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Competition in the Dutch Health care system

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The Dutch healthcare insurance system combines solidarity and competition. It consists of three pillars: tax-funded public insurance for long-term care; mandatory health insurance administered by private organizations providing broad coverage which is determined by the government; and a third pillar financed by out-of-pocket payments and voluntary supplementary insurance for care not covered under the first two pillars. Mandatory health insurance is the most important of these elements. The system is based on the concept of competition between private health insurers and between healthcare providers. Consumers have a free choice of health insurers, and these compete on price, service and choice of contracted providers. Through selective contracting, the health insurers are expected to promote efficiency and quality of care. Prices have been deregulated to a certain extent. Due to market failures in healthcare, there is a large degree of government regulation in both the insurance market and the market for healthcare provision. The system is performing reasonably well.
well, but faces the same challenges as other countries. There is some concern about concentration, which could be leading to increasing market power for insurance companies and hospitals.
Introduction

1 Introduction to the Dutch healthcare system

1.1 Overview

The Dutch healthcare system consists of three “pillars”.1 The first pillar involves tax-funded “government insurance” for long-term care (such as nursing homes, handicapped homes, long-term mental healthcare etc.).2 The second pillar is mandatory health insurance for all residents of the Netherlands. The coverage of this mandatory insurance is determined by the government and includes GP care, hospital care, pharmaceutical care, natal care, curative mental care, ambulance and patient-transport services and some paramedical care (e.g. physiotherapy for chronic diseases, speech therapy and occupational therapy). The third pillar is voluntary supplementary insurance, which can cover anything from spectacles to paramedical care that is not covered by mandatory insurance, to alternative medicine. A large percentage of the population purchases this supplementary insurance, although the percentage declined from 89% of the population in 2011 to 83.6% in 2018.3

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1This paragraph is slightly modified version of the description of the Dutch system provided in Mikkers, [5]
2Contracting with health care providers is delegated to a commissioner, typically the largest healthcare insurer in a region. Financial risks are borne by the government.
3Source: https://www.zorgprismapubliek.nl/producten/zorgverzekeringen/zorgverzekeringsmarkt/.
In this contribution, we will focus on the introduction of competition in mandatory insurance (the second pillar). This system was introduced by the Health Insurance Act (ZVW) and the Healthcare Market Regulation Act (WMG) in 2006.

### 1.2 Introduction of competition

The principal idea behind the Dutch system that was introduced in 2006 is that insurers compete for consumers while healthcare providers compete for contracts with health insurers.

The main characteristic of the Dutch model of managed competition is that consumers can exercise freedom of choice about which insurer they use. Consumers may switch to a rival insurer in order to get a better price for their insurance, better service, or better value in the provider network that they can access. The aim of this model is to align the commercial interests of insurers with consumers’ health and financial wellbeing, whereby insurers can gain

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by purchasing healthcare for consumers in the most cost-effective way (See Mikkers and Ryan [6]).

![Diagram](attachment:image.png)

**Figure 2:** The idea behind competition in healthcare markets

Based on Capps et al. [2], for consumers, we could describe health insurance as an option on a bundle of access rights to healthcare providers. Because consumers choose the insurance with the best network for them in the light of their specific needs, health insurers are incentivized to contract with the best network of healthcare providers.

Healthcare insurers are not obliged to contract with all healthcare providers: selective contracting is permitted. Selective contracting means that insurers may exclude inefficient or poor-quality providers from contracts and negotiate on all dimensions in the contract (e.g. price, quality, volume and type of services).

Prices in the Dutch hospital sector were liberalized gradually from 10% of hospital production in 2006 to over 30% in 2009. In 2012, the liberalized part was extended to all 70% of all hospital care.

Price liberalization was also introduced for pharmacies and physiotherapy, where insurers and providers negotiate prices. In 2012, an experiment with price liberalization in dental care was launched, but following public protests against perceived price increases, the experiment

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was dropped in 2013. Price regulation is still in force in most sectors, with the Dutch Healthcare Authority (NZa) setting (maximum) prices.

2 Regulation in the insurance market

Every resident of the Netherlands is legally required to purchase health insurance covering a standard package of benefits that is determined by the government. Although selective contracting is allowed, insurers are required to contract enough healthcare to meet the demand of their enrollees. This means that waiting lists are - in principal - not acceptable in the Dutch healthcare system. Insurers are also obliged to provide services to all consumers, regardless of their health status: acceptance is mandatory (open enrollment) and there can be no premium differentiation (community rating). To keep the healthcare system accessible for those on lower incomes, to prevent risk selection (or cream skimming) and to ensure a level playing field for insurers, the government has designed an ingenious financing and compensation scheme.

To ensure that the Dutch healthcare system remains accessible for those on lower incomes, roughly half of estimated expenses under the Health Insurance Act are collected by the government on the basis of an income-dependent premium. The other half of the estimated costs are funded through a nominal premium charged by the insurers to their enrollees. Low-income residents receive a ”care allowance” (subsidy) from the tax authorities so that they can purchase health insurance.

Figure 3 gives a simplified example of the financing streams. In this figure, Enrollee 1 is a ”healthy high-income” citizen and Enrollee 2 is a ”sick low-income” citizen.

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5The text of this paragraph is slightly modified from Mikkers [5].
6There are some areas with waiting lists, most notably in mental health care.
7See Van Kleef et al. [7] for a more elaborate description of the Dutch risk adjustment system.
3 Regulation in the healthcare providers market

As mentioned in paragraph 1.2, in many sectors the NZa determines maximum prices, with the hospital sector, pharmacy and physiotherapy being notable exceptions. Since hospital care absorbs by far the largest proportion of all expenses under the Health Insurance Act, we will focus on hospitals in this section.

Within the field of medical specialist care, various types of providers can be distinguished (number of institutions in brackets):

- university medical centres (or UMCs) (8)
- leading clinic hospitals that provide complex care and also have a role in training (26)
- other hospitals (mainly basic healthcare) (35)
- rehabilitation centres and other specialized hospitals (76)
- independent treatment centres that provide care in a limited number of disciplines (229)
Medical specialists are either contracted hospital employees or work within the hospital on a self-employed basis. In the UMCs, they are contracted employees, and the same applies in some specialist institutions. Over 50% of specialists are employed by hospitals. In general hospitals, self-employed specialists often join forces to form a medical specialist company, which makes agreements with the hospital regarding remuneration, the services to be provided, capacity and so on.

Since waiting lists are not acceptable (see paragraph 2) and hospital prices are liberalized, cream skimming by hospitals does not seem to occur frequently.

Hospitals in the Netherlands are financed by means of a DRG-style reimbursement model. This model was first introduced in 2005 following an earlier experiment in 2003-2004. DRG prices are calculated on the basis of historical costs. In 2012, the model was thoroughly revised with a reduction in the number of billable procedures. Another major change was introduced in 2015, when specialists’ fees, which until then had been regulated separately, were integrated into hospital rates, making hospital boards responsible for negotiating fees with their (self-employed) medical staff.

In addition to the DRG system, in the period between 2005 and 2012 a block grant system was in place for hospitals, capping every hospital’s revenue. This system was abolished completely in 2012. However, in response to rapidly rising expenditure in the previous years, the Ministry of Health introduced a further control instrument, which empowers the Minister of Health to cap the annual total of expenditure on hospitals and, in the event of hospital overspending, to charge hospitals for a percentage of their revenue. The annual budgets are determined as part of an administrative agreement between the Ministry of Health and the hospitals’ and insurers’ representative organizations.

We have seen a tendency among insurers to contract hospitals on the basis of revenue caps, covering both regulated and liberalized DRGs. Negotiating individual product prices has there-
fore lost its impact on total expenditure.

Price negotiations between hospitals and insurers have recently been criticized by the public and politicians alike, because 1) these prices are often not made public and 2) even though consumers are not informed in advance of the price of their treatment, that same price is used to calculate the mandatory deductibles that consumers are obliged to pay. This issue has not yet been resolved since it is feared by some that the mandatory publishing of all contract prices would interfere with competition.

4 Competitiveness of the Dutch insurance and hospital markets

Health insurance can be regarded as an option on a bundle of access rights relating to healthcare. The value of this bundle to a particular consumer depends on how much that consumer values the underlying network to which the insurance policy provides access. Most health plans are sold with a network of providers that covers all regions in the Netherlands. However, since travel times account for much of the variation when consumers choose a healthcare provider (see e.g. Varkevisser and Van der Geest [9]), we would argue that consumers are more likely to value networks that include providers close to their homes. We would therefore like to describe the concentration of the insurance market at a local level. Another reason for presenting concentration at a local level is that negotiations with healthcare providers (such as hospitals, general practitioners, physiotherapists, dentists etc.) also take place at this local level.

Figure 4 shows that most local insurance markets are fairly concentrated, with only one small area with an HHI below 2000.
There have been complaints from both the public and politicians that consumers cannot understand the differences between the health plans that are offered by health insurers. One possible reason for this is the large number of insurance plans available, in combination with spurious product differentiation. Consumers may therefore perceive the differences between health plans as much larger than they truly are. A recent report by the Authority for Consumers and Markets (ACM) and NZa showed that health insurer companies offer a substantial number of health plans that do not differ from each other, and sometimes the differences that do exist are made to appear more significant than they actually are [1]. It also found that 72% of consumers could have chosen a cheaper alternative health plan that is similar to the one that they actually chose. On average, these consumers could have saved 93 Euro by choosing the cheapest alternative. Given that the switching rate in the health insurance market is fairly low (around 6-8%) and, as described above, the potential switching gains are high, the authorities

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8In 2018, there were 55 health plans on the market that offer the mandatory insurance package.
have called for policies proposals that would reduce searching and switching costs, spurious product differentiation and other impediments that may prevent consumers from choosing the most cost-effective health insurance for them. If consumers do not (or are unable to) choose their health plans effectively, competition mechanisms in the health insurance market may be undermined.

In addition to a competitive health insurance market, it is also important to have enough competition in the providers market in order for the Dutch healthcare system to function properly. Focusing on hospitals, in Figure 5 shows the weighted average market share for each hospital. This figure shows that the Dutch hospital market is also concentrated, since a substantial proportion of hospitals have market shares above 50%. In hospital markets, where competition should create incentives for efficiency (See Gaynor & Town [4]), a high market concentration means that there may be less competitive pressure in the market. This may result in higher prices and/or lower quality.

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\[\text{Figure 5: Concentration in the Dutch insurance system}\]

\[\text{for each hospital, the hospital level market share is a weighted average of its zip code level market shares and are calculated using claim data from 2016. See Croes et al. (3) and Gaynor & Town (4) for a description of the method we used to calculate the weighted market shares, which is based on a structural model of hospital competition.}\]
Croes et al. ([3]) estimated the impact of competition on quality in the Dutch hospital sector, focusing on three diagnosis groups (cataract, adenoid and tonsils, bladder tumor) used by Dutch hospitals in the period 2008 to 2011. They reveal a negative relationship between market share and quality score for two of the three diagnosis groups studied, which implies that hospitals in competitive markets achieve better quality scores than those in concentrated markets. The authors therefore conclude that more competition is associated with higher quality scores.

5 Competition policy

As we explained in section 1, the Dutch healthcare system is based on the principles of competition. Both service providers and healthcare insurance providers are private organizations and, as such, subject to competition law. Supervision is exercised by the ACM. All mergers above certain thresholds involving healthcare institutions require (prior) approval from the ACM.\(^\text{10}\) Since 2015, a care-specific merger assessment has been applied by the NZa in relation to healthcare institutions, which means that a two-step approval for mergers is now in place. Between 2009 and 2015, the number of independent hospitals fell from 116 to 88.\(^\text{11}\) Mergers between hospitals are increasingly the subject of criticism from public and politicians, although the tendency towards increasing the scale of operations and reducing the number of hospitals actually began well before the implementation of the Health Insurance Act and the Health Care Market (Regulation) Act. The Health Insurance Act did trigger concentration in the insurance market.

In addition, the NZa is empowered to intervene in the case of significant market power for an individual care provider or an insurer. The NZa can instruct a hospital or insurer to provide more information about prices and products, unbundle activities and costs, enter a contract with

\(^{10}\)See Varkevisser and Schut [8] for more information about the thresholds.

another party on ‘reasonable’ conditions, calculate prices according to methods stipulated by the NZa and so on. These measures are seldom used, however, and have never been applied in the case of hospital care. Increasing concentration in the hospital market is problematic for insurers. The concept of the selective contracting is a prerequisite for competition to work effectively in healthcare. However, under the Health Insurance Act, insurers have to meet their legal obligation to contract sufficient care to provide sufficient quality and timely access for their enrollees. The absence of alternative providers will inevitably force insurers to contract with those that remain. In practice, nearly all hospitals are contracted, although some specialist services are contracted with providers who meet quality standards such as minimum volume standards and so on. In effect, the legally required provision of sufficient care to enrollees is acting as a barrier to strong competition between providers, and this is being reinforced further by concentration in the hospital market.

6 Discussion

The Dutch system is an interesting combination of solidarity and competition. Although the market outcomes seem reasonable12, there are worries about the market power of both insurers and providers (especially hospitals and GPs).

Due to market failures, competition in healthcare goes hand in hand with intensive regulation. Because of the close relationship between regulation and competition, it would seem logical to put in place a sector-specific competition policy. The Netherlands has sector-specific competition rules.

Although it is hard to compare countries, the Dutch system seems to face the same challenges as other countries. It needs to move towards value-based healthcare provision and less fragmented healthcare. In theory, the system is based on decentralized decision-making and

12 see e.g. Mikkers [5]
many experiments with different types of contracts between insurers and healthcare providers were supposed to emerge. In practice, we have only recently started to see experimentation with contracts.
References


