because they competed for contracts with purchasers. Effectively, competition was severely curtailed, trusts could not retain the surpluses generated, the only incentive being that of exhausting the budget by the year-end.

[2] For an extensive review of decentralization policies in OECD countries see Mosca (2005).

It belongs to the Bismarck model but unlike the other systems based on social insurance it has a gatekeeping system;[3] prior to the new health care reform that came into force on January 1st, 2006 opt-outs from the publicly accountable system were mandatory for those citizens above a specific income threshold set yearly by the Ministry, who subsequently had to purchase health insurance on their own. Facing more and more difficulties in guaranteeing solidarity and financial accessibility, the Dutch introduced a new health insurance system, which resembles the Swiss Federal Health Insurance Law (FHIL) of 1996, which is based on the concept of managed competition in order to contain costs and achieve a higher level of efficiency.
The aim of this article is to contribute to the analysis of health policy changes in the Netherlands. In order to do so we draw a parallel with the Swiss health care system, which relies on ten years of experience with managed competition in health care. By highlighting the pros and cons of the introduction of market mechanisms in Switzerland we will set out some considerations that can help the Dutch avoid the Swiss mistakes.
This article is organized as follows: Section 2 highlights the changes towards the current structure of the health care system in the Netherlands; the goals of the reform are presented, and the main differences and similarities with the Swiss health care system are set out. In section 3 we explain the strengths and possible weaknesses of the current new Dutch health system, by referring to the Swiss experience. Conclusions and policy recommendations are drawn is section 4.

2. The Dutch Health Care System

2.1 How it was before the introduction of the New Health Insurance System

Health care in the Netherlands originated through the efforts of voluntary organizations, which is why almost all hospitals, except academic ones, are private, non-profit establishments. The system is characterized by private initiative as well as by detailed government regulation. The authority responsible for planning and implementing health policy is the Ministry of Public Health, Welfare and Sport (VWS). The principal characteristics of the system before the introduction of the new health insurance system were the following:

1. A mix of public and private health insurance: The Dutch system could be described as a mix between the German social insurance model and the American private insurance model (Graig, 1999). The guiding principle was that those who could pay for themselves should be excluded from the statutory insurance scheme.[4] The income threshold was set at Euro 33,000 in 2005. In 2005 about 70% of the population was insured in the collective scheme (*ziekenfonds*) and about 30% were privately insured (*particulier*). If the yearly income was above the threshold, then the following year one had to insure oneself privately. In the *ziekenfonds* the insured paid an income dependent rate of 1,45%, and the employer paid around 6,75% to the *ziekenfonds*.
2. Tradition of consensus building: This is the so-called *Poldermodel*, a Dutch political tradition based on negotiation, and consensus building, seeking compromise between different interest organizations. Actors involved in shaping health policies are trade unions, unions of medical professionals, union of health insurers, consumers' organizations, employers' associations,

[3] The gatekeeping role of the general practitioner (GP) comprises the provision of primary care and the coordination of all diagnostic testing. The physician is in charge to refer to the specialist. Referrals and some procedures must often be preauthorized by the gatekeeper unless there is an emergency. In most cases the GPs have the role of gatekeeper in national health systems, while in social health insurance systems patients usually do not need a referral to access specialist care.
[4] The difference with the German system is that when Germans reach an annually determined income threshold, they can choose whether to stay or leave the statutory insurance scheme.

and patients' groups. The mix of these interest groups with conflicting goals gave rise sometimes to policies that created complex rulings.
3. The result of strong supply-side controls by the Ministry was rationing through waiting lists. This characteristic separated the Dutch health care system from that in France or Germany. These supply shortages were a source of great frustration to the Dutch population. Yet, in 1999, 73.2% of the population affirmed that they were very satisfied or fairly satisfied with their health care system, owing in large part to its strong, well-developed system of primary health care.[5]

The Dutch health insurance system prior 2006 was divided into three compartments: The first compartment (*AWBZ*) provided universal coverage and explicitly covered many of the risks associated with long-term care. The second compartment consisted of two different types of insurance: One was compulsory for people below a certain income level established yearly by the Ministry. These people were compulsorily insured by a sickness fund (*ziekenfonds*). Those individuals above the income threshold had to insure themselves privately (*particulier*), and this was done on a voluntary basis. The third compartment consisted of supplementary health insurance that was voluntary.

The Netherlands used, and still does, gatekeeping and budgets. While the former has been viewed as an efficient measure to keep the costs under control (Gerdtham and Jönsson, 2000) while maintaining a high level of quality in providing care, budgets have led to waiting lists and waiting time, although they succeeded in containing costs. Both measures were intended to enhance the efficiency of the health care system, by trying to curb unnecessary costs.

Figure 1 represents the total health care expenditure in 2002, subdivided in private and public share, as a percentage of the GDP of six Western European Social Health Insurance (SHI) systems. Switzerland scores the most, with 11.1% of GDP spent on health, Germany is in the second place with 10.9% and France is third with 9.7%. The Netherlands spent 9.3% of GDP on health, Austria 7.6% and Luxembourg 6.1%. When we analyze the public and private expenditure composition Switzerland falls to the third position with respect to public expenditure (6.4%) on health, while it has the largest share of private expenditure (4.4%), due to its high proportion of out-of-pocket (OOP) expenditure (Mosca, 2005).
It is common belief that a greater private participation in health costs, via OOP expenditure, co-payments, and co-insurance, works as a "braking mechanism" of total health expenditure. Yet, as shown in Figure 1, Switzerland proves the contrary. Although considerable levels of health outlays are privately borne, total costs still balloon.

[5] For further knowledge refer to European Observatory on Health Care System (2004).

Figure 1: Public and private health care expenditure as a % of GDP, year 2002

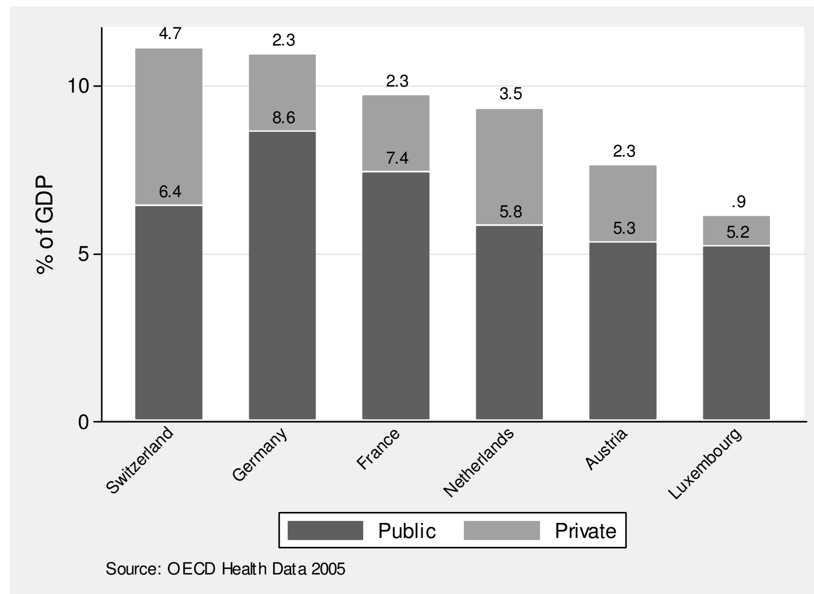
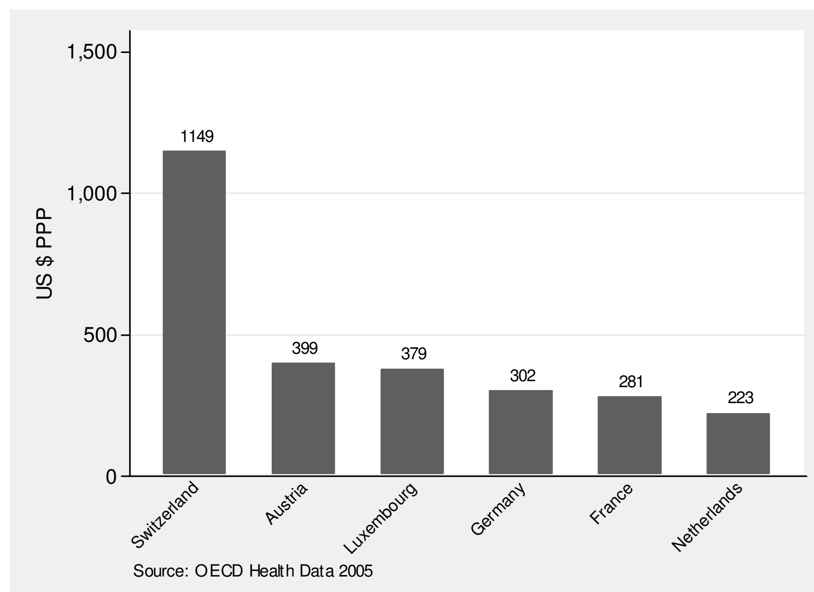


Figure 2 shows the per-capita OOP expenditure levels, expressed in US$ PPP: Switzerland is in the first position with US$ 1,149 per capita, followed by Austria and Luxembourg that are approximately on the same level. Among the six SHI countries considered the Netherlands had the lowest per-capita OOP expenditure in 2002.

Figure 2: Per-capita out-of-pocket expenditure in US$ PPP, year 2002



2.2 The need for reform

The Dutch health care system organization brought continuous debates and discussions about its structure and the needs for reform. Most reform decisions moved in the direction of increasing the level of competitiveness and this highlighted difficulties in introducing effective market competition while maintaining solidarity and financial accessibility.

Over the past 20 years some elements of competition were introduced. Hospital financing for example underwent considerable changes: It went from an open-ended reimbursement in the '80s to the new DBC (Diagnosis Treatment Combination, *Diagnose Behandeling Combinatie*) system in 2005.[6] Furthermore, since February 1st, 2005 for a selected number of DBC some regulated-market principles have been introduced resulting in the so-called *B-segment*. As a result health care providers and buyers can negotiate on hospital charges and production volumes. Next to the *B-segment* there is the so-called *A-segment*. A-DBC tariffs are fixed-price and determined by the Dutch Healthcare Authority (NZa).

The introduction of the DBC system is a significant and progressive step towards clearer and better defined ways of remuneration and funding of health care services. At present the *B-segment* represents approximately 10% of all DBCs. The system however is facilitating the gaining of experience and knowledge, so in the future the *B-segment* will likely be broadened, to make sure that a significant part of the non-critical health care service operates under market principles.[7]

The political parties and the interest associations agreed in 2005 for the new Social Health Insurance system and the Health Care Insurance Act *(Zorgverzekeringswet)* came into force. Through this Act a comprehensive national insurance system has been established to fund universal health care in the Netherlands. The government expected the reform to result in a more equitable and cost-efficient health care market and preserve individual freedom of choice with regard to health care providers.

2.3 The New Dutch Health Insurance System (2006): A solution for all the strains?

As from January 1st, 2006 the Health Insurance System in the Netherlands has changed. The distinction between *ziekefonds* (social insurance) and *particulier* (private insurance) has ceased to exist. This has been replaced by a single health insurance scheme that covers essential care. Everybody living or working in the Netherlands is obliged to take out health insurance; there is a basic package, which is mandatory and defined by law. Moreover, there is additional insurance covering all health services not included in the basic package that can be purchased on a free basis. People can purchase additional insurance either from the same or from another health insurer. Insurers are legally obliged (*verzekeringsplicht*) to accept everybody applying for the mandatory package, regardless of age, gender, or state of health. Furthermore, because of the fact that health insurers cannot charge higher premiums on the grounds of age or health status, the accessibility of care is guaranteed to the whole population. In order to compensate the cost differences between insurers resulting from the different health profiles of the insured people, a system of risk equalization has been put in place. The health care insurer receives some money for providing health insurance services from an established fund

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[6] A DBC consists of all activities and tasks of the hospital and specialists that arise from a particular complaint, for which the patient consults a specialist. This can best be compared with a DRG (Diagnosis Related Groups) system, although there exist some important differences. DRGs are usually coded at the beginning of the treatment while DBCs are coded afterwards; a patient can be coded in more than one DBC; DBC coding is done by the medical specialist and not by additional special personnel; the physician payment (honorarium) is included in the DBC, thus giving a big incentive for upcoding. The DBC system is moreover much more detailed than the DRGs: In 2005 the US system had 559 DRGs, Australia had 679 DRGs, while the Netherlands had about 20.000 DBCs.

[7] Non-critical health services comprise no emergencies and relatively easy surgeries.

(Health Insurance Fund). Payments will be disbursed according to the risk characteristics of insured persons, who form an indicator of the expected costs of care. The risk equalization model contains parameters that correct for health status differences related to age, gender, and other objectively measurable client health characteristics.
Individuals are given the chance to change health insurer once a year, and this is likely to increase mobility and therefore competition between different insurers, also because the latter are legally bound to accept everyone who wants to take out health insurance for the basic package.
The premium for the new insurance consists of two components: i) a community-rated nominal premium that is paid by people as from the age of 18 for the basic insurance. The size of this premium varies between insurers and is unrelated to age, gender, income, or health status; ii) an income-related contribution that equals 6.5% of the income and will be payable up to the income ceiling of Euro 30,015.
A health care allowance has been introduced in order to keep insurance premiums affordable. This allowance is paid via the tax authorities and has been designed to make the system financially accessible to all income groups, so that a tax credit is given to people before they have to pay the insurance premium.[8]

The health insurance system is operated by private (both for-profit and non-profit) sickness funds. Companies are allowed to make profits on the operation of health insurance policies and they can pay dividends to the shareholders. This last point has been a major issue of debate for what concerns the law's conformity to the European Commission (EC) law. The question is whether the operation by private insurance companies is in line with Community law. For this reason VWS asked the EC for legal advice, whose answer was positive.
The new health care system includes a Dutch Healthcare Authority (NZa). Its main tasks are twofold: First, it sets fixed (maximum) prices for hospital care (the so-called *A-segment*); Second, it supervises the health care market and monitors the conditions for fair competition.

2.4 Differences and similarities with the Swiss health care system
The new Dutch health care system is much like the Swiss one because they are both based on elements of competition that have been introduced in order to guarantee – among other objectives – solidarity and cost containment.
The Swiss health care system was constituted in 1911 and underwent a major reform in 1996 through the enactment of the Federal Health Insurance Law (FHIL).[9] The system is permeated by liberalism and federalism (Linder, 1994), and this results in complicated structures and processes involving both public and private health care provision and financing. The FHIL introduced the obligation to take out an insurance policy. Prior to 1996 reform, individuals were responsible for purchasing statutory health insurance from accredited insurance companies (as many as 98% of the population did have cover under this voluntary system) and premiums were risk-related. However, rising costs and lack of solidarity between insurance companies made reform necessary.[10]
As from 1996 Switzerland requires all citizens (also people aged below 18) to individually take out a health insurance policy. The insured may change insurer twice per year. There is free competition among health insurance companies on the level of premiums but not on the services provided, as law

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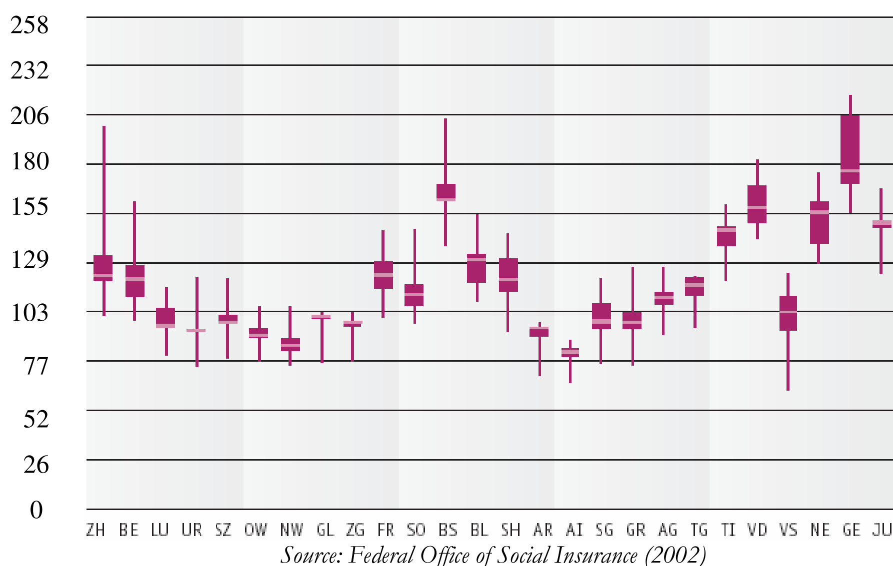
[8] The size of the allowance depends on the income: a single person is entitled to the allowance if his yearly income is below Euro 25,000, while the threshold of a household with a joint income is set at Euro 40,000.
[9] For a comprehensive review of the Swiss health care system refer to Mosca (2005).
[10] As health care premiums were risk-related health insurance was unaffordable for some individuals. The concept of solidarity was missing in the old system. Moreover a system of risk equalization did not exist.

defines those. The main requirements are that no profit should be made from compulsory insurance activities, and that all insurers must offer the same mandatory and uniform benefit package. Moreover, insurers cannot refuse any application for the basic insurance. Individuals can buy supplemental insurance that covers additional treatments and check-ups, all drugs, extended home care, and up to 100% of universal coverage worldwide. Supplemental insurance must not be necessarily purchased together with the compulsory one from the same insurer.
Premiums are community-rated for the mandatory package and there is a considerable variability in inter- and intra-cantonal premiums paid. This variability is due to the strong federalism that permeates the whole system. Decentralization of competences has created a series of significant inter-cantonal differences with respect to public financing, regulatory settings, and production capacity. Mosca (2005) posits that the main determinants explaining health care expenditure differences in Switzerland are cultural, demographic, and structural characteristics of the cantons. In 2002 health care expenditure ranged between a maximum of US$ PPP 2952 in Canton Geneva, and a minimum of US$ PPP 1103 in Canton Appenzell-Innerrhoden. Figure 3 and 4 show the differences of the levels of adult premiums and socialized health care expenditure in the 26 cantons.[11]

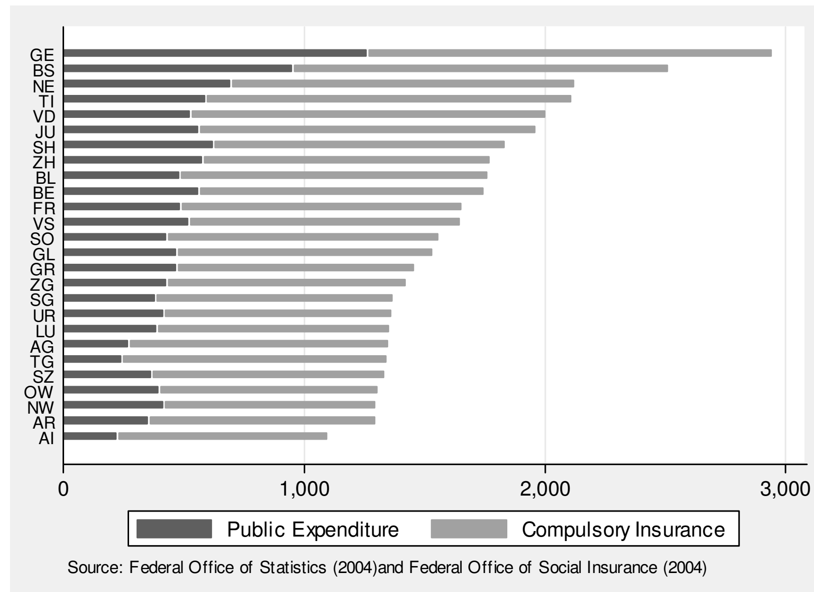
Figure 3: Inter- and intra-cantonal differences in adult premiums, year 2002, US$ PPP



Source: Federal Office of Social Insurance (2002)

[11] The term socialized health care expenditure refers to the sum of two components: 1) public expenditure (cantonal and local direct financing plus means-tested subsidies for needy citizens); 2) compulsory health insurance (CHI) outlays.

Figure 4: Per-capita socialized health care expenditure in the Swiss cantons, year 2002, US$ PPP



To reduce the income consequences of per-capita premiums, both the Confederation and the cantons subsidize the compulsory health insurance premium through tax-financed allocations. These public transfers are used to provide a means-tested subsidy, which varies according to the income and wealth of the insured person. Subsidies are given directly to the health insurance company and not to the individual. Subsidy policies are extremely varied in the country owing to the strong decentralization of health care competences. There are currently ongoing discussion in the political arena on the need to uniform the manner in which subsidies are disbursed.
Both public and private hospitals, as well as nursing homes, are still reimbursed in the bulk of cases on a per-diem basis, and a few cantons started introducing a flat-rate per case financing system based on AP-DRGs (All Patients Diagnosis-Related Groups) as from 2000.

Both the Netherlands and Switzerland have introduced many elements of competition and have moved towards a more consumer-driven health care system, where consumer's/patient's choices are fundamental.
The main similarities and differences of the Dutch and Swiss health care systems are summarized in table 1.

Table 1: Main characteristics of the Dutch and Swiss health care systems

	The Netherlands (2006)	Switzerland (1996)
Goal of the reform	Three objectives: 1. Strengthen solidarity; 2. Guarantee an equitable and cost-efficient health care market; 3. Preserve individuals' freedom of choice concerning the health	Three objectives: 1. Strengthen solidarity; 2. Guarantee quality of care; 3. Contain cost explosion.

	care providers.	
Instruments	Introduction of elements of market competition, promotion of consumer choice, enhancing room for contracting between insurers and providers.	Introduction of elements of market competition in all the three markets.[12]
Institutional context	The system is centralized. The government has ultimate control over planning, management, and financing of health care facilities.	The system is highly decentralized. Cantons are the main bodies responsible for planning, managing, organizing, financing health care facilities. This results in 26 different health care systems within the country.
Type of insurance	- There is a compulsory insurance for every citizen. Individuals below 18 are automatically insured. - The basic package is defined by law.	- There is a compulsory insurance for every citizen. Individuals below 18 must take out an insurance policy (prices are lower than for adults). - Law defines the content of the compulsory insurance.
Insurers	They are legally bound to accept anyone wanting to purchase compulsory insurance.	They are legally bound to accept anyone wanting to purchase compulsory insurance.
Premiums and premiums variability	- Premiums are community-rated. - There is some premium variability between insurers, although in a much lesser extent than the Swiss market.	- Premiums are community-rated. - There is a wide variability in the level of premiums both between and within cantons and between insurers.
Policy options	- In-kind policy: The insurer concludes for the insured a sufficient number of contracts with care providers. The insurer will then pay the amounts directly to the care provider. Under this policy, if one prefers to go to a not-contracted care provider, he might not receive full reimbursement of all the costs incurred. - Reimbursement policy: The individual is free to choose any care provider, but he has to pay the bill first and then he is reimbursed by the health insurer.[13]	The insured can freely choose the service provider (GP, specialist) because of compulsory contracting (i.e. all medical practitioners have the right to be party to a framework contract with all health insurers). The individual chooses any health provider and pays the bill first, and is subsequently reimbursed by the health insurer. Occasionally some health practitioners and insurers can agree that the insurer pays the bill first.[14] Should the insured opt for a HMO plan then the access to health providers is closely managed.[15]

[12] The three markets refer to: 1) the health care insurance market; 2) the health care provision market, and; 3) the health care procurement market.

[13] Note that the insurer and health care provider can agree that the insurer pays the bill first.

[14] In practice GPs normally bill the patient/insured. Hospitals and home care services bill the insurers first.

[15] Note that managed care policies in Switzerland were not so widespread as, for example, in the USA. German- speaking cantons have tended to opt for managed care plans more often than French- and Italian-speaking cantons (Federal

Switching	People can switch once a year.	People can switch twice a year.
Hospital funding system	DBC's (Diagnosis Treatment Combination).	As from 2000 some cantons introduced the AP-DRG's system as a means to finance hospitals. This system is gradually evolving throughout the country. Yet, some cantons still use a per-diem system as hospital funding mechanism.
Selective contracting	Yes, for the in-kind policy.	Only under HMOs and PPOs solutions or when the GP acts as a gatekeeper, but these forms of managed care are not very widespread. [16]
Deductibles	Yes, with different amount choices.	Yes, with different amount choices.
No-claim bonus	Yes, up to Euro 255 per year.	No.[17] It exists only for additional insurance.

3. Possible strains to the actual health care system organization

Both Switzerland and the Netherlands have introduced many elements of market competition in their health care system. Such competition is expected to boost efficiency, innovation, consumer-choice and cost control. Moreover it also increases flexibility and helps rolling back the dominant position of the national government (the state) in health care. However, in both cases, the government still decides the content of the basic package of the health insurance: So, on the one hand the state is increasingly turning to market forces in order to enhance efficiency and curb costs, but on the other hand it wants to keep the basic tenets of equal access to affordable health care for all citizens. Both countries are thus facing the classic trade-off between efficiency and equity in health care.

The Swiss now rely on ten years of experience with market mechanisms in health care. Because of the many similarities of this system with the Dutch reform, it is interesting to take a look at the current strains of Switzerland, compare them with the situation in the Netherlands, and draw some conclusions.

3.1 Let competition play its role

In both countries consumers are free to choose the insurer from whom they would like to take out a health policy. The free choice of health insurer granted to citizens fosters competition between them. Indeed, a glance at the number of sickness funds in Switzerland shows that there was a massive decrease in their number, 191 insurance funds in 1992 and 93 in 2004 (Federal Office of Public Health, 2006).

Office of Public Health, 2004). Managed care plans offered nowadays in Switzerland are a somewhat weaker version of managed care programs normally provided in other countries (for instance, in the US). For example, the selected physicians of managed care plans are remunerated with a fee-for-service scheme, not much of an incentive for a family doctor to reduce his services, and hence costs.

[16] Some health insurers introduced the obligation to call a hotline phone number before going to a GP or a specialist. If the customer does that, he receives a discount on his monthly insurance premium.

[17] The FHIL allows health insurers to give a no-claim bonus (see article 62, 2b) on the basic package. In reality insurers hardly use this possibility.

Switzerland thus seems to be a perfect case for choice and price competition since numerous sickness funds (more than 35 in each competition area) provide community-rated premiums, homogenous benefits as well as open enrolment and are compensated through a risk-adjustment scheme. Yet Frank and Lamirand's study shows that there is little switching of health insurer and little price convergence (Frank and Lamirand, 2006). The advocated price competition that might be expected based on standard models of consumer behavior and competitive markets is not taking place. The explanation found by the authors is that, faced with such a high number of possible choices, the consumer "looses" the ability to make an efficient selection. The percentages of switching rates between insurance funds have constantly been decreasing through the years: According to 1996-2000 data, actual switching across insurers was confined to a limited proportion of the population (3.7% per year), consisting mainly of young or healthy individuals.[18] The proportion of people switching in the surveyed population has actually declined from 5.4% in 1998 to 2.1% in 2000 (Federal Office for Social Security, 2001). Such a setting presents a basic challenge to market models of health insurance. Can this situation be translated into the Dutch reality?
According to recent data the switching rate in the Netherlands between insurers has been very high. Approximately 18% of the insured switched to a different insurance fund in the first months of the introduction of the new social health insurance (Dutch Healthcare Authority, 2006). Of course it is difficult to make projections for the years to come, but this first switching behavior shown by consumers demonstrates that competition has played an important role. The Ministry of Health, Welfare and Sport and all the insurers had a very proactive role in spreading information to the population on the fresh changes brought by the new health insurance system. This fact has certainly spurred people to "shop around" and purchase the best policy according to individuals' needs, and contributed in lowering the switching costs, enabling people to understand the financial benefits as well as the possible drawbacks of choosing different insurers and different insurance types.
The Swiss experience certainly teaches a good lesson: The regulatory mechanisms to facilitate choice do not always function effectively. One has to pay attention to the fact that a low switching rate might be caused by a cherry-picking behavior of insurers. Although cream-skimming and risk differentiation are prohibited by law, insurers can select preferred risks indirectly by influencing decisions to join an insurer or to leave an insurer.[19] Moreover another difficulty in changing health insurer might be caused by the fact that it is possible to separate the basic from the supplementary health insurance, which limits switching by people with both covers because the mechanisms of free choice of insurer does not apply to voluntary health insurance.
The Netherlands is certainly going into the right direction with stimulating competition also thanks to the selective contracting clause, which enables to enter into participation agreements only with certain care providers. With multiple competition between insurers, the consumer is given some power over the range and quality of treatment on offer. In Switzerland the inability to contract selectively stifles competition and gives little incentive to insurers to control health outlays. Even if it is theoretically possible to contract selectively with the FHIL, this has not been very much used

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[18] Young individuals (26-40 years) accounted for about 49% of the switches, while people with good or very good self-reported health status accounted for 90% of all switches.

[19] On the one hand an insurer, in order to attract good risks, can adopt a policy based on selective advertising and targeted mailing to healthy and young people, or it can offer appealing supplementary insurance options if clients/consumers buy both basic and supplementary health coverage.
On the other hand the insurer can push away bad risks by providing them with poor service (for example delaying reimbursements and/or deteriorating customer assistance), and by reducing information disclosure.

because insurers seemed more concerned with setting the premium than with reducing the cost of care purchased through selective contracting.[20]

3.2 Hospital financing and competition

The developments in the hospital financing occurring both in Switzerland and the Netherlands are more or less similar to those happening internationally. The Dutch adopted the DBC-system, which is a highly detailed means to allocate funding to hospitals. However, an eye should be kept on the practice known as *upcoding* that has been defined as a deliberate declaration by a medical specialist of a more expensive code than medically necessary, with the incentive to increase his payment (Putters, 2003).[21] It is interesting to note that part of the hospital care (the *B-segment*, which represents approximately 10% of the total of DBC's) has been deregulated about one and a half year ago. This offers a unique possibility to study whether the market mechanisms are effectively working in the hospital sector.

In Switzerland more and more cantons are opting for the DRGs financing system. It is a way to reorganize the inefficient system that was present prior 1996.

3.3 The role of the consumer/patient

The Swiss and the Dutch have implemented market based health reforms, which combine a mandatory social insurance with individual discounts for people who stick to a healthy lifestyle and thus take up less health care resources.

In both countries it is possible to choose between different levels of deductibles for the basic package; of course, the higher the deductible, the lower the monthly premium. In the Netherlands there is also a no-claim formula that allows to receive a refund of maximum Euro 255 per year, if an individual incurs no health costs (visits to the GP, natal, and maternity care do not count for the no-claim). The goal of increased OOP expenditure is to make individuals more responsible about their own health and their use of health services.

There is a considerable difference between the two countries in the level of OOP outlays. OOP expenditure as a percentage of private expenditure on health amounts to 20.8% in 2003 in the Netherlands, against 76,0% in Switzerland (WHO, 2006). OOP expenditure in Switzerland has showed an increasing trend through the years (the average for the period 1996-2003 is equal to 73.4%). The Netherlands exhibits a decreasing trend (the average for the period 1998-2003 is equal to 22.9)(OECD, 2005). Moreover, as reported in Figure 1, the proportion of private versus public expenditure as a percentage of GDP is higher in Switzerland than in the Netherlands.

On the whole such increases in OOP expenditure are likely to have some undesirable effects on access and may therefore bring additional social costs. In pushing the system towards a more consumer-driven health care set-up, where people are given more responsibilities to decide how to allocate their money, one should also consider what the consequences of this behavior will be.

3.4 Premiums and Solidarity

Constant increases of health care premiums in the last years are a thorn in the side of the Swiss health care system. Moreover, the variability of insurance premiums and health care expenditure is

[20] A shy attempt to introduce managed competition via HMOs basically failed because these latter could not negotiate on price with hospitals by establishing preferred provider contracts and probably also because of a certain Swiss attitude of being accustomed to have the luxury of a non-restricted choice between care providers.

[21] Note that a distinction should be made between: 1) actually performing the actions in this more expensive code then necessary, and 2) only declaring this more expensive code while actually performing a different one.

very wide both at inter-cantonal and intra-cantonal level. The growth of total health care outlays is socially perceived as unfair and as a detriment of equity, notwithstanding the fact that poor individuals are subsidized by the state. Health insurers cannot make any profit on the basic package, while they are for-profit entities for what concerns additional insurances. The FHIL obliges health insurers to keep the two bookkeeping systems (basic and additional insurance) separated because of transparency reasons.

Policy makers in the Netherlands should consider this upward cost trend carefully. A transparent bookkeeping system of insurers is necessary for understanding how financial reserves are used.

Health policy experts in Switzerland suggest that the basic benefits package should be thinned, distinguishing between the desirable and the essential care. The one-size-fits-all insurance model implies that insurers are not free to structure their tariffs and benefits. As a result the predicted variety of health insurance products (HMOs, PPOs, GP networks, etc) and premiums has not emerged and so product and quality competition between insurers is stifled, and the consumer literally pays the price of this.

The level of the premiums in the Netherlands with the new health insurance system is lower than what the Ministry had initially calculated.[22] However, some argue that such a lower level of premiums was possible because health insurers have used their past reserves in order to attract a larger number of clients. Moreover, the level of the premiums of those consumers choosing for a deductible (e.g. Euro 500) end up with a discount on their premium that varies between Euro 75 to Euro 252 (Kleef et al., 2006). This demonstrates that the insurers' behavior in the first months of 2006 was characterized by uncertainty about the risk-equalization system in place. There are strong signals that the risk-equalization mechanism across insurers is working imperfectly, namely that risk-equalization contributions do not fully correct for differences in the health status of the insured opting for a deductible and those who do not. At the very end insurers might choose to apply a favorable risk selection, differentiating premiums for those people opting for a higher deductible level (who are probably healthier) from those not choosing any deductible. But such a policy is detrimental to solidarity and shows an emerging trade-off between solidarity and efficiency (Kleef et al., 2006).[23]

The optimal or socially desirable level of consumer mobility crucially depends on the primary goals of introducing consumer choice, the quality of the risk-equalization system, and the available tools for health insurers to influence the provision of medical care (Laske-Aldershof et al., 2004).

The level of Dutch premiums in 2007 is expected to increase due to the legal rule that 50% of the health costs should be paid by the income-dependent contribution rate, and the remaining 50% should be paid out of nominal premiums. The actual set-up of the system does not satisfy this 50-50 rule and as a consequence premiums in 2007 will have to be adjusted to this 50-50 ratio, ensuing a yearly increase of approximately Euro 65 of the nominal premium (Douven and Schut, 2006).

Needless to say that it is interesting to monitor the development of the premium level. If competition continues to play a role as it is now, then we may expect limited increases. The Swiss experience, characterized by an imperfect competition in the health sector and an unclear bookkeeping system of health insurers, teaches something different. The constant increases in health premiums cause troubles to middle and low income households and thus threatens solidarity and equity.

In order to reduce the impact of health premiums on the household income a system of subsidies to health insurers (in Switzerland) and a health care allowance to individuals (in the Netherlands) has

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[22] The Cabinet estimated an average yearly premium for the basic package of Euro 1,106. At the end the average premium of all insurers was set at Euro 1,060 (varying from 990 to 1172).

[23] Political discussions in Switzerland considered the idea of granting a very high discount on insurance premium if the individual opts for the highest deductible.

been put in place. At the moment, in some cantons health care subsidies cover almost 40% of the population. In the Netherlands, about 5,1 million people (out of 16) receive the health care allowance (*zorgtoeslag*).[24]
Of course the basic tenet that health care should be affordable and accessible to everyone still stays even in a system that is implementing lots of competition. But how sustainable is it? Growing premiums and the consequent growing number of subsidy/allowance recipients does not seem to be the right direction where to go. Solidarity versus low income groups might become at risk, and so the financial sustainability of the whole system.

3.5 Cost explosion
One of the main goals of the Swiss change in the health system was to introduce more competition in order to reduce the cost explosion taking place in the country. Switzerland is in fact only second to the US concerning the quota of GDP spent on health. If we look at how such percentage has varied in the last ten years, it does not seem that the FHIL helped lowering health expenditure. Care is very expensive and premium growth does not reflect in a parallel growth of quality of health care services. In order to be able to control outlays it is necessary to have a sane and competitive set-up of the system. This should start by giving incentives to patients, providers, and insurers. Insurers are to develop innovative, lower-cost insurance policies (e.g. managed care). At the same time competition between health providers should be stimulated much more; in this respect the practice of selective contracting on the procurement market would boost more competition.
At the moment the Dutch system gives incentives to patients, providers, and insurers thanks to the selective contracting clause, the participation into costs of patients/consumers, and the competition established between insurers. However, it is important to stress that competition should not only be on price. It is of primary importance to keep an eye on the quality of care delivered (for example through the development of outcome indicators).[25]

4. Conclusion
The Netherlands changed its health care insurance system in 2006. Many elements of competition have been introduced, the main objectives being efficiency improvement, cost containment, solidarity between social groups, and stimulating an increased role of the consumer. In order to achieve this it is necessary to stimulate competition on all the three markets (insurance market, provision market, procurement market). This reform closely resembles the Swiss FHIL of 1996, which goals were to strengthen solidarity, guarantee quality of care, and contain cost explosion. In both countries the driving motivation of the reforms was to use competition between health insurers as a mechanism for introducing market-oriented health care reform. Owing to the fact that Switzerland introduced market mechanisms in health care ten years ago, it is interesting to evaluate the performance of the Swiss system and learn from their experience. This means for the Netherlands learning from their successes and avoiding their mistakes.

The Swiss health care system is facing nowadays serious challenges such as increasing health care costs, a surplus in medical facilities, and rising levels of demand due to an ageing population, expectations and advancements of new technology available (OECD, 2004). Because of lack of central coordination and the existence of 26 different health care systems, there are situations where sophisticated and expensive hospital infrastructure is available in two places only a few kilometers

[24] See De Volkskrant, 3rd November 2005.
[25] In the Netherlands there are ongoing debates about the development of outcome indicators for health care next to the classic ones that are currently used (e.g. mortality rates).

apart, but in different cantons or covering only a relatively small population of some thousand people (Wyss and Lorenz, 2000). The level of service provision is thus in some areas inefficiently high. If the positive side of this is that queuing is not a major problem in Switzerland, that shortages of care do not happen even in rural areas, and that the quality of care is generally considered high, the negative side is that from an economic point of view there is a waste of resources, which are inefficiently used, especially at the hospital level. The Swiss case shows that in a complete decentralized system, reforms may be particularly hard to take place. The scant mobility of consumers in the Swiss health insurance market stifles a healthy competition between insurers. Moreover, the lack of selective contracting on the procurement market is a disincentive to insurers to control health outlays and compete with each other.
Yet it must be underlined that there are some advantages connected to a highly decentralized health care system. There are more health care resources available and more proximity to the needs expressed by the population; the system experiences no implicit rationing (such as waiting lists); there are no shortages of care since the supply of health services is ample; the access to the health system has no barriers and the patient is empowered because (s)he has free choice over providers; finally, if all these previous conditions are fulfilled, it is likely that the public satisfaction over the health care system is high (Mosca, 2005).

The Netherlands and Switzerland have moved towards a consumer-driven health care system. In other words, what they have in common is the implementation of effective consumer choice, in order to foster more responsibility by health care users. People are encouraged to take responsibility for their future health earlier in life and are rewarded with lower monthly health insurance contributions. The Dutch implemented this via a no-claim bonus and different levels of deductibles for health insurance. The Swiss introduced something similar with different choices of deductibles and (very limited) managed care plans.[26]
The level of OOP expenditure differs greatly between the two health care systems. In general there has been a progressive shift of costs onto the private sector (Docteur and Oxley, 2003). When the goal is to contain health expenditure and therefore avoid spiraling costs, pushing more costs onto the private sector can indeed allow total health care expenditure to increase at a moderate pace. However, if citizens shoulder more health costs the financial accessibility to health care services deteriorates.
In the Netherlands attention should be paid to the evolution of private expenditure, and the aim should be to avoid a heavy transfer of costs on private outlays. High OOP expenditure are detrimental for equity reasons. Moreover, in terms of cost containment this transfer of costs can be viewed as a short-term solution, which does not yield any added value in the long-term. The Dutch system currently has a no-claim refund, which is granted to those individuals who do not incur any health care costs in a year. Although there are some ongoing debates about the fairness of this refund – some people argue that the no-claim formula basically goes to the detriment of those who are sick – it can be regarded as a manner to stimulate better individual decisions about the use of health resources.

There is currently significant market competition in the Dutch health insurance. A lesson learnt from Switzerland is that competition can work if there is also liberalization on the supply side (more room

[26] Note that other countries are implementing measures going in the direction of a consumer-driven health care system. The USA started with the introduction of medical savings accounts (a tax-advantage savings plan that allows money to be put in before tax is paid on it and then to withdraw the money tax free for qualified medical expenses). Denmark is charging an extra fee for seeing a consultant. Germany introduced a general fee for seeing a GP.

for selective market contracting) and if there are no monopolists, cartels, barriers to new entrants, information asymmetry (Maarse, 2006).
The Dutch and the Swiss health care system share many similarities. At a first glance it seems that the Netherlands has handled some strains better (selective contracting, more incentives for consumers, lower number of insurers). It is a health care system that can be taken as an example for other countries: In this respect there are already some signals that Germany would like to shape its health system in a Dutch manner (Paans, 2006).

To conclude, maintaining solidarity in health care funding while introducing competition between insurers is a difficult undertaking. Owing to the forces unleashed by competitive markets, introducing competition without damaging solidarity cannot be achieved solely through deregulation. The solidarity safety net has to be designed very carefully, and this requires supervision of health care markets. Moreover a constant oversight is needed to understand if greater competition among health insurers leads to more efficient and effective health care, and if newly implemented mechanisms that combine solidarity with competition are successful in sustaining the policy objectives (Saltman and Figueras, 1997). Policy makers continue to face the classic dilemma in health care of equity and efficiency. The Dutch market needs to be monitored and evaluated in the coming period so to better understand how competition is evolving and if the desired effects of efficiency, innovation, consumer-choice and cost control are reached.

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