

Early experiences with the Dutch health care reform¹

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Abstract

The Dutch health care reform has increased competition in the health insurance market. An unexpectedly large mobility among the insured has been accompanied by fierce competition among insurers on premiums. Despite this successful development, there are two points of attention for this market: the growing concentration, and the risk that selective contracting with preferred providers will not take off, because in practice the insured can still go to a non-contracted provider without having to pay much more. In the end the reform plans are aimed at the health purchasing market; on this market much remains to be done. Many of the relevant policy plans have already been drafted: more financial risk for health insurers, a new payment system for hospitals, and better information on the quality of health care. It is still unclear whether these necessary conditions will also be sufficient for a smooth operation of the health purchasing market. There are risks, mainly associated with the use of information on the quality of health care.

2.1 Introduction

On 1 January 2006 the Netherlands took the first steps towards a system of managed competition in curative health care. The key idea of the reforms is to increase efficiency by promoting competition among health insurers as well as health care providers. Both government control through supply management and free-market competition are problematic because of significant information asymmetries in the health care sector. In a system of managed competition the intention is to overcome the problem of information asymmetry as effectively

¹ This paper is based on CPB, Centraal Economisch Plan 2007, Speciale onderwerpen, Eerste ervaringen met stelselherziening zorg. This version is prepared for the Euroframe EFN Report.

as possible by devolving decision making to the lowest possible levels in the sector within strict public framework conditions:²

- compulsory insurance;
- open enrolment;
- community rating;
- risk adjustment among insurers.

From 2006 on all Dutch consumers have to be insured for health care costs. Before the reform, insurance for the higher incomes was voluntary. The basic insurance package is determined by the government and is identical for all insured. However, insurers have some freedom in the way they offer the relevant health care services. Insurers have to accept all applicants on the same terms; they are not allowed to differentiate premiums by personal risk characteristics. They are allowed to give a reduction on group contracts, but this is maximised at 10% of the price of individual contracts. To make community rating possible, all insurers have to participate in a risk equalisation scheme. In this way insurers with many old and unhealthy customers should still be able to set competitive premiums. The idea is that insurers compete for consumers by offering good quality health care at attractive premiums. The role of cost-sharing in the Netherlands is limited.

Although it is still too early for an evaluation of the healthcare reform, after more than a year of operation it is worth looking at what the results have been thus far and what the situation is now. In this section we examine the experiences with the health insurance market, in which the insured buy a health insurance policy (section 2.2), and the purchasing market, where insurers buy health care for their insured (section 2.3). In 2.4 we draw some preliminary conclusions.

2.2 Health insurance market

On the health insurance market the new health care system created a very dynamic situation and fierce competition among the insurers on premiums, with the insurers coming under pressure from the many insured who switched insurers in 2006. The fierce competition is leading to mergers among insurers, which might strengthen their market power. An open question is whether insurers in practice have sufficient opportunities to contract selectively. That is to say, whether insured can choose preferred provider policies, which include specific choices with regard to the provision of healthcare.

Switchers

In 2006 many more insured took the opportunity to switch health insurers than before the health

² See the description in the *Central Economic Plan 2005*.

care reform: in fact, a total of 18% of the insured switched insurers.³ To make a considered choice, insured should have access to information about the level of the premium, the extent of the coverage, and the quality and the performance of the insurers. However, at the moment there is very little information available about the quality of the purchased healthcare, and, moreover, insurers are not buying very selectively yet (see below). The insured do have information about the quality of the insurers' services. But it is not clear to what extent the switchers in 2006 took account of this information in addition to the differences in premiums.

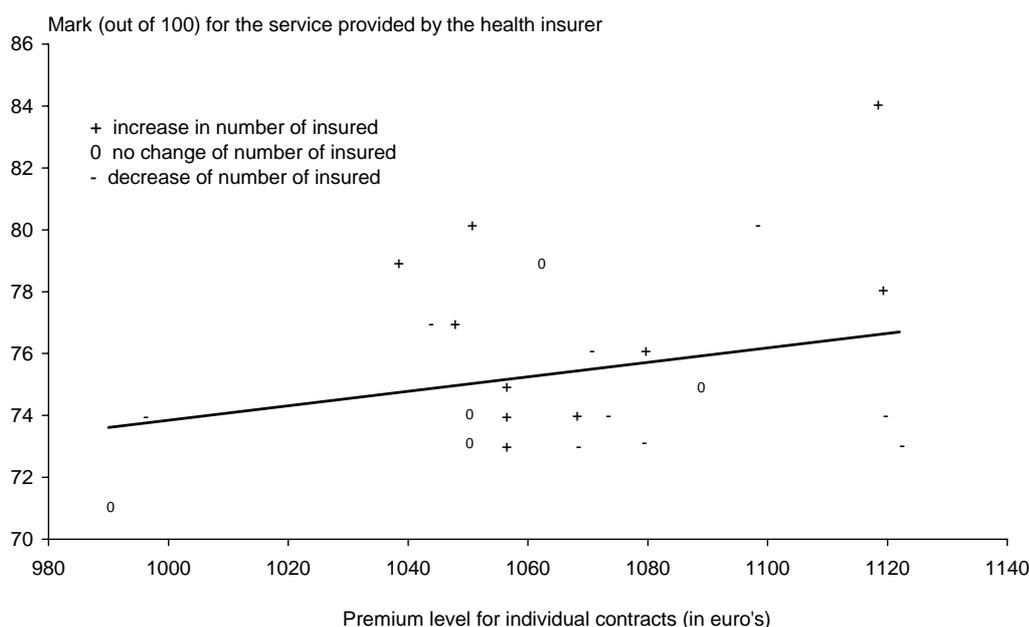
Figure 6.5 compares, for the various insurers, the insured's appreciation of the quality of the insurers' service with the premiums the insurers charge for basic insurance packages for individual contracts⁴. The regression line indicates a positive correlation between the level of the premium and the quality of the service. The figure also indicates for each insurer whether their customer base increased (+), remained the same (0) or decreased (-). The figure shows that of the insurers which can boast a favourable premium/service balance, which are situated above the line, the number with an increased customer base exceeds the number with a decreased customer base. Especially for the four insurers with relatively high premiums there seems to be a clear correlation: they can attract new customers if they provide a very good service, but they will lose customers if they provide a relatively poor service. It seems, then, that the insured have been able to identify insurers with favourable premium/service balances.

In the future more information should become available about the quality of the health care which insurers buy in. Only then can the insured incentivise insurers to distinguish themselves on the basis of the healthcare provided or through preferred providers. At the moment many activities are being unfolded to gather more information about the quality of healthcare (see below).

³ NZa (Dutch Healthcare Authority), "De tussenstand op de zorgverzekeringsmarkt", Monitor zorgverzekeringsmarkt, June 2006. Before the reform there was open enrolment for the lower incomes who were compulsorily insured, but in practice there was very little switching.

⁴ On the determination of the evaluation figures, see M. Hendriks, D. Delnoij, S. van der Meulen - Arts, W. Brouwer and P. Spreeuwenberg, "Ervaringen van verzekerden met de zorg en zorgverzekeraars, Consumenteninformatie voor www.kies.beter.nl", NIVEL, 2005, www.nivel.nl.

Figure 6.5 Switchers in relation to health insurers' premiums for individual contracts and their services



Fierce competition on premium

Health insurers competed fiercely on premiums not only in 2006, they are also doing so in 2007. This is evident from the low mark-up which insurers use on top of their expected expenditures on healthcare. Table 6.3 shows the premiums in 2006 and 2007, which are averages for individual and group contracts.

Table 6.3 Average premiums for the basic health insurance package (in euros)		
	2006	2007
Average market premium	1030	1103 ^a
Notional premium	970	1051
Average mark-up	60	52

^a Provisional estimate.

The table shows how the average premium in the market in 2006 and 2007 is made up of a notional premium and a mark-up. The notional premium is set annually by the government on the basis of an estimation of total expected healthcare spending. Since 2006 insurers no longer run a risk on this estimation of total health care spending, since this figure is adjusted retrospectively on the basis of actual outlays. Hence for an average health insurer, the notional premium will cover their health care expenditures in full. This means that the average mark-up is a good indicator of the additional funds, on top of their healthcare expenditures, which the insurers generate to cover their operating expenses and to make a profit. The average mark-up in 2006 of 60 euros is appreciably lower than the operating expenses of many former public health insurance funds and private insurance companies in the past. Insurers are estimated to

have made losses of 570 million euros in 2006 on their basic insurance packages and of 40 million euros on their supplementary policies (in addition to the compulsory basic package).⁵

The question is whether this strategy of low premiums in 2006 was a one-off. The literature refers in this context to a “bargain-then-rip-off” strategy.⁶ In this strategy insurers initially try to capture the largest possible market share through low premiums; at a later stage, when the market has calmed down and consumers are less inclined to switch insurers, they then raise the premiums. Although the number of switchers is likely to be much smaller in 2007 than in 2006, the evidence shows that insurers did not rely on this strategy. Initial estimates show that the mark-up in 2007 is around 52 euros, which is comparable to the mark-up of 60 euros in 2006. The two figures are not strictly comparable, however, because owing to an error in the calculation of the risk-adjusted premium subsidies, insurers were overpaid by around 250 million euros (around 20 euro per premium payer) in 2006. Compared to the situation without this error, the insurers had some scope to set the mark-up lower in 2007. All in all this leads to the conclusion that the fight over customers has not abated in 2007, and that insurers are still competing hard on price in the basic health insurance package.

Consequences of competition

The intention behind introducing more competition in the health insurance market is to elicit a stronger responsiveness to consumer preferences and greater efficiency. But it may also generate unwelcome side effects, such as risk selection or compromises on the quality of health care.

A number of reactions point to an increase in efficiency. Several health insurers, for instance, have announced plans to make savings on staff and costs. The mergers among insurers may also suggest an attempt to organise health care provision more efficiently, even though the empirical evidence shows that mergers often do not lead to efficiency gains. It may be that larger insurers can negotiate better with healthcare providers. However, there is also a danger that greater concentration will lead to greater market power and consequently to higher mark-ups. By now the Dutch health insurance market consists of six large concerns, which together have a market share of around 90%, and seven smaller regionally based companies.⁷ At the moment more mergers are being planned, but these still have to be approved by the competition authority. It is difficult to determine what would be the optimum number of insurers.

Until now the insurers seem to have concentrated their efficiency efforts mainly on their own operating expenses and less on stimulating efficient health care production. In addition to securing efficient healthcare provision, insurers can also cut costs through risk selection. To that end they need to attract customers who have a favourable risk profile compared to the

⁵ DNB, *Statistical Bulletin*, June 2007.

⁶ M. Pomp, V. Shestalova, L. Rangel, “Switch on the competition: Causes, consequences and policy implications of consumer switching costs”, CPB Document 97, 2005.

⁷ E. Schut, “Marktwerking in de zorg één jaar later”, *ESB-dossier “Markt in werking”*, 2006, pp. 20-24.

contribution which the insurers receive from the health insurance fund.⁸ A potential instrument for risk selection is a selective acceptance policy for supplementary insurances, in order also to avoid unfavourable risks in the basic health insurance package, where they are bound by “open enrolment” (i.e. an acceptance obligation). This form of selection does not seem to be evident yet, however. Insurers have accepted all applicants for most supplementary insurance policies in 2006 and 2007.⁹

In 2006 around 46% of all insured were covered through a group contract, compared to only 29% in 2005.¹⁰ In 2006 insurers offered an average discount of 6.6% on group contracts. There may be a number of reasons for these discounts. They probably reflect the achievement of economies of scale and the capture of market share. Groups have stronger negotiating positions than individuals and group contracts are often more attractive than individual contracts to insurers as well. Through group contracts, insurers can get a foot in the door with employers, which gives them opportunities to sell other products in their range as well. Risk selection may also play a role; insured groups such as civil servants, pensioners’ associations or sports clubs may well present quite favourable risks overall. Whether the government should worry about this is a question that is difficult to answer on the basis of the information available at the moment. For one thing, this information on group contracts may be used to improve the risk adjustment. For another, virtually all insured are able to join one group or another. The differences with individual contracts are limited, because the discounts on group contracts can not exceed 10% compared with individual contracts.

Open question: preferred provider policies

It is important for the eventual success of the new health insurance system that the insured can choose “preferred provider” policies if they wish to do so.¹¹ The Health Care Insurance Act (ZVW) stipulates that insured are still entitled to reimbursement if they go to a non-contracted provider. According to the explanatory memorandum to the Act, under EU law the personal contribution may not be so high as to become actually an obstacle to obtaining health care from a non-contracted provider abroad. This provision may also have implications for the reimbursement of non-contracted healthcare in the Netherlands. It is unclear what charges the insurer will have to pay if the insured has a preferred provider policy but still makes use of a non-contracted provider. It seems that insurers use different charges under these circumstances.¹² The charges range between 80-100% of a statutory charge or a market-based charge for those treatments for which the government does not set charges. Insurers are free to set the level of the market-based charges. When the non-contracted provider turns out to be

⁸ The insurers receive ex ante standard amounts per insured, which are calculated on the basis of the characteristics of the insured (age, gender, pharmaceutical cost group, diagnostic cost group, income type, region).

⁹ De Bruijn, D. and F.T. Schut, Evaluatie aanvullende verzekeringen 2007, Onderzoek uitgevoerd in opdracht van de Nederlandse Patiënten Consumenten Federatie, Eindrapportage april 2007

¹⁰ NZa, “De tussenstand op de zorgverzekeringsmarkt”, Monitor zorgverzekeringsmarkt, June 2006.

¹¹ Insured may attach great importance to choosing their doctors and believe that they are better off with a policy without restrictions but with a higher premium. If they have such a preference, the market will show this in due course. However, this would mean the disappearance of a key mechanism to improving efficiency in the health service.

¹² NZa, “De tussenstand op de zorgverzekeringsmarkt”, Monitor zorgverzekeringsmarkt, June 2006.

more expensive than the charges (including any discounts) set by the insurer, then the insured must pay the difference him- or herself. At the moment it is unclear what charges and discounts the insurers can use. After all, the crucial question for the courts is, at what charge level will the insured be prevented from going to another provider? If jurisprudence accumulates on this aspect and it turns out that the courts eventually do not allow substantial discounts, then the scope for insurers to direct their insured towards preferred providers will remain limited. This will reduce the scope for achieving efficiency gains in curative healthcare.

2.3 Health care purchasing market

On the health care purchasing market, the main focus is on hospital care. Not only is hospital care a major component of this market, but thus far there have only been limited moves towards competition in other parts of this market. For family doctors there are fixed charges for each registered patient and each consultation. Insurers do not have much influence in this area, although some are trying to improve efficiency through doctors' drug-prescribing behaviour. At the moment, savings in drug purchasing are achieved mainly through a "covenant" (i.e. voluntary agreement) between the Ministry of Health, Welfare and Sport and pharmacists, health insurers and drug manufacturers. Therefore, the remainder of this section will deal primarily with hospital care.

The idea behind the health care reform is that insurers have to buy in good health care for a reasonable price in order to draw clients with an attractive offer. To achieve this, they in turn have to spur on health care providers to provide good health care which is produced as efficiently as possible. There are indications that there is significant scope for improvement in the efficiency of hospital care, which means that there is scope for lower prices without loss of quality or for higher quality at the same prices. In this system of incentives, insurers have to be able to negotiate on the price of hospital care.

In 2005 hospitals were given the freedom to negotiate on 10% of their production in terms of "diagnosis treatment combinations" (DBC's).¹³ This 10% is called the "B-segment". The other 90%, the "A-segment", is still funded through the system of "function-oriented budgeting" (FB), which was introduced in the 1980s.¹⁴ For this 90%, the insurers still negotiate jointly with the hospitals. Within this system a greater efficiency by a particular hospital cannot lead to lower prices. Thus far, then, competition in hospital care can only take place in the B-segment and by purchasing from independent clinics (so called ZBC's).¹⁵ To assess what the free negotiations on certain DBC's have yielded, we will examine below the incentives for insurers to purchase hospital care efficiently, the means of purchasing (selective contracting

¹³ This is the Dutch version of Diagnosis Related Groups. It concerns all hospital care, including outpatient visits.

¹⁴ The financing (i.e. sending out the bills) is wholly based on DBC's.

¹⁵ Broadly speaking, "independent treatment centres" (ZBC's) are former private clinics which have been licensed to provide specialist medical treatments and care but not in combination with extended stays. Since the introduction of the Health Care Institutions Licensing Act (WTZi), ZBC's are allowed to provide health care in the B-segment (see NZa, "De rol van ZBC's in de ziekenhuiszorg", Monitor special, 2007). In the A-segment the DBC charges apply to the ZBC's as maximum charges. This means that they may charge lower prices.

with preferred providers or otherwise), and the quality and price of the purchased health care.

Few incentives for insurers

At the moment insurers have few incentives to buy in hospital care efficiently, because they do not run a serious risk on their actual health care expenditures. Once the ex-ante risk adjustment has taken place, a number of ex-post mechanisms come into operation, so that eventually the insurers run only a limited financial risk on the difference between actual and standard expenditures on their insured (see box).

The motivation to reduce the risks of health insurers is that the risk adjustment mechanism does not yet correct sufficiently for the predictable differences among insured (this mainly due to data problems in the wake of the introduction of DBCs), and that the insurers are not yet in a position to exert significant influence over certain healthcare expenditures.¹⁶ However, a major disadvantage of a reduction of risks is that insurers have only limited incentives for efficient purchasing, in particular that of hospital care. Insurers run much greater risks on other forms of healthcare (such as extramural medication and general practitioner care).

There are various options to further increase the risks borne by insurers on hospital care expenditures. The retrospective equalisation among insurers of the variable hospital care costs could be abolished, and the bandwidth above which these costs are largely adjusted retrospectively could be widened. The threshold for high-risk equalisation could be raised as well. Key is that the ex-post payment schemes are geared to the (intended) funding system for hospitals (see below in this section). For that part of hospital care for which prices including compensation for fixed costs can be negotiated, it seems reasonable to maximise the incentives for efficient healthcare provision. But for other (unplannable) hospital care it would be prudent to move more cautiously. These are forms of healthcare which are not suitable or less suitable to competition among health insurers and hospitals (for instance, the availability of acute care, training of medical specialists, and financing of expensive medication). Within this segment, insurers can exert only limited influence on healthcare expenditures.

¹⁶ Ministry of Health, Welfare and Sport, "Afbouw ex-post compensatie in het risicovereveningssysteem", Letter to the Lower House of Parliament, 2007.

Ex-post payment schemes for insurers for hospital care costs

In 2007 the following four ex-post payment schemes apply in the context of hospital care costs:

1. High-risk equalisation

The costs of an insured above a threshold of 12,500 euros are equalised among insurers for 90%.

2. Retrospective equalisation

The variable costs of hospital care and the costs of specialist treatment and care are equalised among insurers for 30%.

3. Retrospective adjustment of hospital care costs

The fixed hospital costs are adjusted retrospectively on the basis of actual outlays for 100%, and the variable hospital costs and costs of specialist treatment and care for 35%.

4. Bandwidth scheme for hospital care costs

This safety net applies only to the variable costs of hospital care and the costs of specialist treatment and care. When after the application of the above three payment schemes the costs still fall outside a bandwidth of plus or minus 17.50 euros per average insured bound to pay premiums, then these costs are adjusted retrospectively for 90%.

These ex-post payment schemes reduce the risk which insurers run on hospital care costs considerably, as is evident from a stylised example. Let us assume that a health insurer's average hospital care costs are 150 euros higher per insured than other insurers', even after adjustment for individual characteristics of the insured. If 50 euros of this are accounted for by fixed costs, then the insurer runs no risk on this amount. The insurer can only run a risk on the other 100 euros. This risk may be reduced with the application of high-risk equalisation, but we will leave this out of consideration for the moment. In the case of retrospective equalisation, 30% of the additional costs are equalised with other insurers, which reduces the risk to 70 euros. Of this, 35% is adjusted under the retrospective adjustment of hospital care costs, so that 45.50 euros remain. This amount is far more than the bandwidth of 17.50 euros, so that 90% of the higher amount will also be adjusted retrospectively. Hence the insurer runs a risk of 17.50 euros plus 10% of 45.50 euros, or 20.30 euros.

Selective contracting with preferred providers

In a system of managed competition, one of the ways in which insurers can distinguish themselves is by concluding contracts with good and cheap health care providers to which they can send their insured when they need healthcare. Insurers can then offer a low premium as well as good healthcare.¹⁷ Thus far the option of selective contracting with preferred providers has barely been exploited. Nearly all insurers have concluded contracts with nearly all hospitals. These contracts often cover the whole range of health care provided by these hospitals. So the 85% of the insured who selected a policy with fully or partially contracted health care in 2006¹⁸ did not notice much of this practice. A major reason for this is probably that insurers are afraid of losing clients if they impose too many restrictions. Moreover, the insurers still do not

¹⁷ Other ways in which insurers can distinguish themselves is to give the insured a completely free choice of doctor, to secure shorter waiting times, to provide a good service, etc. In theory, an insurer can also distinguish itself by offering its customers health care of a quality that is well above the minimum level. But this is difficult to realise in practice when health care providers work for customers from different insurers, because providers will want to provide the same quality of health care to all their patients. Of course, an insurer can try to contract health care providers that offer high quality.

¹⁸ NZa, "De tussenstand op de zorgverzekeringsmarkt", Monitor zorgverzekeringsmarkt, June 2006.

have sufficient quality information to substantiate a preference for specific providers. At the moment it is probably also difficult for insurers to tempt insured into selective contracting with a much lower premium. After all, the Health Care Insurance Act (ZVW) stipulates that insured are still entitled to reimbursement if they go to a non-contracted provider (see above).

In practice the insured do not yet have a strong incentive to choose a policy with contracted health care, because the price differences are not that significant: in 2006 the cheapest indemnity insurance policy with free choice of healthcare providers cost 1,044 euros, while the cheapest insurance overall was an indemnity insurance policy with contracted healthcare, which cost 990 euros.¹⁹ The premium differences may widen of course if insurers start to contract more selectively in the future.

Still insufficient information on quality

At the moment insurers still do not have sufficient information about the quality of hospital care in order to buy in on these grounds. In 2005 and 2006 insurers and hospitals did make agreements about the quality of healthcare in the B-segment, but these were intended above all to obtain greater clarity about quality. In many cases these agreements were restricted to providers implementing quality indicators and reporting them to insurers. However, the insurers have made progress in terms of gaining greater insight into quality.²⁰ By now nearly all hospitals have adopted the Basic Set of Hospital Performance Indicators (Basisset prestatieindicatoren ziekenhuizen) drafted by the Health Care Inspectorate (IGZ). Furthermore, to obtain more information about the quality of healthcare with regard to specific complaints, a project on “complaint-specific indicators of patient safety and effectiveness” is being implemented. An institute has also been founded, the Institute for Customer Experience Research in the Health Care Service (IKZ), which will conduct standardised research into customer satisfaction. And in the context of health care purchasing the Healthcare Insurers Netherlands (ZN), the industry’s umbrella organisation, developed a number of complaint-specific health care purchasing indicators in 2006, because the other initiatives mentioned here were not yielding results quickly enough to use them in the negotiations for 2006.

Importance of quality information

In the absence of reliable information about quality, there are three risks. Firstly, the insured may not be prepared to take out a preferred provider policy because they do not trust the insurers to buy in good health care. This undermines the negotiating power of the insurers, with the danger that the desired efficiency gains are not achieved. Secondly, there is a risk that insurers will compete on price at the expense of quality rather than on price *and* quality. That this is a possibility is clear from experiences in the United Kingdom, where more competition in a situation of absent quality information led to shorter waiting times, but also to higher death

¹⁹ NZa, “De tussenstand op de zorgverzekeringsmarkt”, Monitor zorgverzekeringsmarkt, June 2006, p. 12.

²⁰ CTG/Zaio, “Monitor Ziekenhuiszorg 2006: Analyse van de marktontwikkelingen in het B-segment in 2006”, 2006.

rates among patients who had suffered a heart attack.²¹ The researchers concluded that "... it may have been a mistake to delay the publication of quality signals until some 10 years after the introduction of a market meant to rely on them". A third risk is that hospitals will concentrate on measured quality, at the expense of quality aspects which are not measured ("teaching to the test", as this phenomenon is known in the education context).

A major open question is to what extent consumers base their choices of health care providers on information about the quality of health care. At the moment it is not possible to give a clear answer to this question. On the one hand, some US studies suggest that quality information does play a role.²² On the other hand, another US study suggests that in their actual selection behaviour customers are led mainly by quality judgements from other consumers and less by objective quality criteria on the contracted health care.²³ Propper et al conclude that British consumers take very little notice of quality information. In the light of all this, one may wonder whether consumer information will actually lead to the appropriate quality incentives for insurers. This may mean that there is a major role for insurers in the collection and interpretation of quality information. They could then pass on their findings to consumers in an attempt to demonstrate that selective contracting with preferred providers can yield not only cheap but also good health care. However, it is by no means certain that consumers will accept the insurer's claims. The insured may therefore have need of what they regard as a reliable party, which will check on their behalf whether insurers are monitoring quality of the healthcare providers. Given the growing importance of group contracts, trade unions and employers may have a role here. Other possible parties are consumer organisations and patients' associations. Another option may be the introduction of additional quality incentives to reduce the risk of loss of quality. This could be done by intensifying the supervisory role of the Health Care Inspectorate (IGZ), but also by offering bonuses to healthcare providers on the basis of specific quality criteria. Pay-for-performance programmes of this kind are also being developed in the United Kingdom and the United States.²⁴ However, teaching to the test is a danger here as well.

Price trends in 2005 and 2006

Have free negotiations in the B-segment actually tempered price increases? For 2005 the new diagnosis treatment combination (DBC) prices can only be compared with what are called "administrative prices" (schoningsprijzen). These are the prices which the predecessor of the Dutch Healthcare Authority (NZA), the Healthcare Charges Board/Health Authority in formation (CTG/ZAio), used to correct the hospital budgets for the DBCs in the B-segment.

²¹C. Propper, S. Burgess and D. Wilson, "Will more choice improve outcomes in education and health care? The evidence from economic research", Bristol, CMPO, 2005. It should be noted that competition was defined very specifically here. Thus prices had to be equal to the average costs; hospitals could not transfer profits or losses from one year to the next; hospitals could not borrow; and hospitals were only assessed for low prices and short waiting times for elective health care.

²²D.P. Kessler, "Can ranking hospitals on the basis of patients' travel distances improve quality of care?", NBER Working Paper no. 11419, 2005; D. Howard, "Quality and Consumer Choice in Healthcare: Evidence from Kidney Transplantation", in *Topics in Economic Analysis & Policy*, vol. 5, 2005, <http://www.bepress.com/bejeap/topics/vol5/iss1/art24>.

²³L. Dafny and D. Dranove, "Do report cards tell consumers anything they don't already know? The case of Medicare HMO's", NBER Working Paper no. 11420, 2005.

²⁴M. Roland, "Linking physicians' pay to quality of care, a major experiment in the United Kingdom", *New England Journal of Medicine*, 30 September 2004, pp. 1448-1454; M. Rosenthal, R. Fernandopulle, H. Song and B. Landon, "Paying for quality: Providers' incentives for quality improvement", *Health Affairs*, vol. 23, no. 2, 2004, pp. 127-141.

The administrative prices were based on data for 12 hospitals, so may not be representative. The prices agreed in 2005 were on average 5% higher than the administrative prices.

In 2006 the situation was different. With an average price increase of 0.5%, the B-segment DBCs remained almost one percentage point below the estimated GDP deflator.²⁵ Hence the prices of B-segment DBCs increased far less than the projected 1¼% price increase for the health service in general. Data from the CTG/ZAio show that a number of insurers negotiated seriously about the prices of a few DBCs.²⁶ These were DBCs which constituted a relatively large share of turnover in the B-segment, or where competition from independent clinics (ZBCs) was strong. However, many DBCs were subject to an indexation of contract prices in 2005 which was more or less determined by inflation. The incentives to adopt a tough negotiating stance were not great as well, because in 2006 insurers ran a very small risk on their health care expenditures and because they could only negotiate on 10% of hospital production. Of the seven most common diagnoses in the B-segment (in terms of turnover), the price of cataracts fell furthest in 2006 (1.3% of the contract price). In 2005 the administrative price of cataracts also had a low mark-up. This was probably due to a combination of competition from ZBCs with low prices and the efficiency gains achieved by improving logistical aspects.²⁷ In that case the ZBCs are playing a useful role in stimulating competition. A health insurer with a large market share in a particular hospital can negotiate a lower price than an insurer with a small market share. This may lead to a consolidation of regional positions of power.²⁸

Further deregulation of prices

A further deregulation of hospital care prices is necessary to make the health care reform a success. For only then will competition bring the socially optimal price/quality ratio. The DBC system developed to replace the FB system still has some shortcomings at the moment.²⁹ However, the parties involved believe that these can be overcome by simplifying the system and making several other changes.³⁰ Further deregulation can be elaborated in many ways. Two key questions for Dutch policy prior to the elections of November 2006 were the following:

1. should price negotiations cover only the hospitals' variable costs, or the fixed costs as well?
and
2. should prices for hospital care be completely deregulated?

As far as the first question is concerned, there are major advantages to making the hospitals responsible for all costs. This would give hospitals an incentive to consider whether and how

²⁵ See the *CPB Newsletter June 2007*.

²⁶ CTG/ZAio, "Monitor Ziekenhuiszorg 2006, Analyse van de marktontwikkelingen in het B-segment in 2006", 2006.

²⁷ Among the independent clinics (ZBCs) the contract prices for the cataract diagnosis were on average 21.3% lower than among hospitals in 2006 (NZA, op. cit., 2007).

²⁸ If these health insurers can offer a lower nominal premium on the back of lower hospital care prices, they may increase their market share and thus become even stronger market players.

²⁹ NZa, "Toetsingskader en criteria voor ontwikkeling DBC-systeem", Visiedocument, 2006.

³⁰ Ministry of Health, Welfare and Sport, "Ruimte voor betere zorg", Letter to the Lower House of Parliament, 2006.

they should invest in buildings and other capital goods. They would try to keep their total costs as low as possible, given the production. Efficiency gains will only be passed on to the insured if hospitals experience real competition. A price including fixed costs could give hospitals too much of a volume incentive (i.e. an incentive to over-cover their capital costs). This problem could be solved by working with a contract between hospital and insurer which is partly fixed and partly variable. Recently the new government decided that price negotiations should concern integral costs from 2009 on.³¹

Considering the second question, free price negotiations could put hospitals under pressure to cut DBC prices where competition is fierce (for instance from ZBCs or neighbouring hospitals). Where hospitals are in a strong negotiating position, free negotiations could lead to higher prices. For now the insurers are still in a relatively weak negotiating position because of the lack of quality information and the problems with selective contracting with preferred providers. The negotiating position of insurers might be strengthened through the introduction of a price ceiling.³² Where competition is strong, prices could come out below the ceiling. Where competition is weak, the ceiling would be binding, so that prices would come out lower than they would have been without the ceiling. Such a ceiling would also give hospitals an incentive to cut their costs, since everything they save they will be allowed to keep (even if they cannot turn a profit in a real sense).

A price ceiling would also have disadvantages. Using a binding price ceiling may have implications not only for prices, but also for the volume of health care and the quality and composition of production. Too much or too little health care may be offered, and the quality of health care may come under pressure in so far as better care would also mean more expensive care. If hospitals end up with considerable market power, many hospitals may decide to insist on the maximum allowed prices.³³ In that case the potential efficiency gains will be more difficult to assess. Developments in the B-segment would then be the main source of information on this aspect. Additional policy measures would possibly be required to mitigate the disadvantages of using a price ceiling. One option to counter some of the undesirable incentives of a price ceiling would be to pay separately for innovations which are not cost-saving (to teaching hospitals, for instance), with the results of the work then being made available to all.³⁴

The new government decided to extend the freely negotiable B-segment from 10% to 20% in 2008. In 2009 the function-oriented budgeting system will be abolished and price ceilings will be introduced for a large part of the A-segment. The government will estimate possible

³¹ Ministry of Health, Welfare and Sport, Met zorg ondernemen, Letter to the Lower House of Parliament, 2007

³² As proposed by the Healthcare Charges Board / Health Authority in formation (CTG/Zaio) in "De zichtbare hand: Uitvoeringstoets Ziekenhuisbekostiging", 2006.

³³ This is not a disadvantage of the system of "yardstick competition" as such, but the consequence of market power. After all, the upshot of fully deregulated prices is likely to be even higher prices.

³⁴ P.J. Agrell, P. Bogetoft, R. Halbersma and M.C. Mikkers, "Yardstick competition for multi-product hospitals: An analysis of the proposed Dutch yardstick mechanism", NZa Research Paper, 2006.

efficiency gains in advance and use these estimates to lower the price ceilings for the period 2009-2011. In 2011 a decision about further deregulation of prices will be made.³⁵

2.4 Conclusions

On the health insurance market, competition has taken root. Not many additional policy measures are required on this market. There are, however, two aspects that deserve attention: the growing concentration on the health insurance market; and the risk that selective contracting with preferred providers will not take off, because in practice the insured can still go to non-contracted providers without having to pay much more. On the health care purchasing market, by contrast, much remains to be done. Many of the relevant policy plans have already been drafted. The essential conditions to boost competition on the purchasing market include a greater financial risk for health insurers, a new funding system for hospitals, and better information on the quality of health care. It is still unclear whether these necessary conditions will also be sufficient for a smooth operation of the health care purchasing market. To ensure that the healthcare reform becomes a success, insurers will have to work hard to buy in good and efficient care for their insured. If the plans for the deregulation of hospital care prices and the introduction of greater financial risks for insurers go ahead, then insurers will have more instruments and incentives to buy in efficient health care. Even so, there are risks involved in the use of information about the quality of healthcare.

A first potential risk is that selective contracting with preferred providers does not take off, because the insured will not trust their insurers to buy in good healthcare on their behalf. In that case insurers will be in a much weaker position in their negotiations with health care providers. A second risk which may occur is that selective contracting with preferred providers does take off because the insured are attracted by low premiums, but that the price competition will undermine quality. If reliable quality information is available and if this is used by the insured, then these risks will not arise. But it is not clear at this stage what kind of information consumers need, and to what extent they will respond to quality information. It is worth considering whether, certainly during the transition period, particular attention should be paid to the quality of health care, for instance through more intensive supervision by the Health Care Inspectorate (IGZ). Perhaps organisations such as trade unions and consumer organisations could play a role in assuring the quality of healthcare as well.

³⁵ Ministry of Health, Welfare and Sport, Waardering voor betere zorg, Letter to the Lower House of Parliament, 2007