Dutch health reform at a crossroads

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Many health policy watchers follow the Netherlands's health care reform experience with great interest. The 2006 reform ended the traditional dividing line between the sickness fund scheme, which covered about 67% of the population, and private insurance covering the rest, and it introduced a single mandatory scheme carried out by private insurers who may go for profit. These insurers must cover all legal residents.

The reform is intended to bring about a system of *regulated competition* in health care. The aim is to introduce competition while upholding fundamental social values, in particular solidarity in health care financing and universal access to health care. Another aim is to enhance consumer choice. Everyone has the right to switch insurance providers by the end of the year.

People pay a set annual contribution, which in 2011 was 7.75% of income for employed persons and 5.65% self-employed persons. To induce competition, everyone also pays an annual premium set by each insurer separately, which this year ranged from 1,068 to 1,272 euro. The government pays the premium for children under 18.

Most people (89%) also purchase complementary health insurance to cover care that is not included in the basic scheme, such as physiotherapy and some forms of dental care. Insurers of these policies are not required to accept each applicant. Risk selection is permitted, but so far it has been quite limited: all insurers have given priority to the preservation and extension of their market share.

Is the health insurance reform a success? The answer depends on the perspective taken. First, the integration of the sickness fund scheme and private health insurance into a single scheme has strengthened solidarity. However, the premium charge (including the employer's part and the contribution for the exceptional medical expenses scheme for long-term care) as a percentage of income is still significantly lower for persons with an income of 100.000 euro than for persons with an income of only 10.000 euro; the percentages are about 7 and 25% of income respectively. How to assess these differences in premium charges is of course a matter of political preference.

Second, although insurance is mandatory, this requirement is not perceived as a serious restriction of freedom of choice. In fact, the reform has enhanced freedom of choice because of the yearly option to switch insurers. This year (2011) consumer mobility is 5.5% versus 3.9% in 2010. However, insurers and subscribers have only limited freedom regarding the composition of the benefits package because it is set by the government.

Third, the 2006 reform the number of insurers has dropped by nearly half from about 57 to 29. However, these figures obscure the concentrated structure of the health insurance market because four major companies (Achmea, Menzis, Uvit and Menzis) have a market share of about 90%, with 20 of the 29 insurers belong to one of these companies. In some regions the market structure is so concentrated that it may restrict freedom of choice.

Fourth, it is fair to say that managed care by patient steering and selective contracting is still in its infancy. So far, insurers have mainly used soft instruments to influence patients, in particular by giving them information on the waiting times of hospitals. However, there are indications of change. Some insurers recently announced that they will only contract hospitals which meet the quality standards of care, for instance in the field of breast cancer surgery.

Fifth, one may argue that that the results as regards the reform's objective of keeping health care affordable do not point to much success. From 2006 to 2009 health care expenditures rose by 19.4% compared to 16% over the period 2002–2005 The fraction of *publicly* financed health care in GDP grew from 6.8% in 2002 to 7.1% in 2005 and from 8.5% in 2006 to 9.5% in 2009 (the jump in 2006 is due to the integration of private health insurance into the basic health insurance scheme). The contribution rate period increased from 6.5% in 2006 to 7.75% in 2011. Over the same period the insurer premium rose by about 38%. Even more problematic is that for the years to come the growth of health care costs is expected to outstrip the growth of GDP by at least 2% a year.

More reforms are therefore foreseen for the near future. An important issue is how to respond to the expected growth of health

care expenditures. The first and most frequently used strategy is to raise contributions and premiums. A second strategy is to raise private payments, for instance by raising the mandatory deductible, asking more and higher co-payments or reducing coverage by removing health services from the basic benefits package. This strategy is politically highly controversial. Private payments have always been very unpopular politically, which helps explain why the fraction of private payments in health care financing (9% to 10%) is low in the Netherlands compared to most European countries. A third strategy is to spur insurers to negotiate low prices with health care providers.

The last strategy relates to the government's strategy in market reform. The government recently announced a continuation and acceleration of the market reform. But it also wants to retain the instrument of fixed budgets to control total expenditures (which implies that cost overruns must be offset by expenditure cuts the following year). Thus, the market reform remains to be a political compromise between the objective of freedom and entrepreneurship on the one hand and the need for central control on the other hand. How the market reform and the tension between freedom and control will evolve in future, is written in the stars of health care policymaking.

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