An Experiment with Regulated Competition and Individual Mandates for Universal Health Care: The New Dutch Health Insurance System

Pauline Vaillancourt Rosenau
University of Texas, Houston

Christiaan J. Lako
Radboud University Nijmegen, the Netherlands

Abstract The 2006 Enthoven-inspired Dutch health insurance reform, based on regulated competition with a mandate for individuals to purchase insurance, will interest U.S. policy makers who seek universal coverage. This ongoing experiment includes guaranteed issue, price competition for a standardized basic benefits package, community rating, sliding-scale income-based subsidies for patients, and risk equalization for insurers. Our assessment of the first two years is based on Dutch Central Bank statistics, national opinion polls, consumer surveys, and qualitative interviews with policy makers. The first lesson for the United States is that the new Dutch health insurance model may not control costs. To date, consumer premiums are increasing, and insurance companies report large losses on the basic policies. Second, regulated competition is unlikely to make voters/citizens happy; public satisfaction is not high, and perceived quality is down. Third, consumers may not behave as economic models predict, remaining responsive to price incentives. Finally, policy makers should not underestimate the opposition from health care providers who view their profession as more than simply a job. If regulated competition with individual mandates performs poorly in auspicious circumstances such as the Netherlands, how will this model fare in the United States, where access, quality, and cost challenges are even greater? Might the assumptions of economic theory not apply in the health sector?

The new Dutch health insurance system combines a Massachusetts-style mandate for individuals to purchase health insurance with the Stanford

Mrs. L. J. K. van der Velde (NVZ) is kindly acknowledged for providing background information about hospital negotiations. We also gratefully acknowledge Ralph Berkien, student at the Erasmus University, Rotterdam, our research assistant for the project. Finally, Hendrik De Heer, graduate student at the University of Texas at El Paso, helped with translations. The authors are entirely responsible for the content and for any possible errors therein.

Journal of Health Politics, Policy and Law, Vol. 33, No. 6, December 2008
University health economist Alain Enthoven’s long-standing model of regulated competition. The results of this experiment are of enormous interest to U.S. policy makers across the political spectrum (Harris 2007). The Dutch initiative especially resonates with those who seek universal coverage grounded in an entrepreneurial orientation with an emphasis on personal accountability for health (Burd 2007; Jost, Dawson, and den Exter 2006). It provides a possible model for those in the United States who believe government intervention is required to repair broken private-market insurance models, but who acknowledge that the public is not receptive to large tax increases to pay for universal coverage (Glied 2006; Nichols et al. 2004).

This article offers an evidence-based assessment of the first two years of the Dutch experiment. It begins by exploring the recent history and context of the reforms followed by a description of the politics involved in adopting the Dutch Health Insurance Act. Next, the organizational and structural components of the new system are sketched out, including the logic of Enthoven’s model and the structure of market competition that is central to it. In the conclusion the success of Enthoven’s model in the Netherlands is considered, and lessons for the United States are examined.

**History and Context of the Dutch Health Insurance Reform**

Prior to the 2006 reform the Netherlands had a complex, mixed public and private health insurance system with a major role for public financing and a broad respect for the private provision of health care. This system was the result of several decades of incremental reform, legislated and implemented by various governments. While it was a fragmented and confusing system, nearly everyone had health insurance one way or another. About 65 percent of the population with incomes below a certain level (32,600 euros in 2004) had compulsory health insurance from one of the Sick-ness Funds and were automatically insured. This program was funded by general taxation (24%), by income-related contributions subsidized by employers (66%), and by community-rated individual premiums (10%) (Helderman 2007: 180; Maarse and Bartholomee 2007). Those above this income level paid for their own health insurance, mostly voluntary, and largely provided by private insurance companies. Civil servants and government employees had their own health insurance program (5%). Supplementary insurance policies were not required, but they were available for individual purchase. About 2 percent of the population was uninsured.
From 1970 to the end of the 1990s Dutch policy makers proposed various comprehensive health insurance reforms, including a more unified insurance system for the whole population, cost containment, greater efficiency, control of the growth of health care facilities, increased market competition among private stakeholders, and less direct government participation in providing health insurance. While the comprehensive reform proposals were not enacted, more incremental (and at times contradicting) reforms became law (Helderman 2007: 177–178). For example, corporatist practices were challenged, and cogovernance forms of health policy making that brought together health care providers, health insurers, trade unions, employers, and government were enacted. Minor reforms, such as selective contracting with providers (employed by some Sickness Funds) and prospective payment experiments, were ongoing. In the end no major health insurance reform was forthcoming because of an economic recession, a change in political orientation of the governing cabinet from Center-Right to Center-Left, and the general absence of clear political leadership (Helderman et al. 2005; Maarse 2002). In short, during this period in the Netherlands systematic, comprehensive health insurance reform was not a high priority, health system costs were not intolerable, quality was acceptable, and there was no evidence that privatizing would be cost-effective or accepted by stakeholders and the population.

By the end of the 1990s the political environment was changing in the Netherlands, and there was growing frustration with the status quo. While 73 percent of the Dutch population reported satisfaction with the health care system in 1999 (den Exter, Hermans, and Dosljak 2005), that percentage declined substantially by 2002 when 47 percent felt the system needed fundamental change (Helderman 2007: 225). Complaints about inefficiencies meant that public support for insurance reform was on the rise. There was an evident dissatisfaction with the two major, parallel health insurance systems, one private and the other public, because each of them had a different set of rules that was seen as unfair. In addition, national economic expansion opened a window of opportunity for comprehensive health insurance reform. Experience with privatization in the social security system was cited by some as evidence that similar measures in the health system might work (Van der Grinten 2007). The technical tools needed for regulated competition were also improving. Payment systems based on Diagnosis and Treatment Combinations (DBC; similar to the U.S. DRGs), effective risk-adjustment mechanisms to compensate insurers, and better health care quality rating measures for consumer use were all in place (Helderman et al. 2005: 189; Helderman 2007; Gress 2006).
In mid-2003 a new coalition of policy forces developed that was decidedly more receptive to comprehensive change. The Dutch government acted, citing the need for cost containment, the expenses associated with the aging population, long waiting lists for procedures, an absence of innovation in the health sector, and a need for more consumer choice (van Kolfschooten 2003; Commonwealth Fund 2006; de Gaay Fortman 2006; Hoogervorst 2007; Netherlands Ministry of Health, Welfare, and Sport 2005b: 1).

The new Health Insurance Act, adopted in 2005 with almost immediate implementation six months later on January 1, 2006, united the two health insurance systems into a single compulsory private insurance system and discontinued the public health insurance system. It broadened options for individuals to choose among insurance plans offered by private companies, establishing an annual open-enrollment period. Government's role was reduced to that of an umpire with the goal of ensuring fair competition among private health insurance companies and protecting consumers (Scott, Tierney, and Walters 1988). Employers no longer paid a major part of their employees' health insurance costs. The Health Insurance Act transformed the Dutch health system from a largely supply-driven system to a more demand-driven health system with an important role allocated to patients/consumers, requiring that they choose between competing, private sector health insurance plans. The adoption of this act is considered by many policy experts to be merely the initial element in a larger program of market reforms of the Netherlands' health system. While the reforms continue to evolve, our assessment here relates only to what had been implemented through early 2008.

**The Politics of the 2006 Dutch Health Insurance Act**

There was substantial disagreement about the details of how the health insurance system could be improved (Van der Grinien 2007). For example, the political Right lobbied for regulated competition, and the Left demanded mandatory universal health insurance (den Exter et al. 2004: 123–124). The government's announced policy goal for the reforms was to achieve cost containment, but some worried that these efforts might compromise the Dutch tradition of strong social solidarity and universal coverage. On the one hand, many policy experts viewed health insurance reform as a logical evolution toward more systematic regulated competition. They saw the Health Insurance Act as a way to realize a neoliberal, entrepreneurial, business-oriented, private sector health insurance
system (Maarse 2006). On the other hand, many disagreed, arguing that the Health Insurance Act was a qualitative break with the past, which threatened the Dutch tradition of equality and the welfare state (Muiser 2007: 10; den Exter et al. 2004: 121–122).

To understand the context of the sea change represented by implementing the act, it is important to understand the Dutch political institutions. The Netherlands has a parliamentary, representative democracy with a praetext monarchy that encourages gridlock and makes rapid comprehensive policy change all but impossible under normal circumstances. Additionally, rules of proportional representation encourage multiparty coalitions, and even after an election that shakes up Parliament, it is rare that the incoming government will replace all the political parties from the previous governing coalition, adding yet another impediment to rapid change.

The adoption of the Health Insurance Act was finally carried out by the cabinet of Jan Peter Balkenende. This governing coalition was formed in mid-2003 of Balkenende’s own party, the Christian Democrats (CDA); the People’s Party for Freedom and Democracy (VVD); and the D’66 (Democrats 66). The CDA has no real equivalent in the United States, though it is sometimes compared with middle-of-the-road U.S. Republicans. In general, the CDA is conservative on cultural and moral issues, supportive of individual rights, and left of center on matters related to poverty, welfare, and human rights. Its members do not balk at restraining market forces to protect these issue areas. The VVD is said to be similar to the British Conservatives or the U.S. liberal wing of the Republican Party, with a strong commitment to the free market (“liberal” in the European sense of the word, emphasizing a liberal free market). D’66 is closest to the British Liberal Party or the U.S. Democrats.

The VVD member Hans Hoogervorst was named minister of health, welfare, and sports in 2003 by the coalition cabinet. He is considered to be the architect of the Health Insurance Act and is given credit for its adoption and implementation. The experience he gained as minister of finance in a previous reform-minded government is often cited as the reason he succeeded in reforming the health insurance system where others had failed in the recent past. Left of center political parties, including the Socialists and the social democratic-style Dutch Labour Party (PvdA), were not part of the coalition cabinet. They opposed its adoption and remain critical of it.

The Health Insurance Act, however, had the support of consumers and patient groups. Consumentenbond, a major consumers’ association, praised the reform because of the important role it gave to consumers in choosing their insurance plan and because it would force health care providers to
coordinate their efforts and reduce waiting lists (Ran 2006). Patient groups; national, disease-specific organizations; and consumer groups influenced the design of the Health Insurance Act in hopes of achieving certain protections under the law. However, these protections were not specified in great detail, and the exact terms of implementing these protections are still under debate (Muizer 2007: 28).

An array of special privileges regarding health insurance for small groups had accumulated over time in the Netherlands. These groups strongly opposed changes that reduced or eliminated their benefits. For example, veterans who previously had free health insurance were not pleased with the reform plan. Likewise, government employees were unhappy because the reform eliminated free health insurance for their adult children (confidential personal interview, May 24, 2006, The Hague). Removing such “acquired rights” is considered to be extremely difficult in most Western industrialized countries, but the government displayed the political will to do so even in the face of substantial opposition.

Organizational and Structural Elements of the Dutch Health Insurance System

The sale of health insurance policies is highly regulated under the new law. To maintain a level playing field for price competition between largely for-profit private companies, the purchase of basic health insurance is mandatory (Netherlands Ministry of Health, Welfare, and Sport 2006: 6–7; College voor Zorgverzekeringen 2007). Almost all residents of the Netherlands and those nonresidents who are liable to Dutch payroll tax are required to purchase a basic health insurance package of mandated services, with few exceptions. Fines and penalties are in place for those who ignore the law (Netherlands Ministry of Health, Welfare, and Sport 2006: 14). This package must include ambulatory medical care (primary and specialist services), hospitalization for up to one year, defined dental care, prescription pharmaceuticals, maternity care, ambulance service, and some rehabilitation. Additional supplementary coverage (sometimes referred to as complementary insurance or by Statistics Netherlands as “optional extra insurance coverage”) for expanded dental care, vision, physical therapy, and so forth is voluntary (ibid.). To ensure that only viable business entities participate in the health insurance market, participating insurance companies are closely regulated and required to be licensed by the Dutch Central Bank (DNB).

Most residents of the Netherlands paid premiums of about 1,106 euros per
year per person (approximately US$1,618.69 as of November 30, 2007) for basic health insurance the first year of the new program (Netherlands Ministry of Health, Welfare, and Sport 2006; De Nederlandsche Bank 2007c). But premiums are only part of the cost of health care in the Netherlands. Employers withhold 6.5 percent of employee salaries (capped at a maximum of 2,000 euros per employee per year). The self-employed and retired pay 4.4 percent of their income into a risk equalization fund. Discounts of about 10 percent are available on policies sold to groups. In fact, in 2006 about 53 percent purchased health insurance as part of a group (Douven, Timmerhuis, and Oolders 2007). In 2007 that figure increased to 56 percent (Douven et al. 2007). The Dutch health insurance reform explicitly encourages purchasing groups by allowing these discounts; such groups are expected to pressure insurers for quality improvements. This is described below.

Insurance companies in the Netherlands are required to sell the closely regulated basic health insurance policy — of one-year duration — at a set price (community rated) to all who wish to purchase it (guaranteed issue) without individual exclusions or preexisting condition limitations. However, the companies may pick and choose to whom they sell supplementary policies because guaranteed issue and community rating do not apply to these policies. In 2006, 92 percent of the Dutch purchased supplementary insurance policies (De Nederlandsche Bank 2006b, 2007c: 42). It is on these supplementary policies that insurance companies expect to make a profit. To enable compliance with the law requiring everyone to buy health insurance, a progressive, income-based, sliding-scale subsidy assists about 38 percent of the population to purchase a basic health insurance policy (Centraal Bureau voor de Statistiek Persbericht 2007b).

**Testing Enthoven in the Netherlands**

The Dutch health insurance reform is the best test to date of regulated competition (Enthoven and van de Ven 2007; Rigoglioso 2007). Alain Enthoven and others noted as long as twenty-five years ago that health insurance reforms such as guaranteed issue (with risk equalization for insurers), universal coverage by individual mandate (required purchase), price competition for a standard health insurance benefits package, and community rating are best employed together (Sekhri, Savedoff, and Tripathi 2005; Enthoven and Kronick 1989; Enthoven and Singer 1995). Each by itself is problematic (Federal Trade Commission/Department of Justice 2004). For example, mandating all to obtain health insurance eliminates cost shifting from the insured to the uninsured, but without guaranteed
issue (requiring that insurance companies sell policies to all those who wish to buy them) some individuals may not be able to comply with the requirement that they purchase health insurance. In the absence of community rating, even with guaranteed issue, insurance companies might charge those already sick so much for insurance that the cost would be prohibitive. Without regulation as to what must be included in the basic insurance policy, consumers might not be able to carry out effective price comparisons among plans offered in the market. Individual insurance mandates might restrict choice and increase costs if not combined with aggressive market price competition for the basic health insurance plan. However, if the elements mentioned above are implemented together, with sliding-scale subsidies for lower socioeconomic groups, and risk equalization for insurance companies, might they promote cost containment while preserving quality and access? The Dutch Health Insurance Act, implemented in January 2006, is testing exactly this proposition.

The Structure of Competition:
Ensuring That It Is about Price for the Basic Health Insurance

The health insurance reform in the Netherlands anticipates and seeks to discourage gaming, “cream skimming,” or “cherry picking” by insurance companies because these tactics undermine fairness and circumvent policy makers’ intent to increase market competition on quality and price. A risk equalization plan, described below in this section, ensures that no insurance company is unfairly disadvantaged. The incentives to discriminate on the basis of “personal characteristics like age, gender, or medical situation,” and to market policies only to healthier groups, are enormous. This is because the cost of care for extremely ill patients is very high compared with the cost for the general public (Netherlands Ministry of Health, Welfare, and Sport 2005a: 19).

The health insurance market in the Netherlands is highly regulated to ensure a level playing field for competition (Rosenau 2003). The Dutch Healthcare Authority (De Nederlandse Zorgautoriteit [NZa]) was established in October 2006 to “ensure the success of regulated market forces.” Its mandate is to protect consumers, to promote competition, to stimulate and monitor the performance of the regulated market forces, and to make certain that “players act efficiently and are given the correct incentives to do so” (Nederlandse Zorgautoriteit 2006: 1–3). Consumer interests are assumed to be central to its mission, but this is interpreted narrowly as
ensuring an efficient market that “gives the consumer the best value for his or her healthcare Euros.” It may intervene when market forces fail, “if the interests of the consumer suffer,” for example, when consumers face “insufficient choice between health insurance companies” (ibid., 1). The NZa has strong enforcement powers to ensure that neither large provider groups nor insurance companies practice predatory pricing. It can use its “administrative coercion” independently regarding the supply, delivery, and pricing of health services. It is empowered to hear complaints and assess problems, and it has a staff of economists to carry out this responsibility. It also works closely with other supervisory and oversight agencies including the Netherlands Competition Authority, the Healthcare Inspectorate, the Dutch Central Bank, the Netherlands Authority for the Financial Markets, and the Data Protection Board (ibid., 5).

To control gaming by insurers the new health insurance law includes regional policy sales coverage and risk equalization. It requires that the largest insurance companies, with more than 850,000 covered lives, offer services throughout the country, not just in the regions and neighborhoods where the population is healthier. Most important, risk-compensation aspects of the new law offer substantial equalization payments to insurance companies that end up with a disproportionate share of the most costly patients (van de Ven et al. 2007). This risk program is paid for by the Health Care Insurance Fund (Zorgverzekeringsfonds), and in some cases payments account for 50 percent of an insurer’s revenue. To qualify for the equalization payments, insurers must register with the Supervisory Board for Health Insurance (CTZ) within NZa.

The risk equalization plan is not perfect, but most policy makers agree that the current plan is an important tool for reducing gaming by health insurers, a necessary but not sufficient condition for competitive insurance markets (van de Ven et al. 2007). However, its long-term effectiveness is questioned by critics who suggest that insurers are likely to find several ways to circumvent controls on gaming. In addition, econometric at the Dutch Central Bank worry that this risk equalization fund may undermine the “stimulus for insurance companies to work towards more cost-effective procurement of health care services” (De Nederlandsche Bank 2007c: 43–44). They have urged Parliament to modify the risk adjustment system so that it is more future oriented—compensating insurers for taking on patients who may need more health care services without rewarding them, retrospectively, for spending more on such patients (ibid.).

Financial incentives in the new Health Insurance Act are complex and targeted as much at the consumer as at the insurance provider. The pol-
icy intent of government health system regulation in the Netherlands is to encourage consumers to focus on the cost of this mandated set of health services, thus requiring that insurance companies compete on price.

Economists reason that if market competition for health insurance is to control the price of insurance policies while encouraging quality, consumers must act as critical purchasers, comparing the products offered in the marketplace and acting freely and rationally on the basis of information they can trust. Whether consumers can fulfill this goal is debatable (Lako and Rosenau 2008). However, government economists contend that it will work if transparency regarding price, access, and provider performance are made available to consumers. To ensure self-sufficient consumers, in the individual insurance market, Web-based online Internet tools were made available so that consumers could compare options when purchasing health insurance policies. The information posted is monitored by the NZa (Verkoulen 2007).

**Performance Results: Consumer’s Premiums Have Increased, Total Health Costs Are Up, and Incentives for Personal Accountability Have Been Revised**

Total health care cost increases in the Netherlands started to decline two years before the reform, and the implementation of the Health Insurance Act in 2006 has not reduced the rate of increase further. Statistics Netherlands reports that total costs increased 4.4 percent the first year and 5.1 percent the second year (Centraal Bureau voor de Statistiek Persberichten 2006, 2007a, 2008). Individual health insurance premiums in the Netherlands rose about 8–10 percent in 2005–2007 and are predicted by government sources to increase by an even greater percentage in 2008 (De Nederlandsche Bank 2006b: 26; 2007b: 17). Insurers will have to increase these premiums even more if they are to begin to make a profit on these basic policies.

Incentives for personal responsibility for health status were included in the reform legislation to control costs, but the means to achieve this were flawed. The Dutch had experimented with health-based risk-adjusted premiums in the past (Custers, Araha, and Klazinga 2007). Building on that experience, the reform law required that insurance companies award a rebate of between 1 and 255 euros to those whose health care costs during the year were less than 255 euros (Lako and de Vos 2006). While intended to reward those conscientious about health behavior and discourage unnecessary care
(general practitioner visits were excluded from the calculation), this rebate was seen by many as unwarranted, unfair, and of little value in terms of cost control (Parliament of the Netherlands 2006; de Jong et al. 2006). As anticipated by health policy experts, the rebate has been replaced by a deductible of 150 euros per year. There is a reduced deductible for the chronically ill and handicapped (Saltman and Dubois 2004).

**Health Insurance Companies:**

**Razor-Sharp Competition for Market Share, Large Losses, and Failure to Negotiate Efficiently with Providers**

Economic theory assumes that if private sector market competition for health insurance is to work in the long term, there must be many insurance companies offering policies at prices that, while low, still permit a fair profit. In 2006 and 2007 insurers in the Netherlands competed for market share rather than focus on quality or on making a profit. This is not surprising in a new market for health insurance (Rosenau 2001). While there are many companies selling health insurance in the Netherlands today, a few large players increasingly dominate the market (Gress, Manouguian, and Wasem 2007). While the NZa has the power to resolve such problems, it has not acted, and there is little precedent to guide action. Policy makers feel the situation is worrisome (personal interview). They would like to see more strong players in the market to ensure that the hoped-for competition will reduce health care costs.

Health insurance companies have registered large losses since the health insurance reform was implemented in January 2006. Except for one fiscal quarter, those losses rose at an increasing rate through mid-2008 (De Nederlandsche Bank 2007e, table 9.6). Health insurance companies have yet to make a profit on the basic plan. Results on the supplementary policies have varied widely from fiscal quarter to quarter. Insurance companies were predicted to lose 320 million euros on the sale of the basic health insurance plans and 40 million on sales of the supplementary “premium packages” (De Nederlandsche Bank 2006b: 24). The insurance industry’s own statistics differ somewhat from those published in the DNB’s *Statistical Bulletin*, but they too report substantial losses (somewhat greater amounts: 400 million euros for the same time period) (Vektis 2007).

Insurers responded to these losses by restructuring their home offices, downsizing, and laying off workers to reduce infrastructure costs (Tamminga 2006). Reducing administrative staff, however, may be counter-
productive if, as a result, processing inquiries and complaints takes longer and customer satisfaction drops. Do these efforts to reduce losses account, in part, for the low customer service ratings that some insurance companies received in a 2007 customer survey (de Boer et al. 2007)?

The Dutch Central Bank does not appear to be worried about the financial performance problems of the health insurers since the health reform was implemented (De Nederlandsche Bank 2007c: 43). As regards consumer premium increases, it emphasized in its 2006 fourth-quarter report that consumers are “still getting good value for their money” (De Nederlandsche Bank 2006b: 25–26). The DNB maintains that the sliding-scale government subsidies and other cost reductions will reduce the impact of these increases on consumers (ibid.: 84). In 2006 it observed that the insurance companies lost money, but the DNB predicted that 2007 premium increases would offset those losses. This did not prove to be the case (De Nederlandsche Bank 2007f). The DNB reassured policy makers, arguing also that the observed consolidation in the health sector would reduce administrative costs for the insurers, thus improving their profit margins over time. Finally, the DNB indicated that despite the losses incurred by the health insurance companies in 2006, the fiscal integrity of the insurance companies remains intact because these companies have greater reserves than required by law. In addition, the DNB notes that health insurance companies are owned, for the most part, by larger corporate enterprises and conglomerates that can absorb the losses (De Nederlandsche Bank 2007c: 43; 2006: 25–26; 2007d; Tamminga 2006).

Economists argue, and the DNB agrees, that if market competition for basic health insurance is to contain costs without direct government intervention, health care insurers must bargain more effectively with health service providers, especially doctors. Reducing their operating expenses is not sufficient because these costs amount to only 7 percent in the Netherlands. Insurance companies are told that they “must have greater control over health care expenses by referring their clients to more efficient health care providers” (De Nederlandsche Bank 2007c: 43). However, there is little or no evidence that the insurance companies are making inroads on this front. The parliamentarians who drafted the new health reform bill report that they are surprised that this is the case (personal interview). Under the former health insurance system, the Sickness Funds “reimbursed primary care physicians through annual capitation payments, while private patients paid practitioners and were then reimbursed by insurers.” The new health system includes a “capitation per patient and a fee per consultation, plus a negotiable reimbursement for practice costs depending on services offered, staff employed, and quality and efficiency indicators” (Grol 2006: 3; Davis
2007; Custers, Arach, and Klazinga 2007; Schoen et al. 2006: 567; Okma 2001). But none of this has made much difference.

The incentives for the insurance companies to negotiate with health services providers are in place; for example, insurance companies are not required to contract with all providers offering a health service. They may encourage patients to use a list of preferred doctors, and they are allowed to negotiate with doctors as to fees for services. They may measure physician performance if they wish and set quality standards (Netherlands Ministry of Health, Welfare, and Sport 2006). Insurance companies are permitted to negotiate with hospitals for discounted fee structures. In 2006, only 10 percent of a hospital’s budget was subject to such negotiations (payment by DBCs) (De Nederlandsche Bank 2007c). In the long term, insurance companies are seeking to increase this to 70 percent of a hospital’s budget, and it will be increased to 34 percent in 2009 (van Nobelen 2006). In addition, a few experiments are ongoing with insurers organizing primary care and pharmacy services directly for those who purchase health insurance policies from them (personal correspondence from Dr. Ab Klink, Minister of Health).

Price Is Not the Only Factor for Consumers

National surveys indicate that consumers are well aware that health care premiums are more expensive after implementing health reform (Consumentenbond 2006). The Dutch Institute for Public Opinion and Market Research, on the basis of a self-administered questionnaire distributed in December 2006 to a random sample of five hundred individuals, found that two-thirds of the respondents were worried about the financial impact of the new health insurance program on their personal financial status (TNS NIPO 2007). Along the same lines, a voluntary poll of 6,635 union members in the Netherlands reported that 70 percent of those who responded felt that the new health insurance reform weakened their purchasing power (Nederlandse Patiënten Consumenten Federatie 2006).

Initially Dutch consumers did, indeed, respond to incentives to compare insurance plans; 20 percent switched insurers when presented with the opportunity to choose a plan the first year of the reform (De Nederlandsche Bank 2007c: 42). The Netherlands Institute for Health Services Research, an independent health care research organization, confirmed the trend (de Jong et al. 2005). This high level of switching was taken as an indicator of success of the new health insurance reform because it was assumed that switching reflected price competition for the basic health insurance plan, which would in turn lead to lower health care costs (Netherlands Ministry
of Health, Welfare, and Sport 2006). Historically in the former health system only 3 to 4 percent changed plans each year (Zorgverzekeraars Nederland International 2006).

However, consumers have not continued to aggressively practice price comparison shopping behavior (Douven et al. 2007). There was a sharp drop-off in such behavior for the second year; only about 5 percent changed health insurance plans (De Nederlandsche Bank 2007c: 42). This puzzled some policy makers. Only about 49 percent of those staying with their 2006 plan for the second year reported being satisfied with service and total coverage of their health plan (de Jong et al. 2006). Other policy experts in the Netherlands are not worried about this but interpret it to mean that the market remains competitive even though prices and the terms of the policies are very similar.

Consumers do not appear to be primarily motivated by price when it comes to the purchase of health insurance. While economists expected the price of the basic package to be central to the decision to switch, only about 28 percent cited it as one of their main reasons for changing health insurance plans for 2007, the second year of the new insurance reform. Incentives for switching were found to be “moving to a group purchasing unit” (33%). This was probably, in part, motivated by cost-savings reduction in premiums offered to group purchasers of health insurance—organized by disease-related associations, labor unions, employers, sports clubs, senior citizen organizations, and so forth (Bartholomee and Maarse 2007). Other switchers were seeking a basic health insurance plan offered by a company that also provided an attractive supplementary package (39%). Many switchers mentioned poor service as a reason for changing (33%). Overall, both before and after the health insurance reform, those under forty years of age were much more likely than others to switch health plans (de Jong et al. 2006).

**Consumer Satisfaction, Access, and Quality after the Dutch Health Insurance Reform**

**Satisfaction**

Public perception of the new Dutch health insurance system’s performance is mixed, and satisfaction is not high. The Consumentenbond surveyed an Internet panel of its membership (and health insurance members) about the new health system midyear in 2006. The responses reported here are from two surveys, with the answers combined and analyzed together. Allo-
gether 3,423 individuals were asked to fill out a questionnaire, and about 55 percent did so (van Nobelen 2006). While the results give a good idea of the range of opinion in the Netherlands about the new health reform system, they are probably not statistically representative of the population as a whole. For example, the level of education is higher in the sample than in the general population, and men outnumber women in the sample by a wide margin (76% to 24%).

Overall, popular approval for the reform varies. Only about 18 percent like the new system better than the old one (van Nobelen 2006), which was quite popular (Ettelt et al. 2006). Many more respondents report that it is worse compared with the previous system (41%). The remainder judges it as neither better nor worse (Consumentenbond 2006). However, those stating that they are “moderately or partially satisfied” with the Dutch health system, without mentioning the reform itself, increased to 71 percent by the end of the first year (2006) according to the Dutch Institute for Public Opinion and Market Research (TNS NIPO 2007). It is possible that with time the population is adapting to it (de Boer et al. 2007).

Most consumers indicated that with the information available to them about the new health insurance program, it is still difficult to compare insurance plans. According to a survey carried out by the Consumentenbond, only about one-quarter reported it was easier to evaluate insurance plans now, compared with the past. However, the percentage having difficulty in choosing a plan has decreased over time, as consumers gained experience with the new system. Three-quarters of respondents indicated that it took them more, or much more, time than they expected to learn about the new system. Despite this, 86 percent of Dutch consumers appear to like the idea of having a choice of health insurance plans, at least in the abstract. While more consumers trust the new health insurance system now that they have had experience with it (25%), overall, levels of trust remain low. Many trust it little (43%). Consumers report that they are increasingly knowledgeable about the new health system—60 percent are comfortable with their understanding of it (Consumentenbond 2006). A consumer satisfaction survey undertaken in mid-2007, based on a random sample of 8,088 individuals with more than thirty different health plans, found that the customer service orientation of companies needs to be improved. Customers do not see great differences between insurance companies on this variable (de Boer et al. 2007).

The Dutch Institute for Public Opinion and Market Research’s survey also found that the public would welcome more information (transparency) about quality of care from providers and medication. Providers were less
enthusiastic about this sort of information being made available (TNS NIPO 2007). Policy experts early on anticipated that this might be a problem (Maarse and ter Meulen 2006). And as indicated above, NZa is moving to improve transparency.

Not surprisingly, some in the Netherlands today are more satisfied than others with the new health insurance system, and certain pockets of serious discontent are evident. One group emerged substantially better off: the government pays the full cost of health insurance for all those less than eighteen years of age. This means that the real winners in the new health insurance system are families with minor children. The Labour Party expressed dissatisfaction with potential premium increases, predicting they would go up 10–12 percent in 2007 (Partij van de Arbeid 2006); they were right about the increases, but the magnitude was lower than what they had anticipated. Several additional points give rise to isolated pockets of dissatisfaction: the fact that individuals are required to purchase health insurance, that there is too little variation allowed between the basic health care plans offered by different companies, and that the basic insurance plans have to be community rated.

Access

Access has been high in the Netherlands, historically, and policy makers successfully sought to preserve it when they restructured the health insurance system. Only about 1.5 percent of the population has failed to purchase health insurance as required by law (Centraal Bureau voor de Statistiek Persbericht 2007b). Solutions for these individuals are being sought (Ministerie van V.W.S. 2007). There is little question that the Dutch support universal coverage—it is widely accepted. The Dutch government’s subsidies to those at the lower end of the socioeconomic spectrum for the purchase of health insurance through a sliding scale of reimbursements also helps maintain access while preserving equity (Netherlands Ministry of Health, Welfare, and Sport 2006; Mackenbach and Stronks 2002).

Subsidies for purchasing insurance are available if the nominal premium is greater than 5 percent of an individual or household’s income. There is an explicit redistribution effect from the healthy to the sick and from the young to the old. In addition, those who designed the system expect an indirect subsidy from the rich to the poor by way of payment mechanisms. Through a combination of both fixed-rate and income-based premiums, the rich end up paying more than the poor, but the poor use more health services than
the wealthier citizens. Finally, there is redistribution from those over eighteen to those under eighteen because, as mentioned above, children under eighteen are automatically covered by the government.

Quality

So far, there is little empirical evidence about health care quality changes in the Netherlands resulting from the new health insurance system, but consumer perception of quality change has been studied. More consumers perceive that quality has been reduced (41%) rather than improved (8%). Mechanisms for ensuring quality of care are largely informal, and there is considerable skepticism as to whether the new health insurance system can improve quality (Custers, Arah, and Klazinga 2007). Stakeholders, including insurance companies, health professionals, hospitals, and the ministry of health, welfare, and sport have specific fiduciary requirements and responsibilities that are legally binding and that involve quality. For example, the government expects “insurance companies to act as effective, customer-driven organizers of care for the people they insure.” Private insurance companies are more than “payers”; they are also “expected to act responsibly to ensure that their policy holders get the health care they need” (Netherlands Ministry of Health, Welfare, and Sport 2005a: 16).

Holding physicians and insurers to these fiduciary responsibilities vis-a-vis patients in the current competitive environment may be unrealistic. Few of them fully understand their new role in the health system. While being held responsible for quality, they must make a living and cover their costs. For example, few health care providers have experience with estimating their costs in advance, as most must do today. Many are focusing on how to merely survive in the heavily market-driven health sector. While they may learn to “bid” for health services eventually, they are conflicted by deeply held beliefs that health services have a social component that is not present in other business and economic sectors (interviews with Dutch providers were carried out by the authors in December 2006).

Group purchase is another policy mechanism adopted to promote quality without direct government intervention. The policy goal is to expand and decentralize the points at which the insurance companies are held responsible. Collective purchasers are assumed to have more power than individuals, be it informal, to require health insurance providers to perform on both quality and cost. Groups acting as agents for their members are expected to function as rational purchasing agents (Maarse and ter Meulen 2006). This
aspect of the new health system encourages group-oriented consumer participation to a greater degree than the previous health system, which relied more on the government to monitor performance.

**Conclusion**

There are important lessons from the Dutch experiment in market-oriented, regulated competition for health insurance, as envisioned by Enthoven, for other countries (Sekhri, Savedoff, and Tripathi 2005). The Dutch experiment includes almost all of the mechanisms that major policy experts, such as Enthoven, have come to consider essential for the success of this approach to health insurance. In addition it includes them simultaneously, thus making it an even better, fairer test.

The Netherlands is culturally, politically, and economically a most auspicious area to test regulated competition. Universal coverage had been achieved already. Stakeholders had experience with community rating and guaranteed issue; these elements, critical for regulated competition, were not obstacles. Overall health system costs per person, per year in the Netherlands were about one-half of what they are in the United States. The Netherlands had already worked on problems having to do with primary care, emergency care, and quality improvement processes prior to implementing health insurance reform. The Dutch health system was among the best in the world on these variables (Grol 2006: 3; Davis 2007). Finally, the legitimacy of political institutions and government agencies seeking to monitor and regulate competition was not seriously questioned (College voor Zorgverzekeringen 2007).

Still, preliminary results, based on the first two years of the Dutch experience, suggest that problems remain. Even when implemented in the best of circumstances, carefully regulated, Enthoven-inspired, market competition does not meet policy makers’ expectations for achieving cost containment while preserving or improving quality and access. In addition, policy analysts in the Netherlands point to several potential problems that might emerge in the future. Will the benefits in the basic package be eroded? Will mergers and acquisitions in the private insurance sector chip away at consumer choice? Will competition undermine quality? Will risk selection be practiced subtly even though it is not legal? Will stakeholders effectively lobby government to remove the restraints designed to preserve solidarity? The 2006 reform privatized only health insurance, but will this set a precedent and lead to the gradual privatization of other health system programs (Muiser 2007: 2)?
The Dutch experience suggests several lessons for the United States. First, it is a mistake to expect dramatic health care cost reductions with the introduction of regulated competition, at least in the short term. Second, regulated competition is unlikely to make voters/citizens happy. Dutch consumers, for the most part, are not highly satisfied with the change. Third, consumers cannot be expected to act as economic models predict. Dutch consumers were slow to adjust to the new market-based competitive system. In addition, they may not be maintaining their aggressive comparison of health insurance plans during the annual open enrollment period, especially if price differences are small. Policy makers counted on them to continue “shopping critically” to ensure competition in the health insurance marketplace. Fourth, if insurance companies focus more on market share than on making a profit, financial losses are likely for a considerable period of time. Fifth, Dutch policy makers thoroughly underestimated the opposition from health care providers. A large percentage of doctors in the Netherlands are primary care physicians in family practice who define their profession as more than simply a job. While they may be well compensated, what brought them to their career initially was also a commitment to helping others, which many view as incompatible with market competition.

A last lesson is future oriented: the DNB predicts that consumer premiums will have to increase considerably in the future if insurers are to make a profit on the basic policies (De Nederlandsche Bank 2007e). Will popular support for the Health Insurance Act erode in the Netherlands if this happens? Might discontent develop as a result, and this then translate into a political backlash? This is most likely if the premiums paid directly by consumers increase substantially.

The experience in the Netherlands has had little impact on policy makers in that country. The experiment goes forward with a new energy and with a confidence that relatively incremental changes will be needed to fine-tune the model and improve performance. In the face of initial failure to control costs, the reaction of the Dutch government has been to reiterate its faith in the free market for health insurance and to argue that cost containment was not an important rationale for the Health Insurance Act in any case (confidential personal interview, April 13, 2007).

The question for U.S. policy makers is this: given the frustratingly imperfect results of the Dutch experiment with market-oriented, regulated competition for universal health care, is it realistic to expect it to succeed in the United States? The challenge of health insurance reform at the state and federal level in the United States is substantially greater because of the need to reduce the number of uninsured simultaneously (Rosenbaum 2006).
In addition, the U.S. health insurance reform starts off with a far higher cost-base than that of the Netherlands. The U.S. public's satisfaction with the health system is lower than it has been in the Netherlands, historically (Blendon, Minah, and Benson 2001). The United States has far more serious problems with quality than does the Netherlands, as well as the highest medical error rate among the seven industrialized countries studied (Grol 2006; Schoen et al. 2007).

Few have questioned the appropriateness of regulated competition for the health services sector, but the experience of the Netherlands should give pause. From a theoretical point of view, a good case can be made that the health sector is an imperfect market and that many assumptions of economic supply and demand may not hold (Rice 2002). There is some recognition by U.S. scholars that, as currently structured, regulated competition is imperfect or ineffective in the United States (Federal Trade Commission/Department of Justice 2004; Hyman 2000). Overall, there is little empirical evidence as to its benefits (Schlesinger 2006: 420).

The critical lesson for policy makers in the United States is that it may be a mistake to put too many of one's eggs in the regulated-competition basket. Neither is it wise to draw firm and definitive conclusions from one case—the Netherlands. But it would be prudent for the United States to explore beyond the regulated competition model, to look for different, more innovative varieties of health insurance reform, some of which may have a greater likelihood of success. Good minds are already at work on this project (White 2007; Rice 2002).

References


Van der Grinten, T. E. D. 2007. Stelselherziening van de Nederlandse gezondheidszorg:


van Nobelen, D. 2006. *Het nieuwe zorgstelsel: Meing 2: Wat is er, nu het nieuwe zorgstelsel een feit is, veranderd in de kennis van en mening over het nieuwe stelsel?* Amsterdam: Consumentenbond.


Contents

Editor's Note  Michael S. Sparer  1027

An Experiment with Regulated Competition and Individual Mandates for Universal Health Care: The New Dutch Health Insurance System  Pauline Vaillancourt Rosenau and Christiaan J. Lako  1031

Learning and Mislearning across Borders: What Can We (Not) Learn from the 2006 Health Care Reform in the Netherlands? Commentary on Rosenau and Lako  Kieke G. H. Okma  1057

Health Insurance Experiments in the Netherlands and Switzerland: A Rejoinder with Updates  Pauline Vaillancourt Rosenau and Christiaan J. Lako  1073

Controlling Prescription Drug Costs: Regulation and the Role of Interest Groups in Medicare and the Veterans Health Administration  Austin B. Frakt, Steven D. Pizer, and Ann M. Hendricks  1079

Managed Care and Private Health Insurance in a Global Context  Jonathan P. Weiner, Joanna Case Farnadas, Hugh R. Waters, and Djordje Gikic  1107

Books Received 1169
Contributors 1173
Acknowledgments 1177
Index to Volume 33 1181