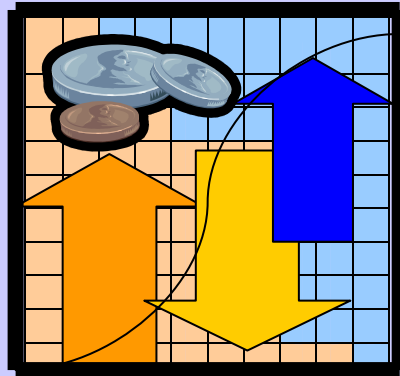




**World Health
Organization**

HSS/HSF/DP.07.3



**The new
Dutch health insurance scheme:
challenges and opportunities for better
performance in health financing**

DISCUSSION PAPER

NUMBER 3 - 2007

*Department "Health System Financing" (HSF)
Cluster "Health Systems and Services" (HSS)*

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The document was prepared by Jorine Muiser. This paper is the result of a desk study. I specially thank Guy Carrin and Inke Mathauer for their valuable comments and suggestions. The views expressed in documents by named authors are solely the responsibility of those authors.

**The new
Dutch health insurance scheme:
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by

Jorine Muiser



**World Health
Organization**
GENEVA
2007

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Executive Summary

This paper describes the 2006 reforms in the Dutch health financing scheme. The reforms represent a systemic shift from supply- to demand-side control. The new model is referred to as regulated competition. It implies enhanced competition between insurers and between providers, but within the boundaries of a legal framework. Most health system functions, apart from stewardship, are devolved to private entities. In 2006, the model was implemented only in a limited part of the health care market. If successful, it may be extended to other segments as well.

This paper analyzes the reforms in view of the health system goals. These include improved health, fairness of financial contribution and responsiveness. The analysis is based on the WHO health financing framework, which applies a number of key performance indicators to the scheme. The new Dutch model is found to provide opportunities for the achievement of the health system goals and to increase efficiency. On most indicators it produces improvements compared to the previous scheme. However, the new model does not give guarantees for high quality performance; it rather brings additional risks of market failure that require constant monitoring and may result in higher transaction and administrative costs than the previous scheme. The paper concludes with a brief discussion about the feasibility of the model for other countries.

Abbreviations

AWBZ	Algemene Wet Bijzondere Ziektekosten (Exceptional Medical Expenses Act), 1968
CG-Raad	Raad voor Chronisch Zieken en Gehandicapten (Council for the Chronically Ill and Disabled)
CPB	Centraal Plan Bureau (Central Plannings Office)
CTG/ZAio	College Tarieven Gezondheidszorg/Zorgautoriteit in oprichting (Health Care Tariffs Board/Care Authority to be)
CTZ	College Toezicht Zorgverzekeringen (Health Insurance Monitoring Board), 2006
CVZ	College voor Zorgverzekeringen (Health Care Insurance Board), 2006
DBC	Diagnose Behandelingscombinatie (Diagnosis Treatment Combination)
DCG	Diagnostic Cost Group
DRG	Diagnosis Related Group
HMO	Health Management Organization
IGZ	Inspectie Gezondheidszorg (Health Care Inspection)
LVH	Landelijke Vereniging Huisartsen (National Association of Family Doctors)
NMa	Nederlandse Mededingingsautoriteit (Dutch Market Authority)
NPCF	Nederlandse Patienten en Consumenten Federatie (Dutch Patient and Consumer Federation)
NZa	Nederlandse Zorgautoriteit (Dutch Care Authority), 2006
PCG	Pharmacy Based Cost Group
SPC	Samenwerkende Patienten en Consument Organisaties (Collaborating Patient and Consumer Organizations)
VWS	Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Public Health, Well being and Sports)
WGBO	Wet op de Geneeskundige Behandelingsovereenkomst (Medical Treatment Agreement Act)
WHR	World Health Report
WMG	Wet Marktordening Gezondheidszorg (Health Market Regulation Act), 2006
WMO	Wet Maatschappelijke Ondersteuning (Social Support Act)
WTG	Wet Tarieven Gezondheidszorg (Health Care Tariffs Act), 1991
WTZ	Wet op de Toegang tot de Ziektekostenverzekering (Acces to Health Insurance Act), 1986
WZV	Wet Ziekenhuisvoorzieningen (Hospital Provision Act), 1971
ZFW	Ziekenfondswet (Sickness Fund Act), 1964
ZN	Zorgverzekeraars Nederland (Health Care Insurers Netherlands)
ZVW	Zorgverzekeringwet (Health Insurance Act), 2006

1. Introduction

The recent health system reforms in the Netherlands are the outcome of a historical process that started three decades ago. As such, the introduction of market mechanisms in the Dutch health sector reflects an incremental process. This is illustrated by the fact that some measures that characterize the new model were introduced before 2006. But the 2006 reforms also represent a radical shift in health system development. They turn a supply side controlled model into one induced by demand. It devolves, in certain parts of the health care market, responsibility for the health system core functions, apart from stewardship, to the private sector. The aim of the approach is double fold: to increase the fairness, transparency and efficiency on the health care market and to achieve the broader health system goals. It is yet to be seen whether the system design will be effective in achieving this double purpose. Important questions that need to be asked are whether there are sufficient guarantees for the government to properly carry out its role as steward, for health care providers to offer care according to their professional standards, for consumers whether the scheme is affordable and whether they will timely receive the care they need. At the same time, the (administrative) efficiency and sustainability of the scheme should be examined, and its impact on the level of health system responsiveness.

This paper compares the design of the previous and the new Dutch health financing schemes in view of the broader health system goals as defined in the World Health Report 2000. It draws on an analytical framework that was developed as a result of this report and focuses on the health financing functions. The framework helps policy makers to monitor the performance of a health financing scheme in view of their targets and to identify critical issues and opportunities for reform. As it is focused on health financing, it represents an intermediate stage in the performance analysis of the health system and does not provide instruments to monitor the level of responsiveness, among other things.

The paper is organized as follows. After this introduction, the analytical framework and its relevancy for the analysis of the Dutch reforms are presented. The third section describes the financing mechanisms and benefit package of the Dutch health financing scheme in general terms. In the fourth section, a historic run-up to the new model is provided and the roles of the health market actors and the government are discussed. In the fifth section the proposed framework is applied to the new Dutch health financing scheme in comparison with the previous one. In section 6 some critical issues and lessons learnt are listed.

2. Analytical framework

Health systems financing represents one of the four core functions of the health system. The other three are stewardship (oversight), creating resources (investment and training) and delivering services (provision). The aim of the financing function is to make funding available and to set the right financial incentives so that all individuals have access (financially and geographically) to effective public health and personal health care (WHO, 2000). Health system financing is supposed to contribute to the achievement of the health system goals of improved health, fairness of financial contribution and responsiveness. To do this, it should meet the following targets:

- (i) generate sufficient and sustainable resources for health
- (ii) use these resources optimally (by modifying incentives and through appropriate use of these resources)
- (iii) ensure that everyone has financial accessibility of health services

To achieve these targets and guarantee financially fair, population-wide access to effective, essential health care, three sub-functions are distinguished in health financing schemes: revenue collection, pooling and purchasing. It is assumed that if these sub-functions are strategically designed, the targets can be met.

Based on these terms, an analytical framework has been developed to facilitate the design and monitoring of health financing systems (Carrin and James, 2004). This framework is useful for countries that aim to achieve universal coverage as well as for those who aim to maintain it while reforming their financing system, for example, to increase efficiency or to accommodate additional care needs. The framework is built on 8 process- rather than outcome oriented indicators that thus facilitate an analysis of the performance of the health financing scheme in view of the broader health system goals. Table 1 shows the framework as used in this paper.

Table 1: Analytical framework		<i>Benchmark / target</i>
Revenue collection / targets (i) & (ii)		
1. Population coverage	<ul style="list-style-type: none"> • % of population covered (= having financial access) by the health financing scheme (per socio-economic group) 	100% for essential care
2. Method of finance	<ul style="list-style-type: none"> • Ratio of prepaid contributions to total health expenditure 	70% ¹
	<ul style="list-style-type: none"> • % of households with catastrophic spending 	Out-of-pocket payment < 15% of total health expenditure ²
Pooling / targets (i), (ii) & (iii)		
3. Composition of risk pool(s)	<ul style="list-style-type: none"> • % of compulsory membership 	at least formal sector employees ³
	<ul style="list-style-type: none"> • Are dependants compulsory insured⁴? (y/n) 	Yes
4. Fragmentation of risk pooling (in case of multiple risk pools)	<ul style="list-style-type: none"> • Number of funds 	Information
	<ul style="list-style-type: none"> • If there are multiple funds, is enrolment open? 	Yes
	<ul style="list-style-type: none"> • Does a risk equalization scheme control risk selection⁵? 	High
	<ul style="list-style-type: none"> • What is the contribution rate variance? 	Information
5. Management of risk pool(s)	<ul style="list-style-type: none"> • Are consumers free to periodically choose between insurers? 	Yes
	<ul style="list-style-type: none"> • Are there incentives for the risk pool(s) to control administrative costs? 	High

¹ Carrin and James (2005); the paper explains that this benchmark is not meant in absolute terms, but as a rough indication only.

² Xu and Evans et al. (2003); again, this benchmark should be taken as a rough indication only.

³ Carrin and James (2005)

⁴ Carrin and James (2005)

⁵ Van de Ven et al. (2003)

Purchasing / targets (ii) & (iii)		
6. Benefit package	• Is the benefit package based on explicit efficiency and equity criteria?	High
	• Existence of consumer incentives	High
	• Are monitoring mechanisms in place to guarantee fairness and quality?	High
7. Health care organization	• Do provider incentives (payment mechanisms) encourage the appropriate level of care (e.g. family doctor system, focus on primary care, substitution)?	High
	• In case of vertical fragmentation, are there incentives to increase coordination within the health system?	High
8. Administrative efficiency	• % of expenditure on administrative costs	< 7% ⁶
	• Are there incentives for transparency?	High

Adjusted from: Carrin G, James C (2005)

In section 5, the framework is applied to the Dutch health financing scheme. A brief explanation of each indicator will also be provided.

3. The Dutch health financing scheme

3.1 Financing mechanisms

Health care financing in the Netherlands is predominantly organized on the basis of social health insurance. Furthermore, there are contributions from general government revenue and, fairly limited, from direct payments. The system consists in three compartments, as illustrated in Box 1. The 2006 reforms mainly affected the second compartment.

Box 1: The Dutch Health Financing Scheme before and after the 2006 Reforms

Before reforms	After reforms
Supplement health insurance (voluntary) Third compartment	Supplement health insurance (voluntary) Third compartment
Sickness funds (compulsory under a certain income) Private health insurance (mostly voluntary) Second compartment	Social Health Insurance (compulsory for the entire population) Second compartment
National health insurance for exceptional medical expenses (compulsory for the entire population) First compartment	National health insurance for exceptional medical expenses (compulsory for the entire population) First compartment

Sources: 'Before reforms' from HIT (2004); 'After reforms' elaborated by author

Three compartments

⁶ Carrin and James (2005); the authors argue that countries while in the early stages of health system development, may have higher administrative costs, but should be able to reduce these with 0.1% per year until the target is reached.

The first compartment of the Dutch financing scheme refers to the Exceptional Medical Expenses Act (AWBZ) that may be reformed shortly. It is a population-wide, mandatory health insurance scheme covering exceptional medical expenses (long-term care and high-cost treatment). Contributions to the fund are income-related salary deductions (with a maximum ceiling) deducted from the taxable income of employees or social security beneficiaries by the employer or the responsible institution. In 2004, the contribution was 10.25% of taxable income; in 2006, this increased to 12.55%. The AWBZ also receives a grant from general government revenue and co-payments from consumers for nursing home costs depending on a person's financial position. The fund is managed by the Health Care Insurance Board (CVZ) who reimburses implementing agencies, including administrative costs.

The second compartment has been reformed and is further discussed in the following section. The third compartment represents voluntary, supplementary health insurance. It refers to health care services that are regarded as less necessary. Almost all sickness funds offer the possibility of voluntary supplementary health insurance to their members. Since January 2006, consumers can buy additional health insurance from another insurer than the basic benefit package. Insurers may apply risk selection only in this compartment.

Key expenditure data

Until the end of 2005, the main sources of health care financing in the Netherlands were the contributions to the Sickness Fund Act (ZFW) and to the Exceptional Medical Expenses Act (AWBZ), taxes, out-of-pocket payments and voluntary supplementary health insurance. Table 2 provides some key health expenditure data for the Netherlands in 2002. Data for 2006 are not yet available.

Table 2: Key expenditure data, the Netherlands (2002), in %

General Government Expenditure on Health of Total Health Expenditure ⁷	65.6
General Government Expenditure on Health of Total General Government Expenditure	12.2
Social Security Expenditure on Health of General Govt Expenditure on Health	93.8
<i>Social Security Expenditure on Health of Total Health Expenditure</i> ⁸	<i>61.5</i>
External resources	0
Private Expenditure on Health of Total Health Expenditure	34.4
Prepaid plans of Private Expenditure on Health	52.3
<i>Private Prepaid plans of Total Health Expenditure</i> ⁹	<i>18.0</i>
Out-of-Pocket Payments of Private Expenditure on Health	24.5
<i>Out-of-Pocket Payments of Total Health Expenditure</i> ¹⁰	<i>8.4</i>

Source: WHOSIS

Tax expenditure on health care, including research, public health services and government subsidies to the ZFW and the AWBZ, were 12.2% in 2002. In 2002, 8.4% of total health care costs were covered out of pocket, including around 4% co-payments in

⁷ GGEH=General Government Expenditure on Health; TEH=Total Expenditure on Health; TGGE=Total General Government Expenditure; PEH=Private Expenditure on Health; PP=Prepaid Plans; OOEPEH=Out-Of-Pocket Expenditure on Health

⁸ (SSEH of GGEH)*(GGEH of THE)/100

⁹ (Prepaid plans of PEH)*(PEH of THE)/100

¹⁰ (OOPEH of PEH)*(PEH of THE)/100

the AWBZ, mainly for nursing home costs, 2% in the ZFW and mandatory private health insurance scheme, and 3% related to direct payments and the private supplementary insurance scheme.

3.2 Benefit packages

Three compartments

The Exceptional Medical Expenses Act (AWBZ) covers the care needs of people with mental, physical or functional disabilities. Since 2003, the benefit package is defined on the basis of functions (type of care) rather than health care products in order to give room to individual demand. Seven functions are distinguished to define the care a person needs. In practice, care is offered in the form of products or combinations of functions, tailor-made to specific individual needs (CVZ, 2004).

The following care functions are currently covered under the AWBZ, restricted to services not covered under any other legal provision: domestic help, personal care, nursing care, supportive guidance, activating guidance, treatment, accommodation. Some of these functions are sector-independent and include social services that are not strictly part of the health system. These will shortly be transferred from the AWBZ to the new Social Support Act (WMO) and fall under the responsibility of the municipalities. The strictly medical services, except for long-term institutional care, may be transferred to the second compartment in the years to come. The following activities are also part of the current AWBZ package: temporary use of an appliance or aid, diet advice (to ZFW since 2005), hospital care after a period of 365 days, rehabilitation after a period of 365 days, prenatal care, tests with regard to congenital metabolism illnesses, vaccinations. Entitlement to the AWBZ benefits is determined by the Regional and Local Indication Bodies. These are independent organizations that establish the kind and amount of care required. Beneficiaries are allowed to choose between in-kind services or personal budgets that enable them, under certain conditions, to purchase their own care.

The benefit package of the second compartment is discussed in the following section. The additional insurance packages (third compartment) are traditionally determined by the insurers in terms of content, scope, conditions and premiums. In 2003, most dental care and physiotherapy were taken out of the basic benefit package (Ministerie VWS, 2006e) and many Dutch started to buy private insurance to cover these needs. Additional insurance before 2006 included (supplementary) dental insurance and physiotherapy, as well as eyeglasses, a higher standard of hospital accommodation, prosthesis, hearing aids, alternative treatment or medicines, and costs incurred in foreign countries. Since the reforms, class differences in hospitals no longer exist. Additional insurance now targets specific age groups, including for example alternative care, speak care, acne care for younger people, and dental prosthesis or hearing aids for the elderly. Furthermore, various options exist to extend the basic package with diabetes care, additional postnatal care, additional glasses/contact lenses, additional dental care, additional physiotherapy, additional psychological care, additional care abroad, etc. Since the reforms, consumers have an increased number of options in terms of additional insurance packages. This reflects an increased level of choice. However, as most of these options come with a price tag, it may also compromise equity, as is further discussed in section 5.

4. The Health Insurance Act

4.1 Historic run-up to the reforms

Mandatory and voluntary health insurance: a two-tier system

The financing scheme that was replaced by the 2006 reforms originated from the 1964 Sickness Fund Act (ZFW). As mentioned above, the reforms took mainly place in the second compartment of the scheme. Until 2006, it consisted in two different forms of insurance: compulsory insurance for those with an income level under a certain level of income and voluntary insurance for those earning more than this ceiling. In addition, there was special coverage for the elderly. The two-tier scheme achieved (nearly) universal coverage reflecting a high level of social solidarity. It provided access to health care and financial protection for the poor on the basis of income-related prepaid contributions. However, the scheme also sustained a level of inequity due to differences in the benefit packages of the mandatory and voluntary scheme. Stakeholders continued discussing the disadvantages for those who earned salaries just above the income ceiling and the risks associated with a small salary increase for those who earned slightly less.

Cost containment in the form of supply side control

Since the post-war expansion of the health system, cost control has been prioritized in the Netherlands as in other European countries. Until recently, control was organized at the supply side (top-down) with the government setting the benefit package, level of contributions and coverage. The 1971 Hospital Provision Act (WZV) and the 1992 Health Care Tariffs Act (WTG) provided the government with additional instruments to control the number of institutions and to set maximum tariffs for all health care services.

The shift to a demand side control model (bottom-up) started with the 1974 Hendriks paper *Structuring Health Care*. The aim was to increase the efficiency of the health system, among others things through two major decentralization processes: functional decentralization or a shift from the public to the private sector, and territorial decentralization or a shift from central to regional and local administrative levels. In the Netherlands, the former was implemented mainly in the 'cure' domain of the Sickness Fund Act (ZFW), the latter in the 'care' domain of the Exceptional Medical Expenses Act (AWBZ), for example through the establishment of regional and municipal services for needs assessment (establishing need for home care, etc.). The former was meant to enhance efficiency through the introduction of market mechanisms on the health care market, the latter through the substitution of inpatient by outpatient care.

Another important starting point for the 2006 reforms was the 1990 Simons Plan (based on the 1987 proposal of the Dekker Commission). The idea was to install one mandatory insurance package for all, covering 85% of the existing provisions, and to introduce competition between health insurers. Ongoing discussions about the level of coverage blocked acceptance of the proposal until 2005, when parties agreed that the existing financing system could no longer address key problems like the lack of equity (due to the income ceiling) and efficiency (long waiting lists for specialized care compared to neighbouring countries and rising health care costs in general). Figure 1 illustrates the most important acts that mark the development of the Dutch health financing scheme. The orange group identifies the acts related to the previous supply-side model; the pink/violet group, those to the new demand-side model.

Figure 1: Major health care acts in the Netherlands

1941 Sickness Fund Decree	1956 Health Act	1964 Sickness Fund Act (ZFW)	1968 Exceptional Medical Expenses Act (AWBZ)	1986 Access to Health Insurance Act (WTZ)	1990 Simons plan	2006 Health Insurance Act (ZVW)
		1971 Hospital Provision Act (WZV)		1992 Health Care Tariffs Act (WTG)		1974 Structuring Health Care (paper)

Source: HIT (2004)

4.2 Regulated competition

The 2006 Health Insurance Act (ZVW) was implemented to address the most important problems of the previous Dutch health financing scheme: a structural unfairness in terms of contributions due to the income ceiling, a lack of transparency due to different regulations for social and private health insurance schemes and a high level of government interference (supply side control) leading to inefficiencies and hindering innovation.

The radical characteristics of the reforms are that health insurance was made mandatory to all. People are no longer insured automatically, but obliged by law to purchase health insurance. Furthermore, enrolment is open, risk selection prohibited and all health insurers are allowed to operate as private companies. The latter used to be permitted only in the third compartment.

Under the new scheme, insurers can increase their membership by offering an attractive nominal premium for the basic benefit package. They can offer a variety of policies, including the cheaper 'natura' polis that offers in-kind provision with limited consumer choice for providers (only those contracted by the insurer) and applies co-payments for providers not contracted by the insurer; the generally more expensive restitution polis that offers reimbursement of expenses with unlimited consumer choice for providers; or a combination of these two. Insurers may also design collective policies to attract special patient groups, like people with a specific disease (e.g. diabetes), from a specific age group (e.g. elderly) or members from a social group (e.g. lower income groups). To such policies a premium reduction of maximum 10% may be applied. Insurers may also offer voluntary insurance packages for services not included in the basic benefit package.

Another new element of the scheme is that competition on the basis of price and quality is also enhanced between providers, as insurers are allowed to contract them selectively. This used not to be the case (there was collective contracting). Full transparency is required in the negotiations between insurers and providers and all actors must apply the same conditions to all of their arrangements. Insurers and providers are also allowed to

form HMO¹¹-like organizations giving consumers a periodic choice not only for insurers, but for 'integrated health care financing/delivery organizations' (van de Ven et al, 2003).

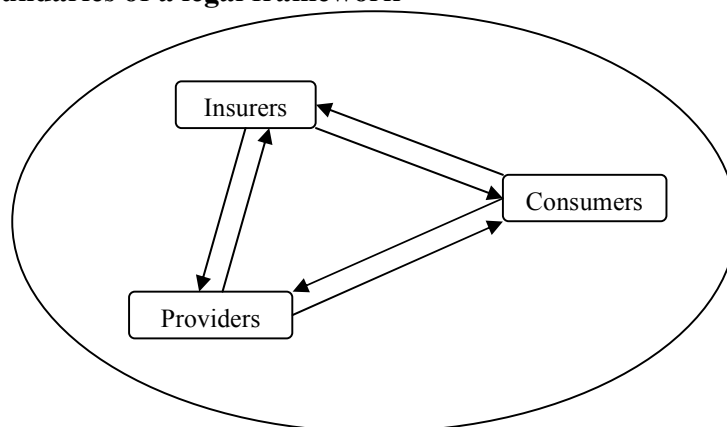
With respect to consumers, the scheme allows periodic choice for insurers and, in certain cases (not with the 'natura' polis), for providers. Furthermore, consumer incentives are incorporated to encourage rational behaviour and quality monitoring. Under the new scheme, the government remains responsible for safeguarding quality, accessibility and affordability of care, but, as outlined above, the other responsibilities are delegated to their owners: the consumers, providers and insurers of care.

A number of the provisions in the new model were already introduced under the previous scheme reflecting the process-character of the reforms. For example, the nominal premium was introduced in 1989. The payable amount was set by the government in during the first two years. Since the introduction of the risk equalization scheme in 1991, the nominal premium is being set by the individual sickness funds. The no-claim bonus existed before 2006 for Sickness Fund members, and the Diagnosis Treatment Combination (DBC) scheme (the Dutch variant to the DRG scheme), which is aimed to facilitate the costing process and increase transparency in the hospital sector, was introduced in the beginning of 2005.

4.3 Key roles for insurers, providers and consumers of care

Regulated competition assumes that incentives, like increased consumer choice and the right to selective contracting, encourage insurers and providers to behave efficiently, i.e. to compete effectively on the basis of value for money (highest quality at the lowest price). Figure 2 illustrates the reciprocal relationship between the health market actors in this model. All actors negotiate with each other with relative autonomy, but are bound by a regulatory framework. Except for the government, the actors keep each other to the rules of law by monitoring the performance of one and other.

Figure 2: Regulated Competition: a level playing field for health market actors within the boundaries of a legal framework



¹¹ Health Management Organizations

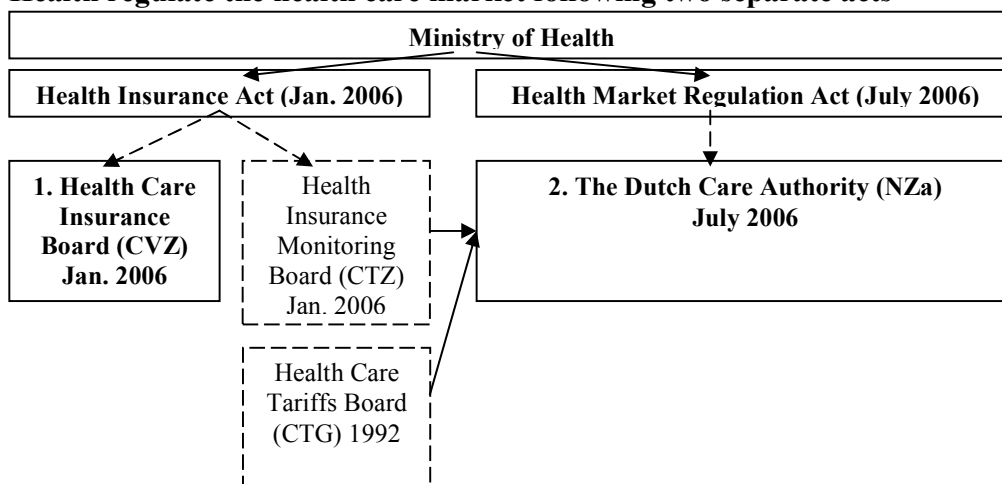
Elaboration by author

Regulated competition requires that consumers inform insurers about their care needs (preferences), steer their behaviour (through the power of choice) and monitor the quality of their services. The government, as steward, has the duty to control for potential market failures. Each of the health market actors plays its own specific role in a relatively open playing field, but within a legally enforced regulatory scheme. The different actors are supposed to hold each other accountable and to report deviant behaviour. The different roles are described as follows: 'Care institutions should take more responsibility for the quality and effectiveness of care. The government steers on headlines and safeguards public interests (quality, accessibility, affordability of care). Health care providers should behave as social entrepreneurs and health insurers must purchase good care. Patients and consumers must protect their rights and take more responsibility for their own health (care) as well (Ministerie VWS, 2006a)'. Apart from regulated competition the model is called 'private social health insurance' (Hasekamp, 2006). In the context of health insurance, 'private' refers to the relative autonomy (in terms of market entry and service production) of providers and insurers on the health care market; 'social' to the overarching concept determining the legal framework to which they are bound.

4.4 Regulation

Regulation by the government is constituted by the Health Insurance Act (ZVW). It describes the duties and capacities of two semi-autonomous bodies, the Health Care Insurance Board (CVZ) and the Health Insurance Monitoring Board (CTZ), among other things. In July 2006, after the adoption of the Health Market Regulation Act (WMG), the CTZ was merged with the Health Care Tariffs Board (CTG) to establish the Dutch Care Authority (NZA). The relation between the different institutions is illustrated in Figure 3.

Figure 3: Two semi-autonomous institutions under stewardship of the Ministry of Health regulate the health care market following two separate acts



Elaboration by author

Health Care Insurance Board (CVZ)

The CVZ is responsible to clarify in an unambiguous manner to insurers, providers and citizens the nature, content and volume of the health insurers' responsibilities, the risks they should insure and under what conditions they must operate. It can do this, for example, by issuing guidelines. The CVZ also has the duty to inform the Minister when the law requires modification.

Health Insurance Monitoring Board (CTZ)

The CTZ provides the Minister of Health and the CVZ with an annual summary report about the implementation of the Health Insurance Act (ZVW), including the rules and regulations applied by health insurers. The Minister forwards this report to Parliament and the Senate for approval. Health insurers are obliged to inform the CTZ about the results of their audits. At the request of the Minister of Health or the CVZ, the CTZ may start an investigation into the performance of health insurers. To promote transparency for consumers on the health care market, the CTZ provides public information about the content of standard agreements and the functioning of health insurers. It also applies the legally stipulated fines for consumers who are not insured and insurers who do not carry out their duties according to the law.

Dutch Care Authority (NZA)

In July 2006, the CTZ was merged with the Health Care Tariffs Board (CTG) into the newly established Dutch Care Authority (NZA). This is also a semi-autonomous body that determines the tariffs and budgets for nearly all health care providers on the Dutch health care market. The NZa also promotes and controls the health care market in collaboration with the Dutch Market Authority (NMa). Its duties and responsibilities are described in the Health Market Regulation Act (WMG). In its role as 'caretaker' of the health care market, the NZa monitors the performance of the different actors and intervenes, when necessary. This already happened in several cases. One insurer, for example, posted a short list with competitive premiums on its website stating that his premium was the lowest. The NZa found this information to be faulty compared to the premiums of insurers not included in the list, and forced the insurer to adjust his website (Hoogervorst, 2006a).

Another duty of the NZa is to determine which areas of the health care market will be opened to competition. Under the current law, hospitals are private organizations, but not allowed to pay out profits to third parties or shareholders (like health insurers). This situation, however, may change in the coming years. The NZa says only to allow competition and profit-making on market segments where this generates concrete benefits for the consumer (CTG, 2006). Others argue, contrarily, that competition must be extended sooner rather than later. They believe that the current setting is too small to produce efficiency results (Berg, 2006; Scheepbouwer, 2006).

In a final note, regulation is crucial for the new Dutch health financing scheme. However, the capacity of the Dutch government to regulate competition between insurers is limited by European legislation. The latter restricts the power of governments to regulate Non-Life Insurance markets. The issue seemed to become a major obstacle during the years preceding the enactment of the reforms, but an exception clause exempted insurance

schemes that replace social insurance. The European Commission formally approved the Dutch scheme before January 2006, but mandated that the government may not intervene more than strictly necessary (Van Ginneken, 2005). It remains unclear, whether or not this ruling will hinder proper regulation by the government in the future.

5. The framework applied

In this paragraph the analytical framework presented earlier in this paper will be applied to the Dutch reforms. Where possible, the (expected) performance on each indicator of the present scheme is set off against that of the previous model.

Revenue collection function

		Before reforms	After reforms
1. Population coverage	<ul style="list-style-type: none"> % of population covered by the health financing scheme (essential care) 	<p>≈ 63% social health insurance + ≈ 37% private health insurance</p>	<p>≈ 100% social health insurance</p>

Population Coverage

Population coverage refers to the proportion of the population that is financially protected by a certain health financing scheme. In the Netherlands, coverage was already practically universal before the new act; the 37% of the population that did not participate in the social health insurance scheme was obliged to purchase voluntary insurance. In terms of actual coverage, the previous scheme left little room for improvement, as no more than 250,000 people were estimated to be uninsured including the opting-out rich (VWS, 2006). The new model, however, attempts to achieve true universal coverage on the basis of the following provisions:

- All citizens of the Netherlands are required by law to register for an insurance fund at the sanction of a fine worth 130% of the premium. The measure is reinforced by the existing civil right codes in the Netherlands.
- All insurers are hold responsible by law to apply open enrolment to all for the basic health care package, also when an uninsured person appears ill at the hospital.
- People who seek care and can not identify themselves, must do so within 2 weeks, but will be attended.
- The income-related insurance premium is collected directly by the tax authority from the employee's net income (or equivalents).
- There is an income-based tax credit to compensate people for whom the nominal premium represents a relative high proportion of their income. Social institutions are available to help people with very low incomes to manage their household budget.
- Municipalities are encouraged to purchase collective policies for their lowest income groups (this facilitates premium reductions up to 10%).
- According to the Koppelingswet¹², non-residents (people without a legal right to live in the Netherlands) have no right to take out basic health insurance. However, they have the right to access health services in the Netherlands at their own costs. Furthermore, in case of an emergency medically essential care is guaranteed (the cost of such care is paid by the government). There is also an annual budget for primary

¹² The 'Koppelingswet' (≈Bridging Act) was enacted in 1998 to clarify the position of people who reside in the Netherlands without a resident or work permit. The law also aims to discourage people to live in the Netherlands illegally (Stichting Koppeling, 2002)

care providers, like general practitioners, midwives, pharmacists and postnatal care institutions to compensate for exceptional costs of unpaid provided medically essential care ('Koppeling' Foundation). Finally, hospitals, rehabilitation centres and ambulance services have a provision within their own budget to cover the costs of dubious debtors. Uninsured patients who can not pay their bill in these institutions can also be covered through this provision. Each year, the amount available for this provision is agreed upon with the health insurance funds.

Despite this, there remains concern within the Dutch society about certain excluded groups, like immigrants who were denied asylum but still live in the Netherlands (some of them for many years). Interest groups argue that a significant number was denied asylum on unjust grounds (for example, when the government unilaterally ruled it was secure for them to return home) and that their number will grow up to 10,000 people in the coming years. The groups claim that the provisions in place for illegal immigrants are ineffective and that health care providers are increasingly reluctant to provide proper care to those who can not afford to pay (Stichting Een Royaal Gebaar, 2006).

A second concern is about 'bad debtors'. Insurance funds have the legal right to stop a contractual arrangement with a beneficiary who does not pay the premium. If this period exceeds five years, other insurers can also refuse insurance to the person who then remains uninsured. In order to resolve this problem, the organization for Health Care Insurers (*Zorgverzekeraars Nederland, ZN*) has suggested to prosecute those who do not pay their premiums while maintaining their membership and annulling their right to switch to another health insurer in order to avoid frivolous 'hopping' (ZN, 2006a). The suggestion was taken to Parliament for approval (Hoogervorst, 2006c).

A third concern refers to the design of the scheme in particular. In the design, the nominal premium and the tax credit are from two different financial flows. This increases the risk for low income groups to use their tax credit (which they receive in advance) for other purposes. If they do so, they would be unable to pay their health insurance premium and remain uninsured (risking the legal fine, etc). In other words, the current financing scheme may turn out unaffordable for the lowest income groups. In order to better understand who and how many people are uninsured, the Minister of Health sent out a questionnaire in March 2006 to health providers, municipalities and interest groups for them to register uninsured people and the reason why. The results of the survey are expected by the end of 2006 (ZN, 2006b).

Recently, interest groups published the first estimates of the current numbers of uninsured people. These indicate that on 1 May 2006 (4 months after the introduction of the new law and the first day that all Dutch had to be officially insured), 16.06 million people were insured out of a total of 16.34 million people who were supposed to. This suggests that around 280.000 people are currently uninsured, an increase of 30.000 people with respect to the previous year (Monitor, 2006a). Both figures are global and not based on verified numbers.

Under the new scheme, population coverage of the health financing scheme did improve principally in terms of equity and fairness of financial contribution. Mandatory health insurance under the same conditions used to apply only to people with incomes up to an established level as others were obliged to purchase private insurance. Today, the mandatory scheme includes the whole population, including the rich. This is rather exceptional in the world.

		Before reforms	After reforms
2. Method of finance	• Ratio of prepaid contributions to total health expenditure	91.6% (2002)	No data
	• % of households with catastrophic spending	8.4% (2002)	No data

Method of Finance

The method of finance is another indicator for the level of protection offered by a health financing scheme. If the ratio of prepaid contributions is high (70-90%) and the proportion of households that incur in catastrophic health expenditure¹³ due to relatively high direct (out-of-pocket or co-payments) or indirect payments (insurance premiums or taxes) is low, the scheme can be expected to provide proper financial protection (Carrin and James, 2004). Table 3 compares some key features regarding the method of payment of the old and new scheme. It shows that total contributions per employee (and self-employed) and the proportion paid by the employee decreased; the proportion paid by employers, however, increased. In turn, there is a radical increase in the flat-rate premium, which is compensated by a tax-credit for low-income groups. Under the new scheme, co-payments are only allowed as part of the 'natura' polis.

Table 3: Key features before and after the reforms

	Before reforms	After reforms
Total contribution as % of employee's income ¹⁴	8.00 % (2004)	6.50 %
Part of the contribution paid by employees	6.75 %	3.25 % ¹⁵
Part of the contribution paid by employers	1.25 %	3.25 %
Contribution paid by self-employed	8.00 %	4.40 %
Who are paying a flat-rate premium?	Members (since 1991) and spouses (since 1995); dependent children free.	All members; dependent children free.
Flat-rate premium	Euros 98 (1998) Euros 188 (2000) Euros 356 (2003)	Euros 1,050 ¹⁶
Tax credit	-	Maximizes nominal premium at 3.5 and 5% of threshold income (a

¹³ Catastrophic spending is defined as being 40% or more of a household's effective income, net of subsistence (food) expenditure

¹⁴ This includes social insurance benefit. After 2006, the maximum income over which these contributions are payable is Euros 30.015 per year; the maximum annual amount payable is Euros 1,950 for employees and Euros 1,320 for self-employed and pensioners.

¹⁵ In 2006, employers pay the full 6.5% but this will be shared on a 50/50 rate as of next year.

¹⁶ This is the standard premium for the current year, based on the average charged by the competing insurers

		percentage of the minimum wage) plus 5% of means-tested income for individuals and couples respectively ¹⁷
Sources of revenue for the social insurance scheme	Contributions, government grants (up to 24% of Sickness Fund Act expenditure in 2004) and special transfer payments for the elderly ¹⁸ .	Income-related and nominal contributions, government grants to cover the contributions of the under 18
Co-payments	Abolished in 1999; only certain deductibles remained for artificial breasts, orthopedic shoes, hearing aids and wigs.	Generally not applied; insurers are allowed to offer package variants that apply an own-risk payment in exchange for a lower contribution rate; co-payments may be instituted for members who purchase a 'natura' contract but seek health care with a provider not contracted by their insurance fund.

According to the Ministry of Health (VWS) the expected net result of the new scheme will be that the Dutch population pays one billion Euros less in the form of taxes and premiums compared to the previous scheme. Others claim that the scheme is expensive and the tax credit pushes government subsidies (Maarse, 2002). In terms of who will benefit most of the reforms, VWS expects these are the elderly and chronically ill that used to purchase private health insurance, as well as families with children. Young healthy singles and civil servants may end up paying more than before (Hasekamp, 2006). Performance data in this respect were not available when this paper was written.

Ratio of prepaid contributions to total health expenditure

As Table 3 shows, under the new scheme the income-related contributions are payable on a 50/50 basis by employers and employees. The level of the contributions is calculated so that their sum equals 50% of the total income of the Health Insurance Fund, which is determined by VWS. Differences between the amount determined by VWS and the real income of the Health Insurance Fund are corrected in the following year. Income-related contributions in principle reflect income solidarity. However, as these contributions are only payable up to a maximum level of income and up to a maximum annual amount per year in the new model, there is also a regressive element to it; those with the highest incomes pay relatively less. But this may increase the willingness of the highest income groups to participate in the scheme, which ultimately increases its redistributive capacity. Income tax in the Netherlands is largely progressive (those with higher salaries pay a relatively greater part of their salary).

Apart from income-related contributions, the new model maintains the previously installed nominal premiums for all insured people (i.e. people over 18 years old), but increases these radically. The flat-rate premium has a regressive character that is now

¹⁷ Van Ginneken (2005)

¹⁸ This refers to a transfer from private health insurers to the sickness funds to correct for the over-representation of elderly in the social scheme since the adoption of the WTZ.

corrected through the tax credit. If the tax credit is implemented properly, the nominal premium under the new scheme can be considered as proportional reflecting income solidarity as well (even though concern remains about people using the tax credit for other purposes).

The nominal premiums are sent directly to the Health Insurance Fund by insurers and topped-up from general revenue covering the contribution for the under 18. Consecutively, the 'equalized' payments are transferred back to the health insurers. This process reflects risk-solidarity.

The level of prepaid contributions in the Netherlands has been high during the last decades. As shown in Table 2, in 2002 61.5% of total health expenditure was paid by social health insurance contributions, 18.5% by private health insurance and 11.6% was contributed from general taxation. This totals 91.6% of total health expenditure covered by prepaid contributions. Out-of-pocket expenditure was 8.4% of total health expenditure, which is far below the target of < 15% (Xu, Evans et al. 2003).

The new law does not apply co-payments for services provided in the basic benefit package, but insurers may apply these to people with a 'natura' polis who visit a provider not contracted by them. With respect to services not included in the basic benefit package, 95% of the Dutch population used to buy private health insurance, rather than making direct payments, under the previous scheme and 93% did so after the introduction of the reforms (Vektis, 2006). All of this indicates that the proportion of prepaid contributions is expected to remain high under the new scheme. However, there is concern that the proportion of out-of-pocket payments of total health expenditure will increase if the government rationalizes the benefit package or introduces more co-payments which it is allowed to do without changing the law. The level of direct payments by uninsured people is also a reason for concern.

% of households with catastrophic spending

The WHO calculates catastrophic health expenditure (Xu, Evans et al., 2003) per country, but so far, no data have been produced about the Netherlands. The Health Insurance Act (ZVW) and provisions like the 'Koppeling' Foundation (Stichting Koppeling, 2002) principally guarantee that the proportion of households incurring in catastrophic health expenditure is low. However, while the level of out-of-pocket payments seems controlled under the new model, some groups in the Netherlands may remain excluded from coverage due to their inability to pay the nominal premium or to their residential status. Furthermore, direct payments may increase when the benefit package is reduced or the level of co-payments increased. In other words, the design of the new health financing scheme does not cover all of these risks and it seems relevant, also for the Netherlands, to regularly calculate catastrophic health expenditure at the household level.

Pooling function

		Before reforms	After reforms
3. Composition of risk pool(s)	• % of compulsory membership	≈ 63%	100%
	• Are dependants compulsory insured?	≈ 63%	100%

Composition of risk pool(s)

% of compulsory membership

With the 2006 reforms, membership is compulsory by law for all Dutch residents compared to 63% under the previous scheme (even though those with salaries above the Sickness Fund level were obliged to take out private health insurance for essential services). However, as mentioned earlier under the new scheme people may not purchase health insurance despite their legal obligation. Therefore, the proportion of uninsured people should be continuously monitored.

Are dependants compulsory insured?

All legal dependants are compulsory insured in the Netherlands. Dependant children under 18 must be registered with an insurance fund by their legal caretakers; their contribution is paid by the government into the health insurance fund. Since 1995, dependant spouses are to become members and pay the full premium themselves. Previously, dependents were only automatically covered in the Sickness Fund scheme.

		Before reforms	After reforms
4. Fragmentation of risk pooling (in case of multiple risk pools)	<ul style="list-style-type: none"> • Number of funds • Is enrolment open? • Does risk equalization control risk selection? • Is there contribution rate variance? • Are consumers free to periodically choose between insurers? / What % does it? 	<ul style="list-style-type: none"> • 22 • ≈ 63% • Medium • Yes • Only ≈ 37% who purchase private health insurance / 1-4% 	<ul style="list-style-type: none"> • 37 (merges may increase risk of market failure) • 100% • Improved • Little, but may increase • Yes, all / 18-30%

Fragmentation of risk pooling

Number of funds

This indicator provides insight in the level of competition on the insurer market. The more funds there are, the more competition there will be. However, when the number of funds increases, the proportion of transaction and administrative costs may also rise. The number of health insurance funds in the Netherlands has increased from 22 in 2004 to 37 in 2006 (Zorgkiezer, 2006). Vektis, the information centre of the health insurance branch, has signalled a slight trend of de-concentration in most provinces (a relative increase in the number of insurers). In the coming years it expects further de-concentration, due to the increased mobility of consumers, as well as concentration, as a consequence of merges between different insurers (Vektis, 2006). During the first half year after the reforms two major merges already occurred. As a consequence, two insurance companies with 4.2 and 3.8 million members respectively (VGZ/Unive and Agis/DeltaLloyd/Menzis) now represent 50% of the Dutch health insurance market (Monitor, 2006b). This may create monopolies and compromise a major objective of the new law: enhanced competition on the insurer market. In these terms, the new model may have increased the risk of market failure on the insurance market compared to the previous scheme. This should be closely monitored, also in the light of regulatory restrictions due to European legislation.

Is enrolment open?

This indicator refers to the problem of risk selection, which occurs when enrolment is not open or health insurers are not obliged to accept all applicants. This is common in private health insurance schemes. Under the new Dutch law, enrolment is open for the basic benefit package for 100% of the population. This was 63% under the previous scheme. However, open enrolment or the prohibition to apply risk selection, may increase the risk of 'subtle' risk selection, which is explained here below.

Does a risk equalization scheme control risk selection?

Risk equalization exists in the Netherlands since 1991 when the nominal premiums were introduced. Following the conceptual framework of Van de Ven et al (2003), the Dutch risk equalization scheme is an external subsidy system. This implies that there are direct (income related) premiums and indirect solidarity contributions (nominal premiums) from the members to the sickness funds. As mentioned above, these indirect solidarity contributions are sent through a solidarity fund (the Health Insurance Fund) and corrected on the basis of solidarity criteria (risk adjusters). Risk equalization has a double purpose in the new Dutch scheme: to prevent risk selection and to create a level playing field for insurers (Hasekamp, 2006). The first aims at equity; the latter provides insurers with room to develop specific packages for and to respond dynamically to people with specific needs (increased quality, diversity and thus efficiency).

Risk equalization aims to compensate the health insurer's risks associated with open enrolment: if insurers are obliged to accept all applicants, the result will be that some will have more high risk patients than others. Without a proper risk equalization scheme, this will force health insurers to apply risk selection by 'subtle' means. As private companies, insurers are interested to control the risk of high costs due to high risk patients in their membership; they will try to do this by 'subtly' attracting low risk patients, for example by developing specially designed additional health insurance packages that attract particularly lower-risk patients.

The risk of this behaviour by insurers, which is undesired, is reduced when a proper risk adjustment scheme is implemented. Such a scheme may be prospective (*ex ante*) or retrospective (*ex post*). Both protect sickness funds against the extra costs associated with higher risk groups. However, contrarily to retrospective schemes, prospective risk adjustment (payment in advance on the basis of risk adjusters, i.e. the number and characteristics of sickness fund members) also encourages insurers to behave efficiently and provides more incentives for effective preventive care than retrospective risk adjustment schemes (Van de Ven et al., 2003).

In the Netherlands, *ex ante* risk adjustment is organized on the basis of the following criteria or risk adjusters: age, gender, region, being an employee (yes/no), disability, Pharmacy-based Cost Groups (PCGs), Diagnostic Cost Groups (DCGs), being self-employed (y/n). The PCG is an outpatient morbidity measure based on information about chronic conditions deduced from the use of prescribed drugs. The DCG facilitates the allocation of people to a restricted number of groups according to the diseases diagnosed during previous hospitalizations.

The scheme functions well for chronic patients whose condition is included in these criteria, like diabetes patients. As it compensates insurers for the higher costs of such patients, they have even shown willingness to design collective policies to attract them. However, collective policies do not exist, for example, for patients that are hearing impaired or have chronic headaches. Insurers claim that as long as these health conditions are not included in the risk equalization scheme, they cannot offer premium reductions for these patients. The latter claim the current risk equalization scheme not to be equitable. Progress in this respect should be closely monitored. Comparing the previous and new model on this indicator, there is improvement. This is reflected in the continuing refinement of the scheme and the inclusion of a growing number of chronic conditions.

Is there contribution rate variance?

The real average premium paid in the Netherlands in 2006 is Euros 1,025. This includes collective policies and the chosen own risk, but excludes the premiums for additional insurance and an eventual reduction of the premium in the case of annual or quarterly, rather than monthly payments. The average premium for individual contracts in 2006 is Euros 1,053 and for collective policies Euros 987. Individuals have paid around 6% more than those who purchased a collective package (Vektis, 2006). Table 4 shows some aggregate data representing the annual nominal premiums set by the different health insurers for 2006.

Table 4: Annual premiums set by health insurers for 2006

	Natura contract	Restitution contract	Combination contract
Average premium	1,066	1,095	1,085
Lowest rate	1,048	990	1,038
Highest rate	1,120	1,172	1,143
Rate variance	72	182	105
Total count	35	19	21
		21	9

Sources: Zorgkiezer (2006), Verzekeringssite (2006)

Each year, the government defines the level of the standard premium, which forms the basis for the calculation of the tax credit. At the end of 2005, just before implementation of the new scheme, the Government had set the standard premium at Euros 1,100, but corrected it downwards to Euros 1,050 following a special provision in the Tax Credit Act. This separate act states that when the real average of the premiums offered by the health insurers differs more than Euros 25 from the standard premium, the government must adjust the latter (Ministerie VWS, 2005a). In other words, the level of insurance premiums set by the individual insurance funds on the basis of price-competition influences the level of the standard premium and of the tax credit for the less well-off. A high contribution rate variance indicates more price differentiation between insurance funds, and thus more price variation in the benefit packages.

The contribution rate variance in the Netherlands varied since the introduction of the nominal premium in 1989. During the first two years the government set the amount payable at Euros 71. As of 1991, the amount is set by the individual sickness funds to enhance competition. Over the last 7 years, both the contribution rate and the contribution rate variance have changed significantly (see Table 5). The radical increase in 2006 is

related to a decrease in the income-related contribution and meant to make consumers more cost-consciousness.

Table 5: Contribution Rate in Euros and Variance in %

Year	Lowest Rate (Euros)	Highest Rate (Euros)	Variance (%)
1999	159	200	125.8
2003	239	390	163.2
2006	1048	1120	106.9

Sources: HIT (2004), Zorgkiezer (2006)

Expectations from the Central Planning Office (CPB) are that the insurance premiums for the basic package will increase next year with 10 to 12%. It is assumed that in 2006 insurers, in order to attract old and new customers, have offered premium rates under the cost price by using up part of their reserves as these were allowed to shrink from 25 to 8% under the new law (Elsevier, 2006). Others argue that a number of the temporary provisions (in the form of retrospective payments to insurers) have contributed to the low contribution rate variance during 2006. As soon as these will be abolished, as is planned for 2007, both the premiums and the contribution rate variance will increase (Vektis, 2006). The NZa is in agreement that the costs of health care may increase in the coming years due to the ageing population, but denies that this would occur because health insurers will apply disproportional increases to their premiums. On the contrary, the organization expects that insurers will continue negotiating low prices with health care providers to keep their premiums low. The NZa promised to analyse the reasons behind eventual premium increases and to intervene when these are used 'completely as a profit for the insurer' (CTG/ZAio, 2006d).

Are consumers free to periodically choose between insurers? What % does it?

During the first 4 months of the scheme, nearly 20% of consumers changed insurers against a baseline figure of 1 to 4% (van de Ven et al., 2003). Vektis published a figure of 18% of the population of which 16% were previous sickness fund, and 24% previous private fund members (Vektis, 2006). More recently, the Minister of Health said that 30% of the population changed from insurer (Ministerie VWS, 2006e). The indicator is crucial, as argued by Van de Ven et al. (2003): 'If, for whatever reason, 'voting by feet' does not work, a necessary condition of the model of regulated competition is not fulfilled. Systematic research in this area therefore deserves a high priority'. Vektis expects that consumer mobility will continue in the coming years and stabilize at 10% in the long run.

		Before reforms	After reforms
5. Management of risk pool(s)	<ul style="list-style-type: none"> Do efficiency incentives exist for the risk pool(s) to control administrative costs? 	Competition only on private health insurance market	Competition between all health insurers

Management of risk pool(s)

Are there efficiency incentives for the risk pool(s) to control administrative costs?

Under the previous health financing scheme, cost containment was imposed by political governance (quantity control and tariff setting). The Exceptional Medical Expenses Act (AWBZ) is based on retrospective compensation, including administrative costs and, as such, has no incentives to increase efficiency. The Health Insurance Act (ZVW) does provide incentives for efficient risk pool management in the second compartment, by facilitating price competition.

Competition between insurers aims to enhance efficiency. It encourages insurers to link premiums to real costs and to minimize administrative costs. The fact that insurers are allowed to contract selectively with health care providers also encourages efficient behaviour on the side of providers. However, regulation and contracting also tend to increase administrative and transaction costs, for example related to the design and monitoring of individual contracts.

The NZa is responsible to set the rules for the administration that health insurers are expected to minimally have in place. The law establishes that insurers must have an electronic infrastructure (Ministerie VWS, 2006b), but no concrete targets or ceilings with respect to administrative costs are defined in the law, like in Germany, for example. This may be related to the purpose of the new law to replace rules by incentives, but this does not provide guarantees. No data have been found about real administrative and transaction costs under the previous and the new scheme. As this is a key indicator, trends in administrative costs for insurers and providers should be closely monitored.

Recently, some first global data were published reflecting average real costs per Dutch tax payer per insurer versus average real income per Dutch tax payer per insurer. On the basis of data from the first four months of 2006, insurers were said to pay on average Euros 1,265 per member and receive Euros 1,825. This would suggest that insurers' overhead costs are approaching 30% (Monitor, 2006c), which is extremely high. The data are not official.

Purchasing function

		Before reforms	After reforms
6. Benefit package	• Is the benefit package based on explicit efficiency and equity criteria?	Differences between social and private health insurance packages	Same benefit package for all, but no full guarantees for equitable and efficient implementation
	• Existence of consumer incentives	Few	Several
	• Are monitoring mechanisms in place to guarantee fairness and quality?	Medium	Improved, but not yet fully guaranteed

Benefit package

Is the benefit package based on explicit efficiency and equity criteria?

Before the 2006 reforms, the benefit package in the second compartment was defined in terms of products including the need for medical and surgical treatment, obstetric care, dental care, pharmaceuticals, hospital care (up to 365 days it was covered under the Sickness Fund Act (ZFW), thereafter under the Exceptional Medical Expenses Act

(AWBZ)¹⁹), aids and appliances, transport, maternity care, care provided by an audiology centre, services of a genetic testing centre, haemo-dialysis (including home dialysis), services for patients with chronic recurring respiratory problems, rehabilitation, services of a thrombosis prevention unit and services financed by a Health Care Insurance Board (CVZ) grant scheme, including in vitro fertilization and intensive home care (HIT, 2004). Each of these categories was described in detail in terms of the services that were (or were not) covered. Since the 2006 reforms, the description of the benefit package in the second compartment has been significantly simplified and is now based on functions. The insured risk in the second compartment is now defined as the need for (Ministerie VWS, 2006b):

- Medical care, including integral primary care as provided by general practitioners and midwives
- Dental care
- Pharmaceutical care
- Appliances and aids
- Nursing care
- Care, including prenatal care
- Accommodation required due to medical care
- Transport related to the above or to benefits covered by AWBZ

Furthermore, health insurers have a constituted care duty towards the insured in such a way that when the insured is affected by the insured risk, he/she has the right to receive:

- the care or other services he/she needs, or
- reimbursement of the costs for such care or services as well as, when requested, activities undertaken to acquire such care or services

The new law establishes that the government regulates the content and scope of the basic benefit package, including the eventual introduction of co-payments with respect to certain types of care and services, or the exclusion of certain types of care and services. In other words, future governments can affect the proportion of pre-paid contributions as a proportion of total health expenditure (key indicator) without changing the law.

The functional description of the benefit package aims to enhance efficiency encouraging insurers to purchase only those care products that are recommended by providers and demanded by consumers. The prices of some of these care products are left to the market or, of those where competition is not considered beneficial to the consumer, defined by the government. While efficiency and equity are pursued in the new model, this is not guaranteed with respect to the benefit package: in the case of failing inspection by the government and monitoring by consumers both the quality and equity of service provision may be compromised. Insurers, for example, may try to convince providers to reduce the costs of their services at the cost of quality. In a recent case, one insurer promised providers a bonus for prescribing cheap drugs. The insurer was sued by a number of patient and provider organizations who were concerned about this manipulative attitude, but won the case. The judge argued that the bonus was not perverse

¹⁹ This is different from, for example, Germany, where the maximum duration of care covered under the statutory health insurance is 6 months, after which coverage will be transferred to the statutory long-term care insurance.

as health providers have the duty to prescribe drugs according to medical, ethical standards and are bound by legal guidelines to prescribe the cheapest possible drugs anyway (ZN, 2006c). In other words, as providers are expected to keep to their professional code, further legislation was not assumed necessary. However, the design of the scheme provides incentives for insurers to increase their profit-margin and thus the risk of compromised quality is not fully controlled. It could result in small changes in service provision that are hardly noticeable for consumers, e.g. coverage of 2 rather than 3 hospital days after a certain surgery.

Another risk of the functional entitlements is that the benefit package can be rationalized without a change of the law. Recently, the Ministry of Health suggested restrictions on in vitro fertilization, for example, but after protests from patient organizations and providers, these were withdrawn. As the above, this example shows how the design of new Dutch scheme requires a strong stewardship role from the government as well as alert consumers and other health market actors. This is particularly the case when benefit package reductions would refer to essential services. These would most probably increase the proportion of out-of-pocket payments to total health expenditure, and thus affect the performance of the health (financing) system in general.

Existence of consumer incentives

This indicator provides insight in how health care consumers are directed through the design of the scheme, and the type of services they are encouraged to purchase. The 2006 reforms provide more incentives for rational consumer behaviour than the previous scheme. The government continues to provide non-financial incentives implementing programs for prevention and health promotion at national and local levels. However under the new scheme, related to the prospective risk equalization scheme, as discussed above, insurers also encourage consumers more and more to take up responsibility for their own health. They invest in websites and brochures to inform their members about risk factors and ways to prevent illness and disability. Insurers also post links on their websites to fitness clubs, dietary clubs and other social services or offer coverage for parts of the costs of such programs. Data about the impact on consumer behaviour of these developments are not yet available.

The new model also incorporates a number of financial consumer incentives. These are described below and where possible, reference is made to some first performance data linked to these incentives, as summarized in Table 6.

- Various levels of own risk (before 2006 only for private health insurance)

Insurers provide incentives to their clients offering them premium reductions in exchange for a certain level of own risk. In other words, those who voluntarily take out a higher level of own risk are rewarded a lower premium as they are expected to care for their own health. Table 6 shows that during the first year of implementation the great majority of Dutch citizens chose a package without own risk. Vektis confirmed that this counts for 95% of the insured in 2006 compared to 33% (plus an additional 33% with a small own risk of Euros 125) in 2005. The organization argues that this change is due to the small reductions offered by insurers for the various own risk options, but it also points to the

tendency within the Dutch population to over-insure. The latter is supported by the high proportion of additional health insurance (93%) purchased, similar to the previous scheme (90% in 2005) (Vektis, 2006). Over-insurance should be monitored closely, as it may increase the level of 'moral hazard' and compromise the efficiency of the system (Berg, 2006).

- Bonuses and 'sin premiums' (before 2006 only for Sickness fund members)

In the Netherlands, the only bonus for consumers is the no-claim bonus. It existed for Sickness Fund members and is aimed to control unnecessary demand. In principal, the non-utilization of primary care services is rewarded. However, in the new scheme consultations with the family doctor and (post-) natal care were excluded as considered essential; it was argued that people should not be encouraged to under-utilize these. Table 6 shows that in 2005, 53% of the Dutch insured population received their no-claim deposit back and 18.5% received it back in full.

Table 6: Some preliminary quantitative performance data (April 2006)

Proportion of insured that has chosen for a level of own risk (this is said to be low due to the fact that risk selection is prohibited by law)	5%
Proportion of collectively purchased insurances	> 40%
Average premium reduction for collectively purchased insurances	6.2%
Proportion of insured that has chosen to purchase a 'natura' contract	68%
Proportion of insured that has chosen to purchase a restitution contract (this sometimes includes contracted care)	23%
Proportion of insured that has chosen to purchase a mixed contract	9%
Proportion of insured whose no-claim deposit was reimbursed (of 8.2 million ZFW insured, 2005)	53%
Proportion of insured whose no-claim deposit was fully reimbursed (Euro 255, 2005)	18.5%

Source: Hoogervorst (2006b)

After the first months in 2006, since the no-claim bonus is applied to the whole population, the branch organization for Health Care Insurers Netherlands (ZN) claimed that the administrative implementation was complex (calculations and reimbursements take place over 2 consecutive years) and the provision itself little effective in financial terms, particularly since the exclusion of the family doctor and (post-) natal care consultations. Therefore, the organization requested the Ministry of Health (VWS) in April 2006 to abolish the provision (ZN, 2006d). In line with this, chronic patient organizations have called the provision inequitable arguing that their members cannot benefit from it. The left opposition also expressed concern about the no-claim clause as it may encourage poor people to under-utilize services, even in case of necessary demand. Other bonus schemes, like the German family-doctor and chronic care schemes are not implemented in the Netherlands. The possible application of 'sin premiums' (the reverse of bonus schemes) as a consumer incentive is widely discussed in the Netherlands, but has not been found in practice (Jeurissen, 2005).

- Increased nominal premium (introduced in 2006)

The increased nominal premium under the new law, supposedly based on real costs by insurers, is meant to increase the awareness of consumers about the high costs of health care. The argument behind the construct is that consumers who realize that insurers have to increase the premiums when the real costs of health care rise, are expected to cooperate and control their demand to keep the premiums low. However, there are two important concerns with respect to this assumption, which if not properly addressed, may affect the level of trust of consumers in the insurer branch and compromise the performance of the scheme:

1. the real costs of health care are not yet fully transparent for consumers, and particularly the real costs made by insurers to administer the scheme are unknown (as illustrated above, critics are collecting evidence about the profit margins of insurers in 2006, which are claimed to be unacceptably high)
2. competition between insurers may be compromised when the recent trend of merges continues and the insurance market gets more concentrated

- Benefit package varieties (introduced for social health insurance in 2006)

Another incentive for consumers to exercise their power of choice on the insurance market is the introduction of benefit package varieties, including the 'natura' polis, the restitution polis, a combination of these two and the collective polices. Performance data show that in the first year of the new model, the majority of consumers (68%) chose a 'natura' contract; only 23% choose a restitution polis. It should be noted, as table 3 demonstrates, that only 21 out of 35 insurers offered a restitution polis and only 9 a combined polis (of which 2 also offered a restitution polis). Furthermore, an increased number of people bought collective polices (if available): 44% in 2006 against 31% in the previous year (Vektis, 2006). Insurers have not fully exploited the option, as the reduction applied (6%) is below the allowed 10%.

- Freedom of choice for insurers and providers (introduced for social health insurance in 2006)

Under the new law, consumers are free to choose between insurers and insurance packages. However, with respect to their freedom of choice for health care providers, there is a difference between the cheaper 'natura' and the restitution polis. Consumers who buy the 'natura' polis will have restricted choice for providers, as insurers have the right to selective contracting. Insurers of 'natura' polis are allowed to introduce co-payments for consumers who choose to be treated by a provider not contracted by them. Therefore, under the new law, the level of choice for providers depends on the financial position of consumers. The incentive provided is that consumers should decide whether they want increased costs or increased choice. But the existence of different packages at different price rates may result in the development of different 'classes' within the insurers' membership and of a multi-tier health system.

Are monitoring mechanisms in place to guarantee the quality of services?

The capability of consumers, technically and legally, to monitor the implementation of the benefit packages (behaviour of insurers and providers), next to the government, is crucial in this scheme. The role of the NZa has been described earlier and is as important

as that of the Inspection of Health Care (IGZ) who monitors the quality of health care in the Netherlands.

From the consumer side, the Patient Act was adopted in 1995 to strengthen the position of patients. Currently, there is a significant number of patient and consumer organizations that defend the interests of specific patient groups which have set up a number of representative overarching organizations, like the NPCF (Dutch Patient/Consumer Federation), the CG-Raad (Dutch Council for Chronically Ill and Disabled) and the SPC (Collaborating Patient and Consumer Organizations).

Over the last few years, these organizations have gained significant power, both in terms of quality and quantity, and shown to be able to effectively influence the design of new laws before enactment as well as to monitor and redirect their implementation. This is illustrated by a recent example whereby a proposed new act, meant to facilitate the further reform of the Exceptional Medical Expenses Act (AWBZ), was adjusted to address the demands of disabled and chronic patients. The new act made municipalities responsible to develop social programs for the disabled and chronically ill in their community (rather than the AWBZ), but failed to define the quality of this responsibility. The patient and consumer organizations feared to lose some of their acquired rights and demonstrated massively against the new law. In the negotiation process they managed to introduce the concept of 'compensation duty' by municipalities, instituting not only the responsibility of municipalities to 'help' the disabled and chronically ill, but their legal duty to provide proper compensation for each individual's specific type of disability and consequent needs (CG Raad, 2006).

Currently, a number of laws cover patient rights in the Netherlands and there are various complaint instruments for patients to express their (dis)satisfaction with the system. However, interest groups are not fully satisfied with the legal position of patients and consumers, particularly since their role is so important under the new law. A number of problems have been identified with respect to the current Patient Act and Medical Treatment Agreement Act (WGBO): these acts describe the duties of health care providers towards patients and consumers, but do not cover all medical acts and fail to institute patient rights, like freedom of choice for providers (in the 'natura' polis) and the right to have access to proper performance information. The availability of such information is considered a condition for the model to succeed, but is not yet to standard (Ottes, 2004).

With respect to the relation between patients or consumers and insurers, the Health Insurance Act (ZVW) institutes the concept of 'consumer voice' giving insurers the duty to offer their members a 'reasonable level' of influence in their policy-making. The new law also constitutes sanctions against various forms of abuse by insurers, but does not provide consumers with a legal instrument to claim their right. In summary, the new act increases the level of consumer choice and formalizes the right and relevance of monitoring by consumers and patients. Full guarantees, however, are not yet in place.

		Before reforms	After reforms
7. Health care organization	• Do provider incentives encourage the appropriate level of care (e.g. family doctor system, focus on primary care, substitution)?	Medium	Too early to say (free price setting may increase risk of market failure)
	• In case of vertical fragmentation, are there incentives to increase coordination within the health system?	Medium	Improved

Health care organization

Do provider incentives encourage the appropriate level of care (e.g. family doctor system, focus on primary care, substitution)?

This indicator provides insight in how providers are directed through the design of the scheme and what services they are encouraged to produce.

- Family Doctors

The Dutch system is a family doctor system. General practitioners are historically self-employed. Patients are obliged to register with a family doctor who acts as the gatekeeper to specialist care. Before 2006, the system generated a relatively low referral rate of 6% of all contacts (HIT, 2004). In October 2005, just before the implementation of the reforms, an agreement was signed between the National Association for Family Doctors (LVH), VWS and Health Care Insurers Netherlands (ZN) to define a policy agenda and a costing system for family care during the year 2006-2007. The agreement reinforces the focus on family doctors, coordination between care providers at the primary care level, modernization and innovation, including the development of chronic care programs and substitution. (ZN, 2005).

In terms of non-financial incentives, the government encourages insurers and providers to focus on primary care and substitution. Financial incentives for family doctors, as illustrated in Table 7, include a capitation payment and a fee per consultation. In addition, family doctors can apply for certain performance related subsidies, like a risk equalization scheme and coverage for uninsured patients. The incentive scheme is mixed and focuses on the provision of continuous, high quality care as well as on efficiency and innovation. Capitation payments promote care continuity and efficiency, but may lead to undersupply and compromised quality. Like salary systems, capitation is considered more successful to encourage proper use of health care and to discourage unnecessary consultations than co-payments (Ottes, 2004). Consultation fees or fee-for-service mechanisms encourage, contrarily to capitation payments, supplier-induced-demand or oversupply (Carrin and James, 2004). It is yet to be seen what the effect is of the mixed incentive scheme. As part of the earlier mentioned agreement, stakeholders have committed themselves to monitor cost trends, including administrative costs, risks due to bad debtors, uninsured patients and entrepreneurship, consequences for pharmacy keeping family doctors, among others (non-financial incentive).

Table 7: Fee structure for family doctors (2006)	
<i>Individual level</i>	Euros (2006)
Consultation tariff (based on the agreed assumption of 8296 consults per year for a family doctor with 2350 patients, which will be monitored and adjusted if necessary)	9.00
Registration tariff per registered patient	52.00
Tariff for not registered patients (for incidental, acute care of people not living in the community of the family doctor)	24.80
<i>Global level</i>	
Module practice support for family doctors	49 million
Module population based compensation (for certain age groups (elderly) and for working in a lower socio-economic neighbourhood)	25 million
Module modernization and innovation, including substitution from secondary to primary care level	75 million
Funds to cover not registered patients	23.5 million

Source: ZN (2005)

- **Physiotherapists**

During a two years experiment in 2005 and 2006, price setting for independent physiotherapists was temporarily abolished. Insurers are now allowed to contract with physiotherapists and to negotiate a price per care product. During the experiment, patients who visit a physiotherapist not contracted by their insurer, pay the eventual extra costs themselves. The experiment aims to provide a better understanding of the effect of free price setting for effectiveness, quality, access and affordability of care. The government also hopes that it offers physiotherapists with new opportunities for innovation, product variation and entrepreneurship. In May 2006, the experiment was extended with a third year (CTG/ZAio 2006c). The first results show that insurers contracted 90% instead of 95% of physiotherapists and that prices increased with 8% (if corrected for inflation with 5%). According to the NZa the latter was due to necessary corrections with respect to previous years, but also to improved quality, effectiveness, as well as the new criteria for transparency and declaration procedures. This may indicate an increase in administrative costs, which is a key performance indicator of health financing schemes. Furthermore, the decrease in physiotherapists contracted by insurers may increase the proportion of out-of-pocket payments to total health expenditure, while an increase in the number of consults paid on the basis of fees-for-services may encourage supplier-induced-demand or over-production.

- **Diagnosis Treatment Combinations and Medical Specialists**

The DTC (Diagnosis Treatment Combinations) scheme was introduced in the Netherlands in February 2005 to make hospital costs transparent. The scheme is different from the DRG schemes that are known in e.g. the US, Australia, Germany and Belgium and are closely related to the 2006 reforms. The purpose of the Dutch DTC scheme is to increase the transparency and support the shift from supply- to demand side steering (facilitating free competition) in most parts of the health care market. In the short-term it is applied in one hospital care segment only.

In the Netherlands, hospital care is divided into three segments:

- The A0-segment represents acute, top-clinical and top-referent care (including training of medical specialists and reimbursement of expensive drugs). It has many potential forms of market failure and heterogeneous products, and is not appropriate for liberalization.
- The A1-segment represents most elective clinical care. For this segment, there are currently proper product descriptions available, but some forms of market failure have to be resolved before transition to the B-segment can take place.
- The B-segment represents poly-clinical care and day treatment (10% of all care).

In the A0-segment, competition between providers is expected to remain as good as non-existent, also in the future. In the A1-segment free competition is expected to be possible in the mid-term, but according to the Dutch Care Authority (NZA), regulation remains important for clinical care during the transition phase, particularly to safeguard public interests in the case of potential regional monopolies. Since January 2006, free competition exists in the B-segment.

The DTC scheme is developed on the basis of a bottom-up process whereby prices are linked to real costs made in individual hospitals. The fees of medical specialists are, as of yet, fixed by the government but integrated in the scheme, so that hospitals can see what the real, total costs are of each of their care products. DRG schemes, like for example in Belgium, are generally used for the macro-distribution of available resources only; the Dutch DTC scheme aims to reflect underlying activities and real costs for each care product and is used for macro-distribution and to establish (competitive) market prices. Different from DRG schemes, the DTC scheme also includes day treatment and poly-clinic care to provide incentives for substitution. In Germany, the DRG scheme uses approximately 800 different DRGs; the first version of the product structure of the Dutch DTC scheme for secondary care was based on a total of 10.000 DTCs (Projectorganisatie DBC GGZ, 2005). During 2006, the total number of DTC's has grown to over 100.000. Medical specialists have complained that it is too complex now and needs simplifying (ZN, 2006e).

Fees for medical specialists are currently calculated on the basis of a fixed tariff per hour (Euros 140 per hour in 2006) and a standard time per DTC, but are expected to be deregulated in the future. The Dutch case based payment scheme is considered to provide incentives for oversupply and for over-diagnosis, but also for less care provided per case, more efficiency per case and more illness episodes. On the one hand, incentives are introduced for hospitals to produce value for money in order to gain contracts with insurers; on the other, hospitals may compromise the quality of services with the aim to increase activity levels, or over-diagnose patients claiming more expensive DTCs than necessary. Furthermore, if according to plan the remuneration of medical specialists will be fully liberalized within a few years, the role of the government to monitor price and salary trends in the hospital sector, will be all the more crucial. Hospitals in the Netherlands are currently private, not-for-profit institutions, but various scenarios are under discussion that will allow hospitals to pay out their shareholders starting between 2008 and 2012.

It is hard to predict whether the above described payment mechanisms will be effective in achieving increased efficiency and a high quality of affordable care for all. Some incentives may encourage undesired provider behaviour, like supplier-induced-demand (over-production), over-diagnosing, and compromised quality to increase activity levels. Such behaviour is supposedly controlled by insurers who are interested in controlling costs and attracting clients at the same time. However, in order to increase their profit-margin, insurers may form alliances with providers, for example in HMO-like organizations (which they are allowed to do). Even though the latter may result in fruitful coordination beneficial to the patient, it also bears the risk of market failure. Independent monitoring by the government and by consumer and patient organizations is crucially important for social guarantees to be sustained.

In case of vertical fragmentation, are there incentives to increase coordination within the health system?

General practitioners are not allowed to work in hospitals in the Netherlands. Consequently, a gap exists between outpatient and hospital care and the health system is fairly fragmented. With the global increase in chronic disease, the need to improve coordination between the different health care functions is more and more recognized. Therefore, a number of experiments are ongoing in the form of shared or integrated care models, and more recently, disease management programs (Vrijhoeff et al., 2001). The development of programs for chronic patients at the primary care level is also encouraged. This indicator monitors health system efficiency and responsiveness, as it refers to the accessibility of services for people with multiple needs. By encouraging efficient behaviour, the new scheme reflects an improvement compared to the previous model.

		Before reforms	After reforms
8. Administrative efficiency	<ul style="list-style-type: none"> • % of expenditure on administrative costs • Are there incentives for transparency? 	<ul style="list-style-type: none"> • No data • Less explicitly 	<ul style="list-style-type: none"> • No data • Explicitly

Administrative efficiency

% of expenditure on administrative costs

As mentioned above, no concrete targets have been set to control the administrative efficiency of the new health financing system. Apart from competition between insurers and providers, there are incentives to increase administrative efficiency, for example in the agreement between insurers and family doctors. The former have confirmed to compensate the latter in case they send in their declarations digitally and according to a uniform standard. As mentioned before, the NZa is the formal institution to monitor the administrative efficiency of the insurers. Global health system administrative costs and the effectiveness of the incentives provided to control these are important performance indicators for the health financing scheme.

Are there incentives for transparency?

Transparency decreases room for corruption or creative bookkeeping and leads to cost savings and administrative efficiency. It is instituted by the new law with respect to the insurer-government, the insurer-provider and the insurer-consumer relationship. The

provision of full, detailed and unbiased information about activities and products by all parties is instituted in various clauses, as transparency is considered a condition for the successful performance of a health financing system based on regulated competition. Fines are instituted for abuse by insurers (for example for a faulty application of the open enrolment rule) and consumers (for example, for not being insured). The practical impact of these clauses depends on the level of reinforcement and sanctioning by the NZa and has to be closely monitored.

6. Critical issues, lessons learnt and concluding remarks

The above analysis illustrates how the presented framework can be used to compare the performance of health financing schemes, in this case, before and after the implementation of reforms.

The new design of the Dutch scheme shows improvement on most indicators compared to the previous scheme, particularly the level of mandatory membership and the fact that there is open enrolment with respect to the basic benefit package for all. As of January 2006, all the Dutch have access to social health insurance under the same conditions. In terms of the proportion of prepayment as part of total health expenditure and the level of catastrophic health expenditure, effects have yet to be measured, as well as the number of potentially excluded people (due to inability to pay or residential status). The indicators that refer to pooling show positive effects in terms of the power of choice exercised by consumers; there is increased consumer choice with respect to the previous scheme and consumers have made use of it. Also the level of health promotion (cost-effective services) seems to have increased compared to the previous scheme. However, the risk of market failure on the insurance market may increase due to merges. The fact that some chronic conditions are not yet included in the risk equalization scheme indicates a potential risk of inequity.

In terms of the benefit package, the reforms have introduced a level playing field for insurers and providers. This allows diversification and may increase efficiency, but also the risk of market failure (compromised quality). The freedom of choice for providers is subject to the financial ability of households, which may affect equity. In terms of health system fragmentation, it is yet to be seen whether there are sufficient incentives to achieve improvements; the expected reforms in the first compartment may further increase performance on this indicator. Reforms in terms of provider payment mechanisms are in an initial and/or experimental phase. Further development and monitoring in this respect is needed, as free price setting may increase the risk of market failure. In terms of (administrative) efficiency, detailed and complete data need to be collected to properly examine the behaviour of the new scheme. Questions that need to be answered in this respect refer to the effects of regulated competition on transaction and administrative costs for insurers and providers, but also, for example, to the effects of the tax credit on governmental subsidies, the effects of competition between insurers on health insurance premiums, the effects of selective contracting on waiting lists and the effects of the risk equalization scheme on risk selection (Maarse, 2002).

The question whether the performance of the new Dutch health financing scheme will contribute to improvements of the health system in general in view of the health system goals, or whether the new design will result in meeting all financing targets, is as yet difficult to answer. In principle, and as confirmed in the analysis presented above, where market mechanisms are expanded over the health care market the risk of market failure increases, and, at the same time, if this risk is properly controlled, efficiency, sustainability and responsiveness may increase. Much depends on the quality of implementation by insurers and providers, and as much, on the capacity of the government, also in view of the European legislation, and consumers to monitor and, eventually, correct undesired behaviour. The full impact of the 2006 reforms in the Netherlands can only be measured in a few years time.

The Dutch experiences are useful for other countries including less developed economies that are interested to achieve universal coverage on the basis of social health insurance. The scheme is based on multiple funds, but may be considered by countries with a single fund as well (they would need to open the health insurance market to competition). During the reforms of the 1990s, Slovakia moved from a centralistic tax-based health financing scheme to a model of regulated competition similar to the current Dutch model. Due to regulatory mechanisms it only has 5 private health insurance funds instead of 37 as in the Netherlands (HIT Slovakia, 2004). However, regulated competition does have a number of conditions. It requires a high level of institutional and administrative capacity at the country level. Particularly, health professionals and financiers must have a high level of technical capacity to work as 'social entrepreneurs'. Their work must be transparent and consumers should have continuous access to data about their performance (internet). Regulation and the reinforcement of law must be rigorous; the government must play a strong stewardship role. Finally, consumers must be technically and legally capable to properly exercise their power of choice. Implementation of the scheme, however, is not necessarily radical. Both in the Netherlands and in Slovakia, to mention just two examples, the implementation was a process of several decades.

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